

The Royal Orthopaedic Hospital NHS Foundation
Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

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

Requires improvement



Medical care

Good



Surgery

Good



Critical care

Requires improvement



Services for children and young people

Good



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Orthopaedic Hospital NHS Foundation Trust is a small, specialist teaching hospital offering planned orthopaedic surgery with 135 beds. The trust provides services to the city of Birmingham with a population of around 1,073,045 and nationally from Cornwall to Scotland. Patient care is delivered by specialist teams and other clinical professionals who look after patients with bone and joint disorders. The trust provides services such as joint replacement, spinal work and bone tumour treatment, as well as orthopaedic and oncology treatment to children under 16.

The trust became a foundation trust in 2007 and there have been significant changes to the senior management team and board in the last 12 months, including a new chair and chief executive.

We carried out this comprehensive inspection because The Royal Orthopaedic Hospital NHS Foundation Trust was selected for inspection as an example of a specialist trust, to enable us to pilot a slightly modified inspection methodology. We carried out an announced inspection of The Royal Orthopaedic Hospital on 4 and 5 June 2014 and an unannounced visit on 24 June 2014. The Royal Orthopaedic Hospital is the trust's only location.

Overall, we rated this hospital as 'requires improvement'. We rated it 'good' for providing effective and caring services, but it required improvement for the services to be safe, responsive and well-led. We rated the core services of medical care, surgery and children and young people's services as 'good' and critical care and outpatient services as 'requires improvement'.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Staff followed good infection control practices. The hospital was clean and well maintained and infection control rates in the hospital were low.
- Patients' experiences of care were good and the NHS Friends and Family Test (FFT) results were higher than the national average for all areas. However, people attending for outpatient appointments rarely, if ever, saw the medical staff at their appointed time.
- The number of pressure ulcers, falls and catheter related infections was significantly lower than the England average. The hospital monitored harm-free care in all patient areas, except recently in HDU, and had taken action that was reducing these avoidable harms.
- Medicines were being safely stored and managed in the wards. However, in the outpatient department (OPD) there were concerns relating to the storage and stock control of controlled drugs, where legal requirements were not met.
- Incidents were reported but not all staff received feedback; nor were lessons learned widely shared across the services.
- The high dependency unit (HDU) did not have equipment available to support a deteriorating patient for up to 24 hours or until transfer to another provider's Intensive Care Unit (ICU) was arranged. The trust addressed this immediately and equipment was on site and available within 24 hours of the issue being escalated.
- Ward rounds in the HDU were not routinely undertaken by the on-call consultant anaesthetists at weekends. The trust took action within 24 hours of the information being escalated, although it was noted that senior managers had been aware of this for some time.
- Several senior posts were being covered by interim managers. Recruitment had been ongoing and we saw that external candidates had been appointed to several of the posts and were scheduled to start work in the near future.

We saw several areas of outstanding practice including:

- The Royal Orthopaedic Community Service provided services within a 24.5 mile radius of the hospital to support the early discharge of patients from hospital.

Summary of findings

- The trust had established patient pre-assessment clinics for surgery, which were available at the same time as their OPD appointment.
- Outreach clinics were held by the ortho-oncologists in Leeds, Sheffield, Manchester, Liverpool, Bristol and Cardiff to improve patient access and avoid patients and relatives or carers having to travel long distances.
- The trust provided pioneering treatments to patients with very complex orthopaedic conditions. Surgeons were using silver coated implants to reduce infection. Other treatments achieving outstanding outcomes for patients included the ITAP implant to attach prosthetic limbs and the use of motorised extendable implants for children and young people.
- Surgeons were using computer navigation based on importing CT/MRI scans to develop a 3D model to remove tumours of the pelvis to ensure maximum removal and clear margins to reduce incidence of reoccurrence from 25% to 10%.

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

Importantly, the trust must ensure:

- Medicines are managed at all times in line with legal requirements.
- Equipment is properly checked and maintained in accordance with electrical safety requirements.
- A chaperone policy is developed and chaperones made available to support patients' privacy and dignity.
- Confidential patient information and records are not left unsupervised in unrestricted public areas of the outpatients department.
- Appointments are organised for all clinics to reduce waiting times for patients and improve their experience in the outpatients department.
- Letters to GPs and other referring bodies are sent out within set timescales to ensure effective communication.

In addition the trust should ensure:

- Resuscitation equipment is checked in accordance with the trust's procedures and records of the checks are kept.
- There is managerial oversight of all outpatient department services to ensure the efficient and effective operation of the department and to ensure patients' experiences of care are improved.
- Discharge arrangements are improved to facilitate early identification and availability of beds for patients admitted on the day of surgery.
- The implementation of the Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote patients' involvement in their care.
- When the reception desk is closed, there is visible signage to direct patients and visitors from the main entrance to other departments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating

Good



Why have we given this rating?

Care and treatment in the medical services were based on published guidance and there was evidence that outcomes for patients were positive. Staffing levels had been set and were maintained by the use of bank and agency staff. Patients who deteriorated were cared for although there were concerns raised with the amount of medical support available out of hours. Patients we spoke with told us they had been treated with dignity, shown respect and had been well cared for by staff. We found that there was good local leadership and services were planned to meet the needs of patients and had reacted to busy periods. There was good multidisciplinary working however discharge and transfer arrangements were not fully effective. The environment and equipment were visibly clean and infection control practices were good.

Surgery

Good



A highly skilled, caring team provided a wide range of surgical services treating patients with complex orthopaedic conditions. Patient safety was promoted and protected by the use of risk assessments and incident reporting and there was local learning from incidents. The risks of infection were well controlled and monitored. Patients told us that they had been cared for by compassionate, friendly staff and were kept fully informed about all aspects of their care. Treatment outcomes were effective and the service participated in national audits and submitted to national data bases to benchmark their performance where possible. Patients were very likely to recommend the service to family and friends. There were patient access and flow issues throughout the patient journey which caused delays in discharge from the theatre recovery and high dependency unit to an identified vacant bed on the wards. We saw surgical wards were well led and supported by directorate managers and matrons. In theatres

Summary of findings

Critical care

Requires improvement



there had been long term use of interim managers however permanent staff recruitment had been undertaken and a new directorate manager had started in post.

Patients received safe care whilst in HDU and some risks to patients were assessed and subject to ongoing monitoring. There was an outreach team available to support staff on the wards and medical colleagues when patient MEWS scores triggered a response.

However, for patients with a deteriorating health condition that needed level 3 care in an intensive care unit, the equipment to support their care and transfer was not available or in place on the unit. We also found that some consultant anaesthetists were not carrying out ward rounds on Saturdays and Sundays despite patients being in the unit. The chief executive and director of nursing acted swiftly to address our immediate safety concerns. A transport ventilator, an agreed interim transfer policy and confirmation that consultants would carry out weekend ward rounds were all in place within 24 hours of us raising the matters.

The service was not working within accepted national guidelines and did not submit data to national studies. Some patient outcome data was collected however it was not benchmarked against other similar services.

Patients and relatives were complimentary about staff and felt they received respectful, compassionate care that preserved their dignity. They told us they were 'at the heart' of their care and treatment. Discharges from the unit were planned, but often delayed, as beds on the wards were not available.

The unit had experienced a lack of on-site senior nursing managerial support for an extended period of time. This had started to be addressed with a matron and deputy director of nursing providing cover for the two weeks prior to our visit.

Governance and risk matters were escalated but not addressed promptly.

Services for children and young people

Good



Children and young people received safe, compassionate and effective care from

Summary of findings

appropriately trained and competent staff. Care and treatment was based on national guidelines and directives and were monitored for quality and effectiveness.

Children and young people and their parents/carers were treated with dignity and respect. Parents and carers were satisfied with the care and treatment delivered to their children and told us they felt included and involved. Staff were positive about working in the family care division of the trust and felt supported and valued in their roles by line managers. Risks were managed at a local and trust level.

The children's ward was being refurbished and due to re-open in July 2014. The temporary ward for children and young people was cramped with limited facilities for them and their families and carers.

Outpatients and diagnostic imaging

Requires improvement



The service was safely managed, caring and effective however improvements were required to improve the responsiveness and leadership oversight of outpatient services.

Patients told us that the service was effective and responsive to their needs, but clinics very often ran late and on occasions patients had been required to rebook their appointment due to the overrun.

We found the outpatient department were not able to understand the extent of cancellations or overruns or respond appropriately. There was no single body able to take responsibility or a leadership role for the performance of outpatients or where data regarding access, flow and clinic efficiency could be shared, analysed and discussed as a single concern.

Requires improvement

The Royal Orthopaedic Hospital NHS Foundation Trust

Detailed findings

Services we looked at

Medical care; Surgery; Critical care; Services for children and young people; Outpatients

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Background to The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust is a small, specialist teaching hospital offering planned complex orthopaedic surgery. The trust became a foundation trust in 2007. The trust has 135 inpatient beds comprising seven adult wards and one ward for children which was being refurbished at the time of the inspection and was temporarily based on Ward 11.

The trust provides services to the city of Birmingham with a population of around 1,073,045 and employs around 900 staff across 40 departments of which 65% are full time and 35% are part time. The trust also provides specialist orthopaedic services nationally, delivered by specialist teams and other clinical professionals who look

Detailed findings

after patients with bone and joint disorders. The trust provides services such as joint replacement, spinal work and bone tumour treatment as well orthopaedic and oncology treatment to children under 16.

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE FRCP Consultant Physician, General and geriatric medicine

Head of Hospital Inspections: Siobhan Jordan Care Quality Commission

Inspection Manager: Sue Walker Care Quality Commission

The team of 28 included CQC inspectors and analysts and a variety of specialists: consultants in orthopaedic surgery for adults and children, anaesthetics and ortho-gerontology, executive director of nursing, NHS Chief Executive and board level manager, orthopaedic nurses, paediatric nurse, physiotherapist, occupational therapist, junior doctor and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection took place on 4 and 5 June 2014, with an unannounced visit on 24 June. Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. We held focus groups with a range of staff in the hospital, including doctors, nurses, physiotherapists, occupational therapists, administration

and clerical staff, porters, domestic staff and pharmacists. We also met with the trust's elected governor representatives and interviewed senior members of hospital staff.

We talked with patients and staff from various areas of the hospital, including the wards, theatre and outpatients department and support services. We observed how patients were being cared for and talked with carers and/or family members and reviewed treatment records of patients. We held a listening event on 3 June 2014 where patients and members of the public shared their views and experiences of the hospital.

We provided 'tell us about your care' comment cards in various waiting areas of the trust to gather patients' views on the care they received.

Facts and data about The Royal Orthopaedic Hospital NHS Foundation Trust

1. Context

- The trust provides services at one location – The Royal Orthopaedic Hospital in Northfield
- There are 135 beds across 8 wards, one is specifically for children
- Population: the trust treats patients from across the country, many of whom have been referred by other hospital consultants for second opinions or for treatment of complex or rare conditions
- Staff employed by the trust : 900 as at 31 March 2014
- Annual budget is £71 million 2012/13 and had surplus of £2.2 million

Detailed findings

- The trust provides services such as joint replacement, spinal work and bone tumour treatment as well orthopaedic and oncology treatment to children under 16.

2. Activity

- Inpatient admissions : 13,343 (2012-13)
- Outpatient attendances : 74,674 (2012-13)
- Deaths in hospital : 4 (2013/14)

3. Bed occupancy

- General and acute: 77.9% (October–December 2013). This is below the England average of 85.9%. It is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital when above 85%.
- Adult critical care: 100% January–March 2014, which is higher than England average 85.7%.

4. Intelligent Monitoring

- Safe: Risks = 0 , Elevated Risk = 0, Score = 0
- Effective: Risks = 1 , Elevated Risk = 0, Score = 1
- Caring: Risks = 0, Elevated Risk = 0, Score = 0
- Responsive: Risks = 0, Elevated Risk = 0, Score = 0
- Well led: Risks = 1, Elevated Risk = 0, Score = 1
- **Total:** Risks = 2 , Elevated Risk = 0, Score = 2

Risk: Patient Reported Outcome Measures (PROMs) (EQ-5D score): Knee Replacement (Primary)

Risk: Composite risk rating of ESR items relating to: Staff sickness rates (01/12/2012 – 30/11/2013)

Complex case mix needs to be considered at a specialist trust

5. Safe:

- No Never Events (serious harm that is largely preventable) were reported by the trust between December 2012 and January 2014
- There were 31 serious incidents reported between December 2012 and January 2014.
- There were 71 incidents on the National Reporting and Learning System (NRLS) between April 2013 and March 2014, in the following categories of harm:
 - Deaths 4
 - Severe harm 11
 - Moderate harm 56
 - Total 71

The trust also reported 235 low harm and 567 no harm incidents.

- For patients suffering from new pressure ulcers, the trust performed better than the England average for seven out of the 12 months (April 2013 to March 2014), including five months where the trust reported no new pressure ulcers. In May 2013 the trust performed 5.3% above the average for patients over 70
- For the number of patients suffering from new venous thromboembolism (VTEs or blood clots), the trust performed better than the England average for 11 out of the 12 months (April 2013 to March 2014), with no VTEs reported in these 11 months.
- For the number of patients suffering from catheter and new urinary tract infections (UTIs), the trust performed better than the England average for 11 out of the 12 months (April 2013 to March 2014), with no catheter and no new UTIs reported in these 11 months.
- For the number of patients suffering falls with harm, the trust performed better than the England average for 10 out of the 12 months (April 2013 to March 2014), with no falls with harm reported in these months. The trust performed 0.5% above the average in November 2013.

6. Effective:

- Hospital Standardised Mortality Ratios (HSMR): No evidence of risk (Intelligent Monitoring) March 2014
- Summary Hospital-level Mortality Indicator (SHMI): No evidence of risk (Intelligent Monitoring) March 2014

7. Caring:

- The CQC inpatient survey has 10 areas and nine apply to the trust: the trust performed better than other trusts in five areas (waiting to get a bed, hospital and ward, doctors, leaving hospital and overall experience) and the same as other trusts for the other four (waiting list and planned admission, nurses, care and treatment, and operations and procedures)
- The Friends Family Test (FFT) inpatient: Above the England average score at 86 with a response rate of 43.9%
- The Cancer patient experience survey has 64 questions: the trust performed better than the England average for 17 questions; average for 16 questions; below the average for 31 questions and was not rated worse than other trusts for any questions.

8. Responsive:

Detailed findings

- Cancelled operations: similar to expected.
- Delayed discharges: similar to expected.
- 18-week referral-to-treatment time (RTT): no evidence or risk.

9. Well-led:

- Staff survey 28 questions: the trust performed better than the England average for four questions; average for 10 questions; worse than England average for 14 questions.
- Sickness rate of 4.8% (April 2012–March 2013) which is just higher than the England average of 4.2%.

- General Medical Council (GMC) training survey: in trauma and orthopaedic surgery, the trust's performance was worse than expected for 'adequate experience', and better than expected for 'regional teaching'.

10. CQC inspection history

- Five inspections since registration in April 2010, December 2011, September 2012, December 2012 and June 2013.
- January 2014: The trust was found to be compliant on all the four outcomes inspected at this location.

Detailed findings

Our ratings for this hospital







Our ratings for this hospital are:

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

Notes

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

Medical care (including older people's care)

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

Information about the service

The medical care team inspected Ward 1 (spinal) and Ward 3 (oncology). We also inspected the rehabilitation services which included physiotherapy, hydrotherapy, occupational therapy and pain management. The therapies team had an established the Royal Orthopaedic Community Scheme (ROCS) outreach team which covered a 24.5 mile radius of the trust. The trust used West Heath Hospital beds for some patients requiring rehabilitation. We visited services in the Royal Orthopaedic Hospital over two days. We spoke with 25 patients, 51 members of staff, including medical, nursing, therapy and support staff, and reviewed 24 patient records.

Summary of findings

We found medical services were safe. The services learned from incidents but staff did not always get feedback on those they had reported. The services performed well in safety thermometer areas. Most of the staff we observed followed infection control guidance. Equipment and facilities were checked to ensure their safety. Medicines management was appropriate. Records were generally complete and up to date.

Staff were aware and trained to deal with consent, safeguarding, mental capacity and associated deprivation of liberty safeguards. Other than basic life support, mandatory training was complete. Patients who deteriorated were cared for appropriately. Staffing levels and skills mix were appropriately set. Staff knew what to do in the event of a major incident.

Medical services complied with best practice and national guidance. Pain relief was available but reviews by the pain team could be delayed at times. Patients had access to appropriate hydration and nutrition. Patient outcomes were positive, although they were not benchmarked. Staff were checked to ensure they were competent. There was good multidisciplinary team working. Seven-day services were partly in place.

Patients were happy with their care and their privacy and dignity were maintained. Patients were involved in their care and information was easy to understand. Emotional support was available to patients who wanted it.

Medical care (including older people's care)

The services planned to meet the needs of its patients and had reacted to busy periods. The flow of the services was not always responsive as the staffing capacity did not always meet the amount of patients. Discharge and transfer arrangements were not fully effective. Patients' individual needs could be met. Complaints were investigated.

There were clear visions and strategies for the services but not always an awareness of what they were. There was good governance and risk management, though the identified risks were not always up to date. There was good local leadership; however, awareness of trust leadership was variable. There was a good service culture locally. There was varied public and staff engagement.

Are medical care services safe?

Good



We found medical services were safe. Incidents were learned from across the services but some staff did not always get feedback on incidents they had reported. The services performed well in safety thermometer areas such as pressure ulcers, venous thromboembolism (VTEs or blood clots) and falls. Most of the staff we observed followed infection control guidance.

Equipment and facilities were mostly checked to ensure their safety. Medicines management was appropriate. The majority of records were complete and up to date. Staff were aware and trained in consent, safeguarding, mental capacity and associated deprivation of liberty safeguards. Other than basic life support, mandatory training was complete. Patients who deteriorated were cared for appropriately. Staffing levels and skills mix were set using an acuity tool. Staff knew what to do in the event of a major incident.

Incidents

- Between April 2013 and March 2014, 31 Serious Incidents occurred at the trust, 48% of which were on wards (15). 2 incidents were reported under medical specialties.
- Pressure ulcer grade 4 and grade 3 accounted for the majority of serious incidents (32% - 11 SIs).
- In inpatients, between April 2013 and March 2014 the trust submitted 11 severe harm patient safety alerts, 2 deaths, 30 moderate harm incidents including 22 pressure ulcers.
- Data for ward 3 showed that there had been seven incidents that month which included a trip, pressure ulcers and violence against staff. These had been discussed at the last ward meeting.
- Root cause analysis (RCA) had been carried out to ascertain the causes of an incident and any future learning.
- The majority of staff reported that incidents were fed back and learnt from across the wards and this was shown in the ward minutes. Some therapy and radiology staff reported not getting feedback on incidents.

Medical care (including older people's care)

- All staff were trained in reporting incidents including in using the online reporting system.
- There were emails/bulletins sent out when incidents had occurred to share learning such as confidentiality breaches.
- Senior nurses and senior clinicians were trained in how to investigate incidents and this learning was cascaded by seniors to lower grade nurses. However, some staff said they had not had any refresher training in conducting incident investigations for a number of years.
- Staff were able to give a range of examples of when incidents had been investigated and actions taken. One example was in hydrotherapy they had introduced a request for extra information in advance from patients as a patient was uncomfortable with therapy in a group setting. There had also been a change to the layout of a reception area after a theft had occurred.

Safety thermometer

The NHS Safety Thermometer measures, monitors and analyses patient harms and 'harm free' care. For this hospital, it showed:

- The trusts prevalence of falls with harm in all patients was better than the England average for 10 out of the 12 months (March 2013 – February 2014) with no falls with harm reported in under the safety thermometer in all those months although they were just above average in October and November 2013.
- There had been 19 falls in ward 3 last year and 25 in ward 1 with four reported in the last month.
- Ward 1 had developed a post fall flow chart and all falls were reported to the falls committee.
- Falls assessments were being completed both on admission and after mobilising after surgery.
- There were lots of methods in place to reduce the amount of falls including, providing non slip socks and reviewing patients' vision and medication.
- The results of fall investigations found patients had not followed guidance by staff such as using their frame or having support to mobilise.
- There were no new venous thromboembolisms (VTEs) with harm for 11 out of 12 months (March 2013 – February 2014) though they reported about the same as the England average in May 2013. VTE assessments in the oncology and histopathology directorate (which ward 3 was part of) and ward 1 averaged at 97%.
- The trusts prevalence of patients with a new VTE was better than the England average for 11 out of the 12 months (March 2013 – February 2014). All the patient records we saw showed that VTEs were fully assessed. However reassessment was mixed with around 50% of the records we saw showed evidence of a reassessment.
- The wards audited weekly whether they completed VTE risk assessments on discharge.
- The trusts prevalence of patients with a new pressure ulcer was better than the England average for seven out of the 12 months (March 2013 – February 2014) with none reported under the safety thermometer in five of those months. However the trust was worse than the average in April and May 2013 and January 2014.
- The trusts prevalence of patients over 70 with a new pressure ulcer was better than the England average for eight out of 12 months (March 2013 – February 2014).
- A trust wide action plan was in place to reduce avoidable grade three and two pressure ulcers and this was updated yearly. Actions included conducting patient harm meetings and RCAs for all pressure ulcer incidents, reporting incidents to directorates and link nurse meetings.
- The trusts prevalence of patients with a catheter who have a new urinary tract infection (UTI) was better than the England average for 11 out of the 12 months (March 2013 – February 2014) with none reported on the safety thermometer in each of those months. However they reported worse than the England average in March 2013.
- Patient records we reviewed showed that UTI assessments were in place for those that required catheter care. There was good catheter documentation.
- The clinical commissioning group (CCG) monitored the trust performance in reporting of dementia, VTE assessments and referral to treatment (RTT). We were informed by the CCG that submissions of reports were often late and a new process was due to be implemented to ensure there was robust validation and timely submission.
- All wards had their performance indicators displayed for the safety thermometer.

Cleanliness, infection control and hygiene

- The majority of people followed good infection control principles however we observed a number of staff not using hand gel entering and exiting wards and bays despite hand gel always being available.

Medical care (including older people's care)

- We witnessed good use of personal protective equipment (PPE) and staff complied with bare below the elbows guidance.
- In the last 12 months the trust reported no cases of meticillin -resistant staphylococcus aureus (MRSA), or C. difficile but one case of meticillin-sensitive staphylococcus aureus (MSSA).
- We found the wards and departments to be visibly clean and cleaning schedules were followed.
- There was a deep clean of equipment every week. All equipment we checked had cleaned stickers applied.
- All patient records we saw showed that patients were being checked for MRSA prior to admission.
- Side rooms were available to isolate patients with an infection. No patients required isolation at the time of the inspection.
- Infection control information leaflets were available for visitors reminding them to wash their hands and not attend if they were ill.
- Staff were very complimentary about the infection control team, comments included that they were 'proactive and dynamic'.

Environment and equipment

- Staff carried out regular checks on resuscitation equipment, fridges for storing medication, fire extinguishers and other environmental risks to ensure the equipment and environment was safe for use. However it was not clearly labelled to show when the equipment had been checked and needed a further check.
- The limited space available was uncluttered. Therapy staff felt space for them was at a premium particularly in providing therapy for those patients with complex needs. Physical space had been risk assessed.
- Staff told us the repair service when equipment failed was very quick.
- There had been a servicing audit in May 2014 for physiotherapy equipment and this showed that items identified for repair had been repaired promptly.
- There had been fires in two areas of the hospital, the most recent 18 months ago. We were told the damage had not been fully repaired due to building works already in progress underneath the area which would have been postponed if the fire damaged area was to be repaired first.

- Patients told us the hospital signage was helpful and had helped them locate the areas they needed to attend.
- Utility areas were clearly signed and locked.

Medicines

- The inpatient survey rated the trust better than average for discussion of medicine side effects.
- The local CCG had raised issues with medicines management within the trust such as accuracy and legibility of some records, staff and patient awareness of some medicines, patients discharged without the right medicines, medicines borrowed across services, a lack of separation between adult and child medicines and controlled drugs checks did not ensure best practice. However, we found that these issues were being addressed by the trust such as more legible prescription records, and patients being aware of medicines they were taking and staff were administering. This meant the services had improved their medicine management to a safer level than when the CCG had last checked the trust.
- There had been 25 medicine incidents last year in both ward 3 and ward 1. We saw that medicine errors had either formal or informal investigations depending on their severity with recommended actions depending on the outcome such as further staff training, meeting with the patient or disciplinary procedures.
- The pharmacists identified on an antimicrobial audit that locum doctors did not get an induction from pharmacy. Checks showed that although medicines prescribed by locums were appropriate the records did not meet the required standard.

Records

- We saw observation charts were being completed in patient's notes. A few notes were loose within the folders. Integrated care plans (ICPs) were complete including mobility assessments, health questionnaires, pregnancy check and allergies. The only record we saw not fully completed was a peripheral inserted central catheter (PICC) line for one patient.
- Patient records we reviewed showed that risk assessments were recorded such as weight, continence, skin integrity, mobility, malnutrition universal screening tool, manual handling, falls, fluids and cannulation.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient records showed that consent was being obtained and documented for procedures such as x-rays and joint registry. We observed verbal consent being obtained for care on the ward such as dressings. However occupational therapist (OT) consented electronically and was a tick box not a signature.
- Staff were aware of their responsibilities under the Mental Capacity Act. There were flags when patients had a diagnosis of dementia. Staff were aware of dementia screening. We saw an example of when a patient had the possibility of dementia was flagged after their operation and they were given appropriate support and information to take to their GP on discharge.
- There was no dementia screening for elective patients although plans were in place to do this.
- There were no DoLS applications but staff were trained and aware of this.
- There were support contacts for staff when patients presented challenging behaviour.
- 14 out of 22 staff records we checked had completed MCA and DoLS training.

Safeguarding

- The trust reported it had a lead safeguarding nurse who had dedicated time for the role.
- Safeguarding training numbers were reported monthly and formed part of performance indicators.
- Safeguarding compliance was reported annually to the Birmingham Safeguarding Adults Board (BSAB) and quarterly within the trust.
- Staff had attended a safeguarding awareness day.
- Safeguarding contacts were displayed and staff were aware of how to whistle blow.

Mandatory training

- In the oncology and histopathology directorate, the overall mandatory training completion rate was 84%. Induction training was 100% and in the spinal directorate (which ward 1 was part of) it was 80.5%.
- Records showed staff mandatory training rates in ward 3 were monitored and proactively managed. All mandatory training except VTE and insulin use was above the trust benchmark of 85%.
- In ward 1 the training rate was 100% other than BLS which was 66%. Staff told us BLS training was hard to access however additional sessions had been arranged to address the low rates.

- Staff felt they could access mandatory training although some junior doctors were unaware of what it was.
- Staff were complimentary about their induction training which included topics such as fire policy, infection control, information governance, equality and diversity, safeguarding and manual handling.

Assessing and responding to patient risk

- An escalation policy was in place for patients that scored (modified early warning score) MEWS of three or higher with bleeps to doctors if not urgent and HDU outreach if urgent. Both escalated up to more senior clinicians such as surgical registrars if there was no response within five minutes.
- Further observations were taken within an hour after a high MEWS score to assess if the intervention has worked.
- We were told it was difficult for nurses to get support from a doctor out of hours if there was a deteriorating patient as there was one doctor available to cover the wards. However, we found no records to show there had been a delay in a patient being seen by a doctor after a high MEWS score.
- Red flag guidelines were in place for those patients self-referring to physiotherapy. This ensured that when staff triaged patients, questions were asked to ensure the patient did not have an urgent or acute care need such as cauda equine.

Nursing staffing

- There were three nursing vacancies (though we were told two by the sister) in the oncology and histopathology directorate and one vacancy in spinal.
- An acuity tool was used to assess patient dependency and set staffing levels. Wards were able to staff to this level constantly.
- There was a high use of bank staff on ward 3 (20%). Staffing levels on the day we inspected was four trained nurses, two healthcare assistants (HCAs) during the day, three trained nurses and two HCAs in the evening and two trained nurses and two HCAs at night for 24 patients, a ratio of 1:6 patients to registered nurses during the day and 1:12 at night. These numbers were as per the acuity tool. However the staffing levels were funded for lower than this (three nurses and one HCA during the day, two nurses and two HCAs in the evening and two nurses and one HCA at night). Staff felt the numbers were too low and staff were working beyond their shift by up to two hours due to their workload.

Medical care (including older people's care)

- Ward 1 had a full staff complement however there was some use of bank staff to bridge the period of staff leaving and new staff starting in post. They had four nurses and two HCAs during weekdays, three nurses and two HCAs at weekends and two nurses and two HCAs at night for 24 patients, also a ratio of 1:6 during the day and 1:12 at night.
- We observed good handovers with pre-printed patient detail sheets. Confidential information was given only verbally. Patients were then checked and told about change of shift as part of handover. History, procedures, acuity and were all talked about.
- Tissue viability nursing support was available 7.30am to 4.30pm.

Medical and rehabilitation staffing

- The trust performed better than expected in the GMC training survey in relation to the overall workload of trainee doctors.
- Turnover was variable. It was 10.4% in the oncology and histopathology directorate and had been as low as 3.9%. In spinal services it was 16.3%.
- Staff in post was 50 in medical with a budget for 57.
- There were no medical vacancies in the oncology and histopathology directorate and staff felt they could always contact an oncology consultant when they needed one.
- There were some concerns raised by staff about the responsiveness of doctors to bleep calls at weekends and out of hours. There was one doctor available at weekends to cover all wards and see patients admitted at those times. Medical cover was supported by the HDU outreach team that operated during weekdays 7.45am – 6pm and Saturdays 8am to 4pm and the on-call senior anaesthetic and surgical colleagues. We saw no documentary evidence of a delay in patients receiving care from medical staff.
- There was an outreach cardiologist available to the trust from another local hospital.
- There were other specialist doctor support from other trusts but this was not formalised.
- Junior doctors felt there was a general lack of doctors on shift. Medical staffing was supported by a group of locum doctors who had been employed to cover doctor training posts that had been removed from the trust due to a national reduction in surgical training opportunities.

- There was some flexibility with therapy staff so if there were patients with complex needs or they required more hands on support, staff were made available. This was normally reactive as therapy staff were not made aware of patients in advance as they were non-elective patients. However they told us they could be more proactive if it was an elective patient who was due for hip or knee surgery.
- There were some vacancies in therapies and a business case had been submitted to increase staffing to match the increased surgical lists at the weekend. Agency staff were covering current vacancies.

Major incident awareness and training

- There was an understanding of how to respond to a fire but not an awareness of business continuity plans.
- There was an up to date major incident policy and staff were aware of how to access help in the event of a major incident.
- Staff were trained to evacuate the hydrotherapy pool in the event of an incident.

Are medical care services effective?

Good



Medical services complied with best practice and national guidance. Patients received adequate pain relief. The pain team was available but there could be a delay before patients could be reviewed. Patients had access to appropriate hydration and nutrition. Patient outcomes were positive although they were not benchmarked against other similar services. Staff were supported and their skills were regularly checked to ensure they were competent. There was good multi-disciplinary team working. Seven day services were partly in place.

Evidence-based care and treatment

- Most of the policies we reviewed were up to date and in use such as the deteriorating patient procedure, Standard Operating Procedure for Sarcoma patients and medicines management. It was clear they had been through a thorough process to ensure they were up to date with current practice with changes and who had reviewed the policy clearly documented.
- The standard operating procedure (SOP) for sarcoma included ensuring care met the appropriate guidance

Medical care (including older people's care)

including alerting GPs within 48 hours of a malignant diagnosis. They had a link with the sarcoma advisory group to ensure treatment being conducted was in line with current medical opinion.

- The cancer peer review stated the trust were compliant with improvement guidance.
- An external review by Deloitte had completed a quality assurance review of the cancer services which identified a number of areas of improvement. When this was followed up in January 2014 by Deloitte, actions had been taken for all the areas to improve.
- The services followed appropriate guidance such as NICE and the Royal College of Physicians and their own local policies and we were provided copies of these.
- Local policies followed appropriate guidance such as the epidural and blood transfusion policies. Where there was no UK guidance, the team used other guidance such as from Northern Ireland.
- There was not a full engagement and integration of the Enhanced Recovery Pathway.
- Link nurses for different specialities were available on each ward to ensure care followed local policies and national guidelines.
- Dietetics and nutrition services could not provide any evidence of how they were meeting good practice standards and that most of the service was provided by custom and practice through a service level agreement (SLA) from another hospital.
- There were no clear referral guidelines to nutritionists and dieticians though there were referral forms.
- The trust participated in all required national audits.

Pain relief

- Patients reported receiving pain relief when needed and their pain was controlled.
- There was a pain team available.
- We were told the pain team were often off site and patients could experience a wait of up to 24 hours for their pain control to be reviewed. On one day, we observed that only one member of the pain team was available for the whole trust and the following day, none of the pain team was available. However the anaesthetic team provided cover when the pain team were unavailable.
- There were programmes in place to reduce medicine reliance such as the functional restoration programme (FRP) to assist in managing pain.

Nutrition and hydration

- Patients we spoke with told us that they were happy with the food they received or replacements offered if requested. However there were no drinks available during therapy sessions which could last up to two hours.
- All patients had their nutritional needs assessed.
- We observed that drinks were within reach of patients.
- Protected meal times were in place and identified by staff wearing blue aprons during serving.

Patient outcomes

- All audits and patient outcome data we saw was positive though had not been benchmarked with similar services other than sarcoma.
- The functional restoration programme had conducted an audit which showed good patient outcomes. However this was not benchmarked.
- Physiotherapy were using the most recent clinical health outcome questionnaire (EQ5D) to review outcomes.
- Shockwave therapy had a 90% success rate for increased function and other commissioning for quality and innovation (CQUIN) measures.
- There was a heel pain audit in April 2014 which measured patient outcomes on foot function index (FFI) and EQ-5D taking into account patient characteristics and co morbidities such as age, body mass index (BMI), physical activity, duration of condition among others. Foot function scores showed a 40% improvement, quality of life scores had improved by an average of six points and pain reduced to an average of one out of ten. However this was not benchmarked against other heel pain treatment pathways in other trusts.
- A CQUIN was in place for avoidable grade two and three pressure ulcers in 2013/14. This showed that there had been five avoidable grade three pressure ulcers in that year although one was under review but there was a target of zero. For grade two pressure ulcers, there was a 20% reduction target from 2012/13 of 23 and there had been 18 in 2013/14.
- Patients were assessed after their pain management programme to judge the outcome of the treatment received. These included a hospital anxiety depression score (HAD) and SF36 health questionnaire.

Medical care (including older people's care)

- Pain management had a turnaround target of five days to send GP letters but were currently only achieving ten days at times. They also used the pain self-efficacy questionnaire (PSEQ) to review their outcomes.
- Hydrotherapy were due to trial 'measure yourself medical outcome profile' (MYMOP) to measure their outcomes but data had yet to be collected for this.
- Therapies had conducted patient satisfaction questionnaires on a yearly basis which identified the need for information in more languages, as well as more information overall such as patient satisfaction with treatment.
- The sarcoma team participated in a number of audits including communication with GPs, 2ww, production of Kaplan-Meier survival curves, complication rates; patient surveys of diagnosis and radiotherapy experience.
- They also participated in the Oncology QIDIS rehabilitation sarcoma report for 2012/13. These showed good comparative outcomes for patients against other similar services.
- Average length of stay for patients on most pathways was between six and seven days but there was a target of three days. We were told this was due to the lack of the integration of the enhanced recovery pathway (EHP) and the lack of the rehabilitation and surgical teams working together to ensure the surgical lists matched the availability of therapy staff particularly at weekends.
- Senior medical staff told us "The oncology service publishes more peer reviewed articles than the Birmingham Medical School".
- Local audits were not benchmarked against other similar programmes. We were told this was due to a lack of IT and research staff and facilities to be able to compare data.

Competent staff

- The NHS staff survey 2013 showed that the trust performed well in: Staff receiving health and safety and equality and diversity training and receiving appraisals within the last 12 months.
- However the NHS staff survey 2013 also showed that the trust did not perform well in job related training in the last 12 months.
- Appraisals and supervisions for staff were in place and up to date. Staff felt the process worked such as getting

training and preceptorship. Staff felt supported to conduct appraisals and although initially physiotherapists were providing appraisals for OTs, they were now being provided by the CNS.

- The 6 Cs (care, compassion, competence, communication, courage and commitment) were part of staff appraisal. However staff felt there was sometimes a lack of pushing personal development goals at times.
- We saw staff received specialist training to meet the needs of patients. Additional training had been provided to ensure patients were appropriately cared for example, therapies staff had received respiratory training and nurses had received training in dealing with knee and hip patients despite being on a mainly spinal ward.
- Staff told us there was no protected study time for nurses.
- We were told there had been concerns with the skills of some locum doctors. We saw the trust had taken steps to address staff concerns and improve the skills of locums through training.
- Staff had concerns that therapists did not have training to deal with spinal injuries however there were senior therapists available for support.
- The pain management team saw children above the age of 12 and were trained to deal with child patients but they did not designate themselves as a paediatric specialist team. Therefore they only took on children referred within the trust.
- Junior doctors said they had a good induction.

Multidisciplinary working

- Sarcoma patients had access to a multidisciplinary team (MDT) including orthopaedic surgeons, radiologists, histopathologists, oncologists, Macmillan nurses, physiotherapists, social workers, occupational therapists and counsellors. The team met on a weekly basis and cases were discussed that had been referred up to 2.00pm eight days prior.
- External MDT work was mainly with University Hospital Birmingham (UHB) for patients with sarcoma in head and neck, skin, upper GI, urology, breast, retroperitoneal, cardiothoracic and gynaecology.
- The Cancer peer review report rated multi-disciplinary working at 83% although the trust rated themselves at 100%.
- We saw and observed that there was good multi-disciplinary working that was effective and well

Medical care (including older people's care)

communicated between doctors, therapies and nurses. This included good multi-disciplinary work with sarcoma patients who were on a shared pathway with other trusts with good documentation and referral process between the trusts.

- However there were no formal links with community therapy services due to the amount of areas the trust discharged to although the therapy teams at the trust could be contacted if specialist support was required.
- Patients were provided with emotional support including psychiatric input if required.
- Staff felt there was a lack of dietetics and nutrition support as it was currently provided via a Service Level Agreement with another hospital at two sessions per week. However we found no evidence that patients were not seen and provided with nutritional support when needed.

Seven-day services

- Therapies staff were available seven days a week. There were 1.5 WTE physiotherapists working on Sundays and staff told us this wasn't sufficient to meet patient needs.
- On call consultant cover was provided out of hours and at weekends.
- There was six day working in radiology and an on call radiographer support out of hours and Sundays.
- MRI scanning was available seven days a week.
- Pharmacy support operated six days a week with on-call support on Sundays.

Are medical care services caring?

Good



Patients were happy with their care and their privacy and dignity was maintained. Patients were involved in their care and information was understandable. Emotional support was available to patients who wanted it.

Patient feedback was good and the FFT results were consistently better than the national average.

Compassionate care

- Patients on NHS Choices rated the trust as 3.5 out of 5 with particularly good comments on the service and the food. However there were negative comments on the care received from doctors.

- Friends and Family test (FFT) showed the trust was better than the national average in the last three months with scores between 80 and 88.
- Cancer patient experience survey results for inpatient stay showed they were better than average for 17 of 69 questions but worse than the average for 31 questions.
- An action plan had been completed for the cancer experience survey to improve information for patients, and the awareness and support for cancer specific staff.
- We observed and were told that patients received good care and feedback across the areas was positive. One patient told us that staff were friendly and had helped them when they needed support. Another patient said their care was "very good towards excellent."
- There was particular praise for the hip workshop. Comments included that staff were "very friendly" and "put you at ease" and "nothing is too much trouble".
- We observed good privacy and dignity with screens used to divide between patients.
- The inpatient surveys for the wards were above the national average.

Patient understanding and involvement

- Patients on NHS Choices gave poor comments on communication and written information.
- The inpatient survey rated the trust better than average for information prior to discharge, contact information for clinicians prior to discharge, views asked of patients about their care, prior discussion of dangers prior to discharge, patients given information on how to complain and information on care.
- Patients were involved in their care. They told us treatment options were explained to them and were understandable.
- Information was understandable and kept up to date. Most patients said they were aware of their discharge plans and were kept informed about appointments and admissions by text or phone call.
- Patients were allocated nurses and doctors and patients were aware who their named clinicians were. When there was a handover, the new staff were introduced. Each department we entered had the staff on shift displayed.
- Only one patient we spoke with was unhappy about the lack of communication they received but once we raised this with staff, the patient's concerns were dealt with.

Medical care (including older people's care)

Emotional support

- Macmillan nurses and outreach staff were available and were involved with patients that required them.
- Counsellors were available. Families were given support for staying overnight.
- The pain team used tuition DVDs and booklets to inform and help patients on self-management pain programmes. The team ensured they followed up patients on the programmes at six weeks and three months to check their progress and ensure they did not require any further support.
- Patients using the pain team service had access to one-to-one support with a member of the team by phone or in person on request.
- The guidelines staff had available for breaking bad news were out of date as they had last been reviewed in 2006.

Are medical care services responsive?

Requires improvement



The services planned to meet the needs of its patients and had reacted to busy periods. The services did not always manage the flow of patients as it did not always meet its national targets such as referral to treatment and average length of stay. Although actions were in place to improve these, they had not yet been implemented. Discharge and transfer arrangements were not always fully effective. Patients' individual needs could be met.

Service planning and delivery to meet the needs of local people

- The trust admits for five sarcoma pathway networks.
- There were 2021 spinal/back procedures of which 353 were decompressions/discectomies, 161 were fusions, and 1338 were injections.
- Oncology and histopathology and spinal directorates were below target with elective activity for the year. Spinal was also below target with non-elective work.
- Although Ward 1 was a spinal ward, it took the overflow from orthopaedic wards and staff were trained to deal with those patients' needs.
- Patients were screened prior to pain management and therapy programmes to ensure they would be suitable using assessment forms. If a pain management patient was considered inappropriate for their programme, they

could be referred directly to another programme within the trust such as FRP. Patients would have to go via their GP if they were more suitable for a programme the trust did not provide such as inpatient pain management.

- Pain management had outreach clinics in the wider local area so patients did not have to travel to the hospital for appointments.
- Physiotherapy appointments were available earlier and later in the day after feedback from patients.
- One patient told us that equipment was already in place for when they were discharged home.

Access and flow

- There was no evidence that delayed discharges were an issue for the trust. They were achieving targets for discharging patients.
- Bed occupancy averaged as 77.9% between October and December 2013, which is below the national average although this was on the increase compared to the previous six months. Ward 1s bed occupancy was 74% in April 2014.
- The trust was within or better than the national average for referral to treatment times for both admitted and non-admitted patients; cancer waits at both 62 and 31 days, and delays in transfers due to bed occupancy. However, the oncology and histopathology directorate waiting time for 62 days was averaged at 86.8% which was worse than the national average. Data for May 2014 showed the service had achieved 100% for the target.
- Sarcoma 62 day wait targets were met unless it was a shared pathway. The trust were due to review its process with other trusts where there were delays and implement a fast track consultant appointment process to reduce the waiting time.
- Average Length of Stay (ALOS) for the oncology and histopathology directorate averaged at 5.5 days for elective and 11 days for emergency. Bed occupancy was averaged at 86%.
- ALOS for spinal was 4.5 days for elective and 8 days for emergency patients. Bed occupancy averaged at 74%. However the target was three days and patients were informed they would stay in hospital for three days. The trust had begun to address this and was planning to implement the Enhanced Recovery Programme in addition to ensuring day case patients were listed earlier on surgical lists. There was also to be more investment in the ROCS team to support earlier discharges.

Medical care (including older people's care)

- Wait times to be admitted within 18 weeks averaged across all services at 89.9% for admitted and 73.9% for non-admitted which was worse than the national average.
- The discharge lounge was effective but workload was very variable. We visited the lounge at various times over the inspection and noted the numbers of patients waiting ranged from zero to six. Two nurses covered the unit from 08.30am to 4.30pm they confirmed that at times they had no patients although on some days they were discharging up to 15 patients.
- The nurses completed a checklist for each patient to ensure they were ready to be discharged and had their 'to take home' drugs (TTO), transport booked if required, appropriate clothing and documentation completed. Hot drinks, meals and reading material were available if patients had a long wait. Paediatric or oncology patients were not discharged through the lounge.
- We saw no record of bed transfers overnight in patient records. There were 38 admissions and transfers after 5.00pm, 14 on Saturdays and 10 on Sundays in 2013.
- If it was necessary, the Macmillan nurses could turnaround a package of care for a patient in four hours.

Meeting people's individual needs

- There was a dementia CQUIN strategy to ensure staff were trained in the assessment, screening, care and treatment of patients living with dementia.
- Dementia nurses were available and staff were aware of whom they were and the circumstances they could refer to them.
- Link nurses were available for different specialities including nutrition, dementia, medicines and infection control. These ensured each patient's individual needs could be met such as those patients with learning disabilities and staff were aware who they were and when to contact them.
- There were in-house CD/DVD's for patients to take home as part of pain management chronic programmes.
- Interpreters or a telephone translation service was available for patients that required them.
- The pain management team were developing a range of booklets and DVDs available which were available in other languages such as Urdu and Punjab. These were also available in a smart phone app that the service had found.

- There was no evidence of the use of picture cards for those patients staff could not communicate with. For example, for choosing meals.
- Patient information leaflets were available in all the wards and therapy areas. These included a leaflet on possible surgical infection risks and how they could reduce the risk of an infection.

Learning from complaints and concerns

- Spinal received 28 complaints, 192 PALS enquiries and 683 compliments in the last year which was within the average compared with other services at the trust. Ward 3's KPI showed they had no formal complaints last month, 10 PALS enquiries and 15 compliments. There were no complaints in the last year in pain management. These were both lower compared to the rest of the trust.
- Staff told us complaints were not always shared and learned from. We were told about an example of a complaint where the feedback was discussed with the individual staff member but not shared with the ward team.
- However we were also told of a complaint response where the action meant referrals were being picked up quicker in physiotherapy.

Are medical care services well-led?

Good



There were visions and strategies for the services but staff awareness of what they were was variable. There was good governance and risk management however risks were not always up to date and current. There was good local leadership however awareness of trust leadership was variable.

There was a good local service culture. There was varied public and staff engagement. Services were innovative and acknowledged issues with sustainability.

Vision and strategy for this service

- Pain management and therapies had clear visions and strategies about how they would improve the service. Pain management were looking at providing more programmes to encourage patients to self-manage their pain.

Medical care (including older people's care)

- Therapies were looking at investing in more advanced equipment and providing more non-surgical musculoskeletal management programmes.
- There was limited awareness of a vision for OTs but there was an action plan for the team including promoting the service, creating lead roles, identify pathways and review the training plan. Some OTs told us the trust was looking at continuing therapy support into the community.
- There was a lack of awareness on the wards of a vision for the services. Senior nursing staff were aware of the trust vision. The only vision a staff member on the wards was able to state was "to be the best".

Governance, risk management and quality measurement

- We reviewed several risk registers including those for the pain service and wards 1 and 3. We saw risks dating back to 2009 which were still categorised as new and had no end dates. More recent entries were dated and the action taken to mitigate the risk. Risks we identified during our inspection were recorded such as the high use of agency staff in ward 3 and not meeting key performance indicators such as referral to treatment times.
- The trust risk register included three items for spinal and two items for oncology. Spinal risks included drug errors, bed in corridors and reduced staffing on ward 1. Oncology risks included cancer waits and blood traceability on ward 3. These had been imported from the directorate risk registers.
- Staff were aware of governance procedures such as how falls went to patient harm meetings and the directorate level mortality meetings and there was a clear structure for how these fed up to the executive team. However, therapists fed back that they were not involved in governance meetings.
- Performance indicators, risks and governance issues were discussed in ward meetings.
- Staff were aware of how their wards were performing on safety thermometer performance indicators.
- Clinical leads, managers and matrons were aware of the risks in their services. For example, there was an awareness of the backlog in imaging and some outpatient waits which had been highlighted in directorate meetings.

Leadership of service

- The NHS staff survey 2013 showed areas that staff felt the trust did not perform well in included:

Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; Support from immediate managers; Fairness and effectiveness of incident reporting procedures; Staff recommendation of the trust as a place to work or receive treatment; Communication from senior managers; Equal opportunities. Bullying and harassment in oncology and spinal directorates were just above the national average as well.

- The trust had analysed the staff survey and broken the figures down to directorate level. There were action plans in place for both the spinal and oncology/histopathology directorates for each question where there was a poor result.
- Direct line management feedback from floor staff was very good with all staff reporting their directorate managers and leads were visible.
- The pain management team felt they were supported by the trust.
- There were regular newsletters from the executive team to update staff on trust wide matters.
- Visibility of the trust leadership was variable with some staff reporting they never saw them whereas others said they did see them and were aware of the ward walks they conducted.

Culture within the service

- The oncology and histopathology directorate sickness rate was 6%. Spinal directorate sickness was 3.3% and the Pain Team rate was 13%. We noted these rates were an improvement from a few months ago and staff told us there was active management of sickness levels.
- The sickness rate was 0.9% for ward 1 and 3% on ward 3.
- In the NHS staff survey 2013 areas that staff felt the trust did perform well in included:
 - Good team working;
 - No pressure to work when unwell;
 - Staff were motivated to work.
- There was good team working on the wards. All staff felt included and involved at a local level.
- Staff were aware of the newly appointed chairperson and some staff were aware the executive team did ward walks on a monthly basis but this awareness was not universal.

Medical care (including older people's care)

- Patient stories were fed back at ward level, both negative and positive, to raise staffs' awareness of the patient experience.







Public and staff engagement

- The FFT response rate was higher than the national average although varied between wards. Ward 1's response rate was 36.64% however ward 3's response rate was 63.64%. The overall response rate in the trust had recently dropped and a plan was in place to identify why this was the case.
- There were regular meetings in wards and departments. Minutes showed discussions included feedback from patients, audits, incidents, governance, complaints and ward/department and trust wide issues.
- Patients were aware of how to complain or compliment services.
- Local ward level engagement was good but there was a lack of awareness of trust level issues by allied health professionals – it was left to the service leads and there was a lack of feedback to them about issues.
- Staff told us that they felt empowered to challenge practice at a local level and were able to feedback any ideas they had to improve the services. Senior management said they were able to influence decisions at executive level due to the small size of the trust.

Innovation, improvement and sustainability

- The National Cancer Peer Review had concerns with the sustainability of the oncology service and lack of clinical trial accrual but praised its innovative working.
- There had been research and capacity improvements to therapies.
- Pharmacists were encouraged to specialise.
- The ROCS team enabled patients to be discharged home earlier and receive support in their own home. This team's model of working was being implemented by other trusts as it was seen as being innovative and was being further invested in by the trust.
- The pain management team were aware that their referrals were reducing. A business case to provide paediatric pain management programmes had been submitted to the executive team and showed there was a demand for such a service.
- The therapies team had ongoing research programmes in occupational therapy (OT), cognitive impairment, scoliosis and amputees. They were also aware of the need to be sustainable by focusing services to prevent/limit surgical interventions for patients as they were receiving an increase in referrals.
- There was a dedicated physiotherapist for research and development with three other members of therapies with research time.

Surgery

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

Information about the service

The trust has 112 beds for planned orthopaedic surgery. Patients with bone and joint disorders receive care from specialist teams, including surgeons, nurses, anaesthetists, physiotherapists, radiologists, pathologists, occupational therapists and other clinical professionals.

The trust provides a full range of orthopaedic procedures. Routine procedures such as hip resurfacing/replacement, knee replacement, shoulder, hand, foot, and arthroscopic surgery are performed. Specialist complex procedures are also carried out, including bone tumour and bone infection treatment. During 2012/13, 13,343 inpatients were treated at the hospital. The Royal Orthopaedic Hospital is a national centre for the treatment of bone tumours, treating more patients than any other centre in the UK.

The trust's bed occupancy rate for October to December 2013 was 77.9% and was lower than the England average of 85.9%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. The trust has not reported any breaches of single-sex accommodation.

During the inspection, we visited five wards, the day unit, the theatre suite, recovery ward and pre-admission ward. We spoke with 38 members of staff, 25 patients, 18 consultants, 11 junior doctors and five consultant anaesthetists. We met and spoke with the clinical lead for surgery and for anaesthetics. We spoke with the governance manager, head of pharmacy, the director and deputy director of nursing, the lead for dementia care and

for infection control. We looked at 10 sets of patients' medical records, observed staff handovers, and followed the patient pathway from the admission lounge to theatre and return to ward. We observed staff interaction with patients, relatives and between the multidisciplinary team. This included a focus group for theatre staff.

Surgery

Summary of findings

A highly skilled, dedicated and caring team provided a wide range of surgical services, treating patients with a range of complex orthopaedic conditions. The trust is a recognised tertiary centre that performs a high proportion of revision surgery. Primary joint replacements are performed on patients with secondary bone and metabolic conditions. The trust participates in national audits and submits to national data bases to benchmark their performance where possible. The use of the five steps to safer surgery safety checklist was embedded by the staff in all areas. We identified that not all equipment had received safety checks in theatres.

Patients told us that they had been cared for by compassionate, friendly staff. They praised the staff for their high standards of care and expressed that they had been treated with dignity, shown respect and were fully informed of their plan of care and potential discharge date. Ward staff were knowledgeable about their patients and showed enthusiasm for their speciality. Patient safety was promoted and protected by the use of risk assessments and incident reporting, although wider learning from incidents was not as practiced.

Care was planned to meet the needs of patient and translation services were available. The NHS Friends and Family Test (FFT) score was high. Elective patients were pre-assessed and admitted via an admission lounge. Discharge planning began on admission as part of the patient's pathway of care. A multidisciplinary approach involving a team of specialist staff supported patients' safe discharge.

Patient cancellation rates were thought to be high in a predominantly elective service. Patient access and flow issues within the hospital were of concern with patients being taken to theatre without a bed available for them in the wards. Patients were held within the recovery area until their bed was available causing a backlog.

Surgical wards were well-led by their ward managers, senior sisters and overall the matron for surgery. In theatres, leadership was less positive and morale was low. Past senior staff changes had led to interim staff taking charge, causing uncertainty and disruption to the

dedicated team. A new theatre directorate manager had taken up post at the time of our unannounced inspection and demonstrated an awareness of the need for stable senior leadership to support the staff, allow innovation and generally raise morale. Training for the nursing workforce was excellent in theatres and a good process was in place to follow up any non-attenders of training.

Surgery

Are surgery services safe?

Good



To promote safe care during their stay in hospital, patients were given a care pathway. Patients were pre-assessed to ensure they were suitable for surgery prior to their admission and their consent was sought. We saw that individual risk assessments were in place within the patient records. The records we looked at were legible and up to date.

The staff told us they were encouraged to report incidents and they did receive feedback. We found that the feedback was not widely distributed to encourage learning. Theatre department staff told us they did not report all incidents.

The trust used the 5 steps to safer surgical safety checklist in theatre and this was being audited to ensure individual and departmental adherence. We observed the checklist being widely used to promote patient safety.

We identified that radiology support was limited in theatre. Theatre lists were organised and then rescheduling occurred to accommodate more effective use of radiographer time. An integrated care pathway had been introduced but theatre staff thought it inflexible on occasions.

We found that sufficient, qualified staff with the appropriate skills were available to meet the needs of patients. To ensure patient safety, there were regular reviews of the nursing skill mix. Staff in theatres regularly worked additional hours to cover overruns and absences. It was noted that there was a high sickness/absence rate in theatre.

We found that servicing of equipment has not been undertaken within the required timescale.

Incidents

- Between April 2013 and March 2014, 31 serious incidents (those requiring investigation) occurred at the trust. Ward areas accounted for 48% of all incidents, operating theatres accounted for 23% of incidents – 15 of these were reported on the surgical wards and seven were reported in theatre.
- Pressure ulcers grade 4 and grade 3 accounted for the majority of serious incidents. Confidential information leak accounted for 10% of incidents.
- There were three serious incidents (SI's) reported in April. These related to a wrong dose of heparin through a Hickman line (a central venous catheter), a wrong side local anaesthetic, and a grade 3 pressure ulcer.
- Between April 2013 and March 2014, the trust submitted 11 patient safety alerts which were classified as severe harm.
- Between May 2013 and April 2014 surgical specialties had the highest number of incidents at 82.3% overall; 41 incidents (80.6%) were reported as moderate; nine severe and one death. The specialist nature of the trust has resulted in the high number of surgical incidents.
- There were 71 incidents reported by the trust to the National Reporting and Learning System (NRLS) between May 2013 and April 2014. An analysis of all death or severe harm incidents reported to the NRLS, against the number of incidents expected to occur at a trust, based on the number of bed days, did not indicate any potential under-reporting.
- Between May 2013 and April 2014, the trust submitted four patient safety reports which were reported as deaths. Three of the deaths were attributed to surgical specialties. Investigations had taken place for the incidents and an inquest into the cause of death was to take place for one case.
- The incidents were categorised into six areas, the majority falling under three categories – 30% were categorised as 'implementation of care and ongoing monitoring/review', 20% were categorised as 'medication' and 20% were categorised as 'patient accident'. Of the incidents categorised as 'implementation of care and ongoing monitoring/review', two related to patients developing pressure ulcers and one related to a patient who returned to hospital with chest pains after undergoing day surgery which should only have taken place once the patient had lost weight. Nine out of 10 of the incidents occurred in surgical specialties.
- The trust submitted 50 moderate harm incidents, 80% of which occurred in inpatient areas. The majority (56%) of incidents were categorised as 'implementation of care/pressure ulcers'. Route cause analysis of these incidents was completed. Of the 10 pressure ulcers noted, only one was avoidable; nine were unavoidable, acquired before going into hospital.

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- We saw that serious incidents were followed up with an action plan to address the issue and risks were identified and addressed on the wards.
- Mortality and morbidity meetings were held around every two months and senior clinical staff were invited to attend.
- Ward staff were unaware of the details and the findings of the mortality meetings but thought they were discussed at management level.

Safety thermometer

- There were no falls with harm for 10 out of the last 12 months (March 2013-February 2014).
- The trust's prevalence of falls with harm in all patients was better than the England average for 10 out of the 12 months.
- The trust's prevalence of falls with harm in patients over 70 was better than the England average every month in the reporting period.
- Reportable incidents for April 2014 categorised as (adult) inpatient falls, a total six incidents, all of which were deemed unavoidable.
- All reportable falls had been individually reviewed and were unwitnessed by staff members. Three falls occurred while giving patients' privacy in hospital toilets and bathrooms. The patients were noted as being in the post-operative period of their recovery and had been deemed safe for independent mobilisation using their recommended aid. Two falls were as a result of patients mobilising independently to visit the toilet. It is to be noted, these patients were actively rehabilitating post-surgery. One fall happened at the patient's bedside while attempting to stand independently.
- All six patients had full mental capacity. The analysis of the falls showed that five of the patients had a falls questionnaire completed at the time of reporting and documented appropriate risk assessments had also been completed.
- Overall there were no new venous thromboembolism (VTEs or blood clots) for 11 out of 12 months (March 2013-February 2014).
- The trust's prevalence of patients with a new VTE was better than the England average for 11 out of the 12 months (March 2013-February 2014).

- The trust's prevalence of patients with a new pressure ulcer was better than the England average for seven out of the 12 months (March 2013-February 2014). Audit demonstrated that there was a month-on-month reduction in avoidable pressure ulcers noted.
- The trust's prevalence of patients over 70 with a new pressure ulcer was better than the England average for eight out of 12 months (March 2013-February 2014).
- The trust's prevalence of patients with a catheter who have a new urinary tract infection (UTI) was better than the England average for 11 out of the 12 months (March 2013-February 2014).
- The trust's prevalence of patients with a catheter who have a new UTI was better than the England average every month in the reporting period; the use of silver-coated catheters was thought to be responsible for this.
- We saw the results of the Safety Thermometer recorded on each ward, displayed for staff and patients, and this data was submitted on a monthly basis.

Cleanliness, infection control and hygiene

- In the last 12 months the trust reported no cases of MRSA, MSSA or Clostridium difficile (C. difficile).
- MRSA screening took place for all planned admission and unplanned emergency patients.
- Trust policy stated that all emergency admissions must be screened for MRSA. A number of emergency admissions were identified in the monthly infection control audit as not having been screened on admission during April, although they were all isolated in side rooms on arrival.
- Compliance with key infection control trust policies was measured within nursing key performance indicators (KPIs) by the ward sister and collected on a monthly return to the matron. A traffic light system was used to score the data received from the wards.
- Within the large/small joints directorate sustained performance was noted across Wards 2, 10, and 12. Ward 10 had remained as an overall rating of green, with Wards 2 and 12 remaining amber in May, although continued improvement in metrics was noted. Key areas of required focus for the managers appeared to be safety checks and elevated sickness.
- Sustained performance was noted in the theatre directorate. Theatres 1, 5, 6, 8, 9, and 10, had no

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additional patient safety red indicators (other than the efficiency KPI). Theatres 2, 3, 4, and 7 showed two reds with training, workforce and safety highlighted as individual red indicators within different theatres.

- Hand-sanitising points were seen outside wards and departments and staff and relatives were observed using them before entering. Hand basins were stocked with soap and disposable towels and hand-washing guidance was displayed.
- We saw staff adhering to hand washing, hand gel, wearing protective clothing and the use of isolation rooms for infected patients. This was noted taking place in between patient care and at other times.
- 'Bare below the elbow' policy was adhered to.
- The 2014 infection control policy and procedure was available on the intranet. A paper copy of the policies was held on some wards. On Ward 2 the paper copy of the infection control policy was not the most up-to-date version as it was dated for review in September 2011. The hand hygiene paper policy was dated 2014.
- The trust set itself quality improvement priorities for 2013/14. One target was to reduce 30-day surgical site infection (SSI) rate from 1.9% to 1.5% for primary hips and 4.9% to 4.5% for primary knees. Evidence showed that this had been achieved with primary hips SSI recorded as 1.1% and primary knees SSI recorded as 2.3%.
- The trust was involved in research in the use of silver-coated implants which medical staff told us was reducing the incidence of post-operative infection.
- Decontamination of theatre equipment was off-site with a 24-hour turnaround; however, surgical trays could be fast-tracked. A purpose built on site decontamination unit was used for 'on loan' equipment and 're-wraps' if there was any damage to the outer wrappings of the trays. The staff in the unit were passionate about their work and understood how important their role was for good patient care. Their relationship with their off-site provider was supportive.

Environment and equipment

- The ward environment was well maintained. Wide, well lit corridors promoted patient transfer and safety.
- The operating theatre suite comprised of nine laminar flow theatres with one non-laminar.
- Staff told us pressure relieving equipment was available when required and we saw it in use on the wards, supporting patients comfort.

- We saw resuscitation equipment available on the wards; this was checked daily and part of the ward KPI's.
- Estates facilities issues were handled by the in house team of staff
- Larger maintenance issues were addressed off site. Articles were sent with a reference number to ensure equipment could be tracked.
- Any incident relating to equipment was logged and analysed.
- There was good support from companies supplying specialist equipment including that was required for meeting bariatric patients' needs.
- In ward areas records showed that the resuscitation equipment was checked daily. In theatre safety checks on some theatre equipment and anaesthetic equipment were not recorded as having been completed. We found that servicing of equipment has not been undertaken within the required timescale. For example the date sticker on equipment had expired. PAT testing was out of date by several months.

Medicines

- Ward based pharmacy technicians and dedicated pharmacists were responsible for checking patient medication and ward stock.
- Intravenous fluids were stored in locked cupboards.
- Drug chart issues and any queries were identified on a daily basis.
- Pharmacy operated Monday to Friday 9am – 5pm and Saturday 9am -2pm.
- Out of hour's medicine advice was available from on call pharmacy
- A senior onsite bleep holder carried the emergency drug cupboard key when out of hours support was required.
- The emergency cupboard was monitored by the pharmacy staff.
- The competency of qualified staff was measured prior to administering medication to patients on the ward.
- Staff were appropriately supported when involved in medicine incidents, this included writing a statement, supervised practice, reflection, mentor support, educational development and capability procedures.

Records

- Pre-operative assessments were completed for all patients.
- Each patient was risk assessed on admission for surgery.
- Care plans and care pathways were in place with individual risk assessments for each patient.

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- Post-operative care pathways ensured patients vital signs were monitored and reviewed.
- Effective pain control was seen as an essential part of patient early recovery. Pain management was part of the surgical pathway. Patients were given pre-physiotherapy pain relief and its effectiveness was monitored.
- VTE scores and care were audited on discharge and monitored through the KPI's.
- Patients with a high Waterlow score were monitored and supported with pressure relieving equipment and with regular movement.
- A blood transfusions link nurse was identified on each ward. They were responsible for ensuring staff competencies were monitored and the policy and procedure were adhered to.
- Spot checks were completed on care plans to audit their quality. This was recorded on the wards but ensured staff confidentially.
- We were told and saw records to confirm that documentation was an agenda item at each ward meeting. The ward sister audited five sets of notes a month. Trends were identified with the relevant link nurses.
- Bi-monthly documentation meetings were held by the clinical nurse tutor. Good practice was discussed and new documentation looked at prior to implementation.

5 steps to safer surgery

- Each patient's notes were reviewed post theatre as part of the audit process regarding the safety checklist.
- The safety checklist was examined for any omission in completion. The following check list areas were examined; no form evident in notes, sign in section incomplete, time out section incomplete, sign out section incomplete, omission of signatures present on the checklist. The data was broken down in this way to ascertain if there were any trends found in respect to completed checklists.
- 29 consultants scored 100% compliance with the safety check list. Two consultants achieved lower compliance rates however this affected a very small number of patients.
- The total number of checklists audited was 167. The total number of checklists that had one or more sections not fully completed and therefore considered non-compliant was two. The total number of checklists that met the 100% compliance criteria was 98.8%.

- The safety checklist was a Commissioning for Quality and Innovation (CQUIN) target for the trust. Good compliance was recorded with every form being checked in recovery. If a member of staff failed to take part, they were emailed by the theatre manager, and this was copied to the clinical leads. Audits demonstrated that there was consistent compliance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told that, at the stage of pre-admission, a patient's capacity to give their consent was considered and support from relatives and carers was sought should the need arise.
- Mini-mental tests were completed when required.
- Mandatory safeguarding training included Mental Capacity Act 2005 and its associated deprivation of liberty safeguards and staff attendance was monitored in each directorate.
- Some of the theatre staff had not been able to attend the update training due to covering for staff shortages.
- After the inspection the trust informed us that trust business and learning days (TBaLD) occurred on alternate months. These were designed to provide theatre staff with minimal operating days in which to complete mandatory training. We were also told that this approach had proven successful to support staff to meet mandatory training requirement.

Safeguarding

- Mandatory training was provided by the matron with safeguard lead responsibilities.
- Safeguard alerts and cases were reported to the Matron.
- Multidisciplinary team review meetings were held on the wards.
- Where patients were in vulnerable circumstances, they were supported by the hospital social worker.

Mandatory training

- Responsibility lay with ward sisters to ensure that staff were trained and attendance and appraisal rates were recorded.
- The February 2014 mandatory training records for large joint wards showed 24 out of 25 staff had completed mandatory training. Small joint ward's rate was 100%, spinal surgery 88.5% and theatres was 76.97%. Staff shortage in theatre had impacted on training time being allocated. The compliance level was set by the trust to be at a minimum 85%

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Assessing and responding to patient risk

- The pre-operative clinic was multidisciplinary led. This included nurses, therapists, medics and anaesthetists. A senior nurse, Band 8a, supported the service and team developments. Various investigations were carried out dependant on medical histories which may include electrocardiograms, blood tests, urine tests, height, weight and blood pressure. The results of the tests determine suitability for theatre.
- The modified early warning score (MEWS) was used to quickly determine the degree of illness of a patient. Monitoring the MEWS alerted staff to the deteriorating patient and the need for medical intervention.
- MEWS scores were audited by the outreach team. Outreach staff trained new staff about care of the deteriorating patient.
- Management of deteriorating patients was handled by the nurse in charge, outreach and on-call anaesthetist out of hours. Requests were sometimes delayed due to only one anaesthetist being available in the hospital; if necessary the on-call registrar was contacted.
- Ward-based senior house officers (SHOs) supported nursing staff, reviewed patients and completed investigation requests. Ward rounds were completed when and as required.
- The bone tumours multidisciplinary team met to review up to 80 cases a week. The results were audited using a data capture programme developed in-house. The unit regularly published research in peer-reviewed journals.

Nursing staffing

- 130 whole time equivalent (WTE) staff worked in the surgical, spinal and theatre directorate.
- The trust vacancy data for March 2014 showed that, across theatres, there were 35 WTE nursing/healthcare assistants' vacancies, and in the six adult wards, there were 22 WTE vacancies. Bank staff were used to fill vacant shifts and recruitment was ongoing.
- On the main wards, four qualified staff were on duty. One nurse was the allocated coordinator and three nurses, supported by two healthcare assistants, were responsible for the care of the patients in three ward areas.
- Advanced nurse practitioners supported some specialities, including upper and lower limb, arthroplasty, arthroscopy, oncology and spinal. They

supported their medical colleagues, nursing staff and patients. Nurse practitioners, specially trained in advanced health assessment, made clinical decisions to assist the medical team.

- Ward-based physiotherapists and occupational therapists supported the patients on the ward, assisted by up to four technicians.
- We observed a ward handover with the whole team. We also saw 'ward board' handover meetings between multidisciplinary team members. All the patients were discussed, including high-risk patients, potential issues and staffing levels.
- All new staff completed and signed a ward induction checklist.
- We saw agency staff having a ward tour prior to commencing their shift.

Surgical staffing

- Out-of-hours cover for weekend and night-time was an on-call system.
- There was one doctor at SHO level providing medical cover out of hours and at weekends. Concerns were raised about the escalation of identified medical issues for patients but we found no evidence that patient care was delayed.
- 24-hour consultant-led care was supported by the SHO initially with the registrar and anaesthetist on call out of hours.
- Ward rounds took place daily. Multidisciplinary meetings were arranged to plan patients' care and treatment.
- Consultants provided surgical cover six days per week and there was an on-call requirement out of hours and Sundays.
- The nurse in charge joined with the medical staff to complete the ward rounds.

Major incident awareness and training

- The senior bleep holders and matrons received major incident training. Two communication exercises occurred in the twelve months prior to inspection and a table top exercise was undertaken in March 2014.
- The major incident policy was stored in the bleep holder's folder.
- The major incident policy was available on the intranet dated April 2014. Unscheduled emergency procedures followed protocols within the 'Inter-hospital transfer of sick adult patient' policy.

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Are surgery services effective?

Good



Data supplied by the trust during the inspection demonstrated the outcomes for patients were good. Patients told us they had received compassionate care with good pain control. The trust was a recognised national leader in treating patients with complex orthopaedic problems. However we found the enhanced recovery programme had not been fully implemented.

All 25 of the patients we spoke with were positive about the care and treatment they had received. They praised the staff for their professionalism. Attendees at the listening events reported positive experiences at the trust.

Evidence-based care and treatment

- All care plans, reviewed by the clinical educator /lead nurse adhere to National Institute for Health and Care Excellence (NICE) guidelines, for example, VTEs, cannulas, blood transfusions.
- Between November 2013 and April 2014 primary total hip replacements length of stay was 7.3 days and total knee replacement was 6.9 days. Data from the Getting It Right First Time (GIRFT) Provider Profile Report and Dashboard of January 2014 showed that the average length of stay for hip replacements or revision was 5.69 days at the trust, below the national average of 6.15 days. The average length of stay for knee replacement or revision at the trust was reported as 6.36 days, slightly above the national average of 5.83 days.
- The trust was rated as 'low green' or 'low risk' for access to elective secondary care (diagnostics and treatment) from general practice. There were no areas where the trust was shown to be worse than others.
- The enhanced recovery programme had not been embedded.
- Trust policies and procedures were available on the trust's intranet and staff reported they could access them easily. Many of the policies were very lengthy and not clear to staff, for example, the incident reporting policy was around 150 pages.
- Standard operating procedures were available.
- Staff were encouraged to access NICE guidance online.

- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) review of the perioperative care of surgical patients recommendations were being adhered to. Patients scheduled for elective surgery were all seen and fully investigated in pre-assessment clinic.
- There was evidence of a wide range of audits carried out in the trust.

Pain relief

- Post-operative pain relief was considered within the pre-operative assessment.
- Qualified ward staff collected their patient from recovery, ensuring their pain was in control, a pain control care plan was in place and the pain score was monitored.
- Patients told us that their pain had been well-controlled while on the ward. We heard that staff responded quickly to any analgesia requests.
- Patient controlled analgesia was available and preferred by some surgeons.
- Pre-activity analgesia was given. Regular, slow-release analgesia, plus fast-acting analgesia were prescribed.
- Spinal analgesia was preferred by some consultants, although this did delay the patient becoming mobile.
- The ward pharmacist reviewed patient-administered analgesia.
- The dedicated pain team worked closely with the outreach team to review complex patients.
- A dedicated chronic pain nurse practitioner was available on site.

Nutrition and hydration

- Patients told us the meals ranged between 'good' and 'adequate'.
- We saw patients had drinks available and we were told staff continually asked if they needed to be refreshed.
- Care plans were put in place for patients 'at risk' of poor nutrition and fluid intake.
- Malnutrition universal screening tool (MUST) scores were completed and monitored.
- Dietician referrals were made when necessary.
- A food diary and supplements were commenced for patients requiring support.
- A red tray system was in place for patients requiring assistance.
- Daily menu choices were completed for all three meals.

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- Patients' hot meals were served from heated trolleys on the wards to ensure that meals were served at an acceptable temperature. There was a nutrition noticeboard available on the wards for patient advice.

Patient outcomes

- National Joint Registry data was collected.
- Hip fracture audit data showed no evidence of risk.
- The GIRFT report showed the trust performed 186 hip revisions and 121 knee revisions in 2011/12 and the reported outcomes were similar or better than the national average. They also performed 44 shoulder replacements and eight elbow replacements.
- All NHS patients having hip or knee replacements were invited to fill in Patient Reported Outcome Measures (PROMs) questionnaires, which the trust uses to measure their performance: Hip replacement - 96.3% of patients completed the questionnaire; and knee replacement - 100%.
- The trust participated in national audits such as PROMs for hip and knee replacement surgery. The overall knee replacement Oxford score in GIRFT identified 14.32% average health gain. The national average was 15%. The overall hip replacement Oxford score in GIRFT identified 19.02% average health gain. The national average was 20.09%.
- All National Joint Registry metrics for the trust scored within the national average.
- The trust noted in the GIRFT report that the total orthopaedic and spinal activity was 7,713 cases. For the majority of the metrics used to assess the performance of the orthopaedic activity, the trust was above the national average.
- We saw examples of outcome data across all specialities which contributed to national registries where they existed and the results were considered excellent by our specialists. The data was also used to benchmark the trust's performance against other specialist trusts.
- We noted patients having joint replacement surgery were asked to consent for their details to be released to the National Joint Registry to contribute to the annual report.
- Length of stay data was gathered by the discharge team. Patients were informed on admission of the length of time they were expected to be in hospital.
- A patient in the admissions unit told us they had been waiting since 7.30am until 2pm with no update as to what was happening.

- The average Anaesthetic Society of America (ASA) rating was 1.96 lower than the national average of 2.13. The ASA physical status classification system is a system for assessing the fitness of individual patients before surgery.
- The average Charlson Comorbidity Index score was 0.58 higher than the national average 0.46. This suggests that patients admitted to the Royal Orthopaedic Hospital were more complex than the national average or that the trust is in an area that caters to patients with more complex needs.
- Outcome data from the National Joint Registry showed results comparable to the national norm, with better than average rates for revisions at five years.

Bone Infection Unit

- The bone infection unit is a regional referral centre for the management of bone infection.
- The specialist bone infection unit provided multidisciplinary care.
- The trust told us that the number of joint replacements, and therefore subsequent revision arthroplasty, was increasing due to the aging population in the UK.
- We were told that deep infection of a prosthetic joint was rare and specialist advice and treatment was necessary. Surgeons told us they used an 'ice cream cone prosthesis' fixed with cement containing very high doses of antibiotics and reported a reduction in infection rates from 25% to 6%.
- Surgeons, as part of a research programme, were working with the prosthetic manufacturer to coat the very large metal implants with silver to reduce infection. They reported the infection rate had reduced from 10% to 5% for the 10-15 patients requiring this surgery each year.
- Orthopaedic surgeons with expertise in infection and limb reconstruction work with microbiologists to give effective care.
- Specialist nurses, including tissue viability and nutrition, also work with the team, aiding a patient's recovery.
- The Royal Orthopaedic Community Scheme (ROCS) is a team of specialist nurses, all of whom were independent prescribers and physiotherapists who supported patients in their home and facilitated earlier discharge from hospital.

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Competent staff

- Staff appraisals were recorded as Personal Development Reviews (PDR) which the ward sisters monitored. Staff were sent pre-PDR forms with the next meeting date.
- PDR rates were 95.9% in large joint wards, 100%, in small joint wards and 61.2% in theatres.
- Staff received supervision and the frequency was monitored. New staff had a preceptor for support and guidance for six to 12 months.
- Mentorship training was completed by qualified staff.
- Updates were available for all link nurses.
- The plaster technician team showed commitment, although we were told they were understaffed. They prided themselves on the education provided to staff around preventing the development of pressure sores for patients in a cast.

Equipment

- IT function was limited and did not work as one system in the trust. This caused delays in the transfer of data and patient information.

Multidisciplinary working

- We saw good examples of multidisciplinary team working across the adult surgical wards.
- Patient notes were multidisciplinary and there were records of regular team meetings.
- Dieticians and physiotherapists attended the ward and ward meetings. We were told that, when required, the radiologist would attend the ward multidisciplinary team meetings.

Seven-day services

- There was a consultant presence during operating hours six days a week, with on-call support on Sundays.
- Outreach services and the anaesthetic department were available in six days a week during core times to give advice. They supported staff to manage patients with complex needs. An on-call anaesthetist provided cover out of hours and on Sundays.
- The radiology department provided services six days a week with on-call support for out-of-hours requests. This was similar for pharmacy.
- Physiotherapy services were available seven days a week.

Are surgery services caring?

Good



Feedback from patients, relatives and reviewing the data provided by the trust, assured us that surgery was delivering a caring service.

The trust performed higher than the national average in the NHS FFT with a score of 86 overall for March 2014.

Throughout the inspection we witnessed compassionate and caring interactions from all staff groups. The trust's patient experience survey achieved good results, with patients and relatives leaving positive comments.

Compassionate care

- We heard from patients that they had been dealt with in a compassionate way. They praised the staff for their good communication skills and their friendly manner.
- The FFT score for the Royal Orthopaedic Hospital was 86 and the response rate was 43% for the month of March 2014. This was better than the national average score of 73 and 34% response rate.
- This score is in the top quartile nationally, and both the response rate and score met the CQUIN requirements. The response rate had shown a slight improvement from last month. Public and patient services staff attended the wards in person to remind staff of the importance of continuing to encourage responses.
- The proportion of respondents who stated that their discharge was delayed for more than four hours, due to waiting for medicine, to see a doctor or for an ambulance, was similar to expected.
- The ability for a trust to conduct safe and timely discharges is important for overall patient flow through the hospital. Patients need to be discharged when ready and any information and support provided to ensure the patient does not need to be readmitted into hospital. Within the Adult Inpatient Survey, there are two questions that refer to the process of discharge. The trust was similar to expected to other trusts for delay to discharges.
- Patients told us they had been treated with compassion. They told us that the call bells were answered in good time.
- One relative told us the care had been 'second to none' for their husband and themselves. They had received emotional and psychological support from the staff.

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- We observed staff interacting well with patients. Staff were seen taking time to talk to patients. Patients told us that they felt fully informed prior to being admitted and during their ward stay.

Patient understanding and involvement

- Patients were allocated a named nurse on each shift. We witnessed staff introducing themselves to patients and there was a bedside handover with patient involvement.
- Patients were very knowledgeable about their care and treatment and were involved in planning their care. We observed one patient being received on to the ward from theatre; staff were seen to be attentive and reassuring.
- Patients told us they were informed of their potential date of discharge and had been updated on a daily basis about their progress.
- The trust has performed better than other trusts for 17 of the 69 questions asked in the 2012/13 Cancer Patient Experience Survey. Associated with this, they have also performed worse than other trusts for 31 of the other questions asked in the survey.
- The Cancer Patient Experience Survey is designed to monitor national progress on cancer care. 152 acute hospital NHS trusts took part in the 2013/14 survey, which comprised a number of questions across 13 different cancer groups. Of the 64 questions for which the trust had a sufficient number of survey respondents on which to base findings, the Royal Orthopaedic Hospital NHS Foundation Trust was rated by patients as being in the bottom 20% of all trusts nationally for 31 of the 64 questions. These included 'poor information or understanding of treatment', 'no named person to contact or no contact details' and 'important questions remained unanswered'.

Emotional support

- Clinical nurse specialists were available to support patients.
- Arrangements were in place to refer patients for psychological support.
- Staff told us that mental health needs were monitored.

Are surgery services responsive?

Requires improvement



Surgery services were not always responsive to the needs of patients during their admission to hospital. An admissions lounge was used to process patients into the hospital, admission times were staggered, however the numbers of patients brought in led to overcrowding in the waiting room. Some patients experienced prolonged waits of up to four hours and told us the chairs were very uncomfortable.

The management of patient admissions and bed availability did not ensure patients were allocated a bed prior to surgery. Patients were allocated a bed from recovery. This system caused a backlog in recovery and was a source of concern for staff but had not been listed on the risk register.

The day unit had been open since August 2013 and had been responsive in reducing the waiting times for minor surgery. The staff used a 'task and finish' system to assess the flow of patients and the care provided.

Care was planned to meet the needs of the patient, translation services were available with written information in other languages available on request. The trust showed evidence of conducting safe patient discharges however there was evidence that discharges were not happening in time to ensure patients in recovery experienced a timely transfer out to the wards. Patients and relatives were involved in the multidisciplinary approach to ensure the safe, effective discharge of patients. There was a discharge coordinator available to coordinate complex discharges.

Service planning and delivery to meet the needs of local people

- The hospital provided a national specialist orthopaedic service and accepted referrals from across England in accordance with the NHS England commissioning contract.
- Other referrals were accepted by the trust from the rest of the UK, funded by other agreed contracts.
- The trust's published bed occupancy was reported as 77.9% between October and December 2013.
- The trust achieved all 18-week referral to treatment times (RTT) in quarter one and quarter two 2012/2013.

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However, it did breach the admitted 18-week RTT target for quarter three and declared a risk for quarter four. The backlog of patients waiting for over 18 weeks increased to 711 at the end of December 2013. The trust had a plan in place to return to compliance with the target for quarter one 2014/15.

- The radiology department had identified GP appointments each evening between 5pm and 6pm and took direct referrals.
- The hospital provides outreach clinics to patients needing follow-up appointments, having completed their inpatient treatment. We were told that the orthopaedic oncologists held clinics in Leeds, Sheffield, Manchester, Liverpool, Bristol and Cardiff to improve patient access and prevent patients and relatives/carers travelling long distances.
- There was no evidence of any single-sex compliance breaches.

Access and flow

- The bed manager oversaw the utilisation of beds. There was a bed management meeting daily at midday to ensure the availability of beds and staff across the trust.
- Patients were pre-assessed for their procedure in the outpatient department.
- Patients were admitted through the admissions lounge. Staff told us admissions were staggered and everyone on a morning theatre list reported on the day of admission between 6am and 7am. Patients on an afternoon list were brought in after 11am.
- The lounge comprised a small room to accommodate a patient waiting area and staff desks with a small clinical room attached that was used to admit patients and carry out the nursing risk assessments.
- As part of the ward admission process, the patient's expected date of discharge was discussed.
- Total orthopaedic and spinal activity reported in January 2014 (GIRFT) was 7,713. Information provided by the trust showed that there had been 333 patient cancellations on the day between November 2013 and May 2014.
- The majority of patients cancelled on the day were treated within the required 28 days.
- Theatre staff told us they had numerous verbal complaints from patients about the delay in getting taken to the ward as beds were not available.

- There was no clear referral process for the plaster technicians, which could lead to wasted journeys by staff around the hospital. A referral criterion was being developed.

Meeting people's individual needs

- Ward staff spoke confidently about their training and competency to deal with patients with complex needs.
- Translation services were available – we saw a contact number displayed on ward noticeboards.
- In the case of learning disability patients being treated at the hospital, the outpatient facilitator identified them in pre-assessment.
- Staff encouraged the use of a patient passport if available. The passport detailed the key information about the person and how they wished to be cared for.
- The trust agreed that carers can stay on site if necessary.
- Dementia screening took place for all patients over 70 years.
- Ward-based dementia champions had level 1 dementia training and they attend quarterly meetings.
- A 'This is me' passport was available to patients living with dementia. Dementia champions promoted the use of the trust communication booklet on all patients living with dementia admitted to the hospital.
- The patient-led assessments of the care environment (PLACE) scores exceeded the national average in all areas. The hospital scored 97% for cleanliness of the wards, fixtures and fittings, 93% for facilities, 89% for privacy, dignity and wellbeing and 92% for patients' food and hydration.
- Patient Opinion is an independent non-profit feedback platform for health services, which aims to facilitate honest and meaningful conversations between patients and providers. There were 68 comments on the trust's section of the Patient Opinion website, with some overlap with the comments on the NHS Choices website. Patients felt communication, empathy and organisation could be improved.
- The Royal Orthopaedic Hospital NHS Foundation Trust had one review on the NHS Choices website for the period January 2014 to February 2014. The negative comment related to a patient receiving insufficient information about care and treatment. The star ratings on the NHS Choices website give the Royal Orthopaedic Hospital a score of 3.5 out of 5.

Surgery

Learning from complaints and concerns

- The trust had 100 upheld complaints in 2012/13. This was a 59.7% increase from the 63 complaints upheld in 2011/12.
- In April 2014 one complaint was received in small joint directorate, three in large joint directorate, four in spinal and one in theatre.
- The complaints response rate was 75% which was below the KPI of 80%. The outstanding complaint was due to a prolonged delay providing feedback from a consultant; this was escalated within the directorate.
- Ten formal complaints were received, covering areas such as: clinical outcome; surgery cancelled twice on the day (within two weeks); nursing care/approach; orthotics service; poor service and delays; and approach of registrar.
- Every six months, the Ministry of Justice publishes a summary of Schedule 5 recommendations which have been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. There were no concerns for this trust highlighted in the Schedule 5 report.
- After the inspection the trust informed us that Quarter 4 data showed that the key performance indicators (KPI) for complaints responses were met at 80.4%.

Are surgery services well-led?

Good



At ward level we found motivated senior sisters leading dedicated, enthusiastic staff. They showed evidence of being well-led with high standards of professionalism. Staff morale was mostly high on the wards.

There was an interim theatre manager in post providing support to the nursing staff and making positive efforts to maintain a good working ethos. The staff team in theatre were also dedicated and enthusiastic. However their morale had been affected which was attributed to the pressures of overrunning lists and working additional hours to cover staff vacancies and Saturday lists. A new theatre directorate manager had commenced in post at the time of our unannounced inspection and showed an awareness of the issues and challenges in the department and willingness to provide leadership and support to the staff.

Vision and strategy for this service

- Staff told us the trust's vision was on the intranet and displayed on the ward.
- An updated strategy had been introduced within the surgical directorate but had not been fully implemented.
- Staff told us that the annual PDR outcomes had been set linking their relevance to the local strategy at that time.
- Staff told us that this had led to some confusion around the PDR review; it was felt that local discussion prior to its introduction would have been beneficial. This issue had yet to be resolved.
- There was some confusion over a 'new vision' being introduced without consultation and staff felt their input should have been considered.

Governance, risk management and quality measurement

- The trust participated in all of the clinical audits it was eligible to take part in.
- Risk registers were monitored in each area and action plans supported the risks in being reduced.
- Information boards were visible in patient areas containing governance data to inform patients, staff and visitors of the clinical audit results month on month. Action plans had been developed to support wards not achieving their targets.
- The trust's risk register did not include all identified risks highlighted by staff during the inspection. For example, patients who have recovered from surgery were waiting in the recovery area for long periods of time while a bed was identified and allocated for them on the ward.
- The risk register contained current staffing issues, clinical issues and estates concerns.
- There was evidence of theatre staff facilitating a theatre patient harm meeting and review of the theatre risk register.

Leadership of service

- The medical director oversaw the clinical leads and was seen to be proactive by the trust and consultant colleagues.
- The senior sisters and a matron were visible in the wards supporting staff, ensuring training and appraisals were completed and undertaking quality audits.
- Ward staff told us the director of nursing had visited the ward. They had shown an interest in the staff group, patient care and training needs.

Surgery

- The majority of staff we spoke with knew the chief executive but were less sure of who their directorate managers were.
- The trust performed better than expected in the General Medical Council (GMC) training survey in relation to the overall workload of trainee doctors, although we were told that the induction in theatre was inadequate.
- We were told by staff that out-of-hours support for ward staff and junior medical staff was insufficient for assured patient safety and monitoring post-surgery. Senior House officers supported junior colleagues with additional on-call support from surgical registrars and anaesthetists.
- A matron and directorate manager were responsible for the admissions and day case unit to provide senior leadership and support.

Culture within the service

- Staff sickness absence rates in surgery were; large joints 15.25%, small joints 0.52%, Spinal surgery 6.31%, and theatres, anaesthetics and critical care were 35.44%. These vacancies were being covered by bank staff and absence was being managed through the human resource department.
- Staff were encouraged to share good practice and support each other when things went wrong; although, this was isolated within the area and wider learning was not always shared.
- We heard of the 'family' that worked together to form the team of dedicated staff.
- Patients told us of the caring nature of staff.
- Staff were proud to work at the hospital.
- Staff told us they felt privileged to work at the hospital.
- We were told that learning from incidents and complaints was embedded in the wards.
- Staff told us they received feedback when they had reported an incident.
- Staff in theatres demonstrated awareness and learning from incidents, however, they shared with us that they did not always report incidents, and, when they did, they did not always receive feedback.
- The staff in theatre all came across as caring and passionate about their service. They felt privileged to work for a specialist unit providing world-class surgery.

- Observations in theatre showed good team working with clear communication and challenge.







Public and staff engagement

- Staff told us they felt they were not given time to cascade good practice due to limited protected learning time.
- The trust performance was tending towards worse than expected for four out of six of the NHS Staff Survey questions. All negative feedback had been drawn up on an action plan which had a designated lead and a specific monitoring method noted. Actions were to be met by November 2014.
- The trust performed better than expected in the GMC training survey in relation to the overall workload of trainee doctors.
- The theatre focus group was overall very positive. The staff loved their work and would recommend the hospital to family and friends.
- Band 2 healthcare assistants expressed a concern that there was no progression for theatre support workers, unlike on the wards. There was no National Vocational Qualification (NVQ) pathway.
- Staff felt well-supported but expressed concern about all the interim managers and felt they would like more stability. The chief executive and director of nursing had been to the department and recognised and discussed their concerns.

Innovation, improvement and sustainability

- We saw that certificates were awarded to recognise and celebrate achievements, for example 'Best ward of the month for KPIs' and highest audit scores.
- Staff told us there was friendly rivalry between wards to achieve high results in standards of care and quality, such as the amount of days without reporting acquired pressure ulcers or infections.
- We heard of many plans of systems which were 'going to be' introduced, 'shortly commenced' or 'planned for the future' with little insight in to best practice already embedded in speciality centres elsewhere in the country.
- The enhanced recovery programme was 'going to be' fully commenced in the near future when all those involved had agreed the protocols.

Critical care

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

Information about the service

The High Dependency Unit (HDU) is a purpose built facility. It is situated near the theatre suite and has the capacity to accommodate 12 patients but planned and delivered care for 10 patients.

We visited the unit over three days, and observed a discharge to one of the wards. We spoke to seven patients and four relatives about the service. We also spoke to 19 staff including medics, nursing staff and allied healthcare professionals, who worked in HDU.

To undertake this inspection we spoke to patients and families and staff within the unit. We analysed audit results and looked at documents relied upon for the running of the service.

The most patients being cared for in the unit during the inspection was eight.

Summary of findings

Patients received safe care whilst in HDU however the equipment to support the care and transfer of a patient with a deteriorating condition were not adequate.

The HDU did not have a ventilator available to support a patient who had deteriorated to level 3 for up to 24 hours and during the transfer to another provider. We also found that patient safety was compromised as ward rounds were not routinely being undertaken by some anaesthetic consultants on Saturdays and Sundays. The Trust acted swiftly to address our immediate safety concerns regarding the availability of a transport ventilator and ensure consultants carried out ward rounds at weekends. However senior managers in the Trust were aware of the issues and action could have been taken sooner.

The service was not working within accepted national guidelines such as NICE or Core Standards for Intensive Care Units. In addition to this, the HDU did not benchmark itself against other similar services. This made it difficult to compare the patient outcomes it did record with other services.

There was a multi-disciplinary team in place however ward rounds were carried out without the involvement of all disciplines. We found that patients received respectful, compassionate care in HDU. Patient's dignity was maintained and they felt at the centre of their care.

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Patients understood their rehabilitation plans well and their responsibility within it. Discharges from the unit were planned, but often delayed, as beds on the wards were not available.

We found that HDU has had a sustained period over the last year during which there had been a lack of nursing management and leadership. This had resulted in the staff team feeling demoralised however we found the staff were very supportive of each other. The trust had installed an interim matron to oversee HDU and, in addition, the Deputy Director of Nursing had assumed senior managerial oversight of the unit in the two weeks prior to our inspection. Governance and risk matters were escalated but not always addressed promptly.

Are critical care services safe?

Inadequate



Patients received safe care while in HDU, however, arrangements and equipment to support the care and transfer of a patient with a deteriorating condition were not adequate. The service did not have the ventilator equipment to support a patient who had deteriorated to level 3 for up to 24 hours and during the transfer to another provider. We also found that patient safety was compromised by ward rounds not routinely being undertaken by anaesthetic consultants every weekend.

There was a designated nurse in charge but the role was not supernumerary and at times included holding the hospital bleep to provide advice and support across the hospital. The band 6 nurses were undertaking roles in which they required protected time to fulfil and this was not available to them. Agency staff usage was high and combined with bank (overtime) staff numbers called into question the calculation of unit staffing establishment.

Other safety issues noted included an unlocked medicines cabinet and the use of two folders for checking the adult resuscitation trolley which caused confusion.

The trust acted swiftly to address our immediate safety concerns regarding the availability of a transport ventilator and the consultant weekend cover. However, as these had been ongoing issues which senior managers in the trust were aware of, action could have been taken sooner.

Incidents

- We spoke to staff about incident reporting, and all agreed that the culture within the trust was not one of blame. Staff were encouraged to complete incident forms and understood the information was used as a learning tool.
- Nursing and medical staff confirmed that they received feedback of the investigation when they completed an incident form.
- Documents supplied to us by the trust showed that, from January to April 2014, there were 41 incidents reported. These were categorised as 'red' being the most severe, of which there were six. We looked at the type and spoke to staff and senior trust staff about this. Some incidents related to administration of blood

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products, and we were told and saw how this was subsequently managed to remove this issue. We also saw that the two most recent 'red' categorised incidents related to band 6 nurses wanting support for an additional role they had taken on. Senior trust staff said that, in line with all incidents, they would be investigated and actions taken and shared.

- One member of staff told us of an incident which had taken place regarding a patient developing a pressure sore inside their plaster. Staff told us that the outcome actions were shared at handover, and unit meetings. Staff received support from the appropriate clinical nurse specialist and additional training. In addition to this, a policy document was updated to reflect the new practice to be used in future.
- Deaths that had occurred had been identified as within the normal expected ranges compared to other hospitals. Data was collected from April 2012 to January 2014.
- Records were maintained of the incidence of pressure ulcers. For the two most severe types there were no incidents between January and May 2014. For the less severe type (grade 2) there was one incident recorded in the same timeframe.

Safety thermometer

- The NHS Safety Thermometer looks at four areas of preventable harm that could occur to patients. These are: pressure ulcers; venous thromboembolism (blood clots in lower limbs); falls with harm; and urine infections following catheterisation.
- The trust maintained records of these occurrences and the information was often shared with visitors to wards and units by being on display. However, in the HDU, this information was not on display. One staff member we spoke with thought that it was but was unable to find it.
- We reviewed documents relating to the Safety Thermometer and found that the HDU did not record all the findings associated with it. However, the trust overall had results which indicated that there was a lower incidence of harm than the national average.

Cleanliness, infection control and hygiene

- The trust recorded MRSA and Clostridium difficile (C. difficile) incidents, we saw documents which stated that, from July 2013 to February 2014, there were zero incidences of either. In the same timeframe, there was one incidence of MSSA. The records were maintained for HDU, anaesthetics and theatres as a whole.

- We observed and saw documentary evidence of cleaning taking place within the unit. The HDU had dedicated cleaning staff. In addition, we observed that, when patients were transferred out of the unit, equipment such as monitors were cleaned by healthcare assistants on the unit.
- Each bed space had hand-wash facilities. Hand gel was available all around the unit and at entrances.
- We observed staff complied with 'bare below the elbows' in line with trust policy, washed their hands following each interaction and wore appropriate personal protective items such as gloves.
- The HDU had a dedicated infection prevention link nurse. The link nurse audited compliance with trust hand-washing policy. From January to March 2014, they recorded full compliance. However, there was no record of audits and the results for April and May 2014.

Environment and equipment

- The HDU was equipped to care for patients requiring level 2 interventions. There was an informal arrangement with a local NHS Trust to transfer patients whose condition deteriorated and needed additional mechanical support to breathe. The trust was a member of the Midlands Critical Care Network and worked to an area wide network policy for the transfer of patients. The HDU did not have a ventilator available to support those patients on-site and during the transfer process. We were told that 61 patients had been transferred in the previous 12 months. The trust made arrangements to have the equipment needed following our inspection.
- During the unannounced inspection we received further clarification regarding the patients who were transferred due to deterioration. While there were 61 transfers out of the hospital, three patients were transferred because they had deteriorated and required level 3 care in an Intensive Care Unit. This meant that these patients would have required mechanical assistance to breathe. The other transfers were because they needed specialist input such as coronary care.
- The lead clinician for HDU informed us that patients requiring ventilation were transferred to theatres and cared for by the anaesthetist, operating department practitioner and senior scrub nurse to facilitate the transfer. Patients were transported in an ambulance which had a ventilator on board.
- We raised our concerns about these arrangements with the chief executive and director of nursing. We received

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an action plan the following day which included details of the temporary loan of a transport ventilator to be on site from that day and a copy of the order form for the purchase of permanent ventilator equipment.

- The HDU was equipped with the equipment required to support patients to recovery. This included vital signs monitors and syringe drivers. Equipment had maintenance dates and had been PAT tested (portable appliance test).
- Staff confirmed that, when new equipment was purchased, they were offered and attended training. We saw documentary evidence of staff attending training.
- Staff were aware and concerned that some equipment was no longer to have spares available after December 2014. Senior staff within the unit were unaware of what actions had been taken to address this. However, we saw documents which had assessed the risk, and action plans were in place to replace this equipment prior to it becoming obsolete. The trust was undertaking a procurement process and provided evidence to show the equipment has been ordered.
- Key performance indicator (KPI) data for January – May 2014 showed that the resuscitation trolley had not been recorded as being checked daily 100% of the time. In February 2014, the unit recorded a result of 82% and they recorded one month of 100% compliance with the other months above 90%.
- The unit had both an adult and paediatric resuscitation trolley. We saw that the trolleys were checked to ensure they were fully stocked.

Medicines

- We found that most medicines were stored correctly within lockable cabinets. However, during our inspection we did find one cabinet unlocked. Staff agreed that it should have been locked at all times. We spoke to a senior member of the trust who told us this had been an issue on the unit and it was being addressed with spot checks.
- We observed and spoke with a pharmacist who attended each patient daily within HDU to ensure their medications were not contraindicated (that is, might be harmful to patient conditions).
- We observed nurses dispensing medicines to patients; we saw that all checks were completed to ensure it was the correct person receiving the correct medication at the correct time.

- We observed staff checking the controlled drugs; this was done by two qualified staff. We also saw that the checks had been done every day and signed by the checking staff.

Records

- The unit had both an adult and paediatric resuscitation trolley. We saw that the trolleys were checked to ensure they were fully stocked. However, we saw there were two folders in use for the adult resuscitation trolley which staff signed to prove that they had been checked. This led to confusion as to which was to be completed and resulted in gaps in the one attached to the trolley. This could have contributed to the audit results of less than 100% compliance rate.
- We looked at five sets of patient medical records. Some of the notes we reviewed were disorganised with some results missing. However, others we saw were completed in full, results were printed out and attached to the record for review by the doctors. Care pathway documentation was completed prior to the patient being moved out of HDU to ensure that ward staff were aware of the last observations, pain scores and risk assessments.
- Records of activity on the ward were not completed uniformly. Within the KPIs we noted that the safety dashboard information was not recorded in full. Records were maintained regarding successful catheter insertion, but no record of occurrence, or not, of urinary tract infection following catheter insertion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that staff had undertaken training which included the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards. Staff told us they were up to date with this training.
- Records seen confirmed that the majority of staff had completed this training as e-learning modules.

Safeguarding

- Within HDU two staff has been identified as leads for safeguarding, one for adults and one for children. We noted in documentation supplied by the trust that the lead for children had not completed their mandatory training. We did not have the detail to ascertain if it was the safeguarding children element. The analysis was undertaken by the trust in April 2014.

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- The adult safeguarding training rate was 96% with one more person booked on the next course.

Mandatory training

- We saw documents which showed that nursing staff attended mandatory training, maintaining an attendance rate of more than 90% for this year up to May 2014. Documents provided by the trust showed that the medical staff rate for mandatory training was 74%.
- Nursing staff told us they were able to access their mandatory training and continuing professional development.
- At the time of the inspection, the HDU did not have a dedicated senior nurse responsible for nurse education. We were told that this role had been filled and the post-holder was due to start at the end of June 2014.

Assessing and responding to patient risk

- When patients deteriorated to such a level that they required the support from a critical care unit, for ventilation for example, they needed to be transferred to another hospital. We saw documents which showed that in 2013, 61 patients had to be transferred to another hospital for a range of reasons, for example, skin rashes, persistent nose bleed needing an ear, nose and throat (ENT) referral to a cardiac event needing cardiology review. The 61 transfers included three patients requiring level 3 care/ventilation.
- Patients were transferred to local hospitals when they had deteriorated but this was as an informal agreement. We were told there had been a preliminary meeting with another local NHS provider to set up a service level agreement to care for deteriorating patients. However the trust provided assurance that it was a member of the Midlands Critical Care Network and worked to an area wide network policy to transfer patients who required level 3 critical care.
- A clinically agreed 'interim management and transfer of level 3 patients policy' was ratified by the trust executive team and confirmed by the chief executive prior to our unannounced inspection visit.
- We saw documentation which demonstrated that staff had attended training to recognise deteriorating patients training.
- HDU staff completed the modified early warning score (MEWS) documentation which assisted them to identify deteriorating patients and take appropriate action.

- We saw that the unit was organised so that the number of nursing staff allowed for the close monitoring that patients required with each nurse looking after either one or two patients' dependant on the patient need.
- Medical support was available and staff said that, when a doctor was not on the unit, they had no problems accessing the support from a Consultant. When the consultant was not on the unit a registrar was assigned to the unit and could always be contacted to attend in a timely manner. This meant that medical cover was available at consultant or registrar level 24 hours a day.
- Critical outreach was available; this team was made up of both medical and nursing staff who reviewed patients within 24 hours of discharge from the unit. If a patient deteriorated on the ward the critical outreach team were contacted to support and stabilise the patient.
- There was no written protocol or policy in place to support staff in actions to take in the event of a patient having a massive haemorrhage. Medical staff we spoke with confirmed this was the case. It was usual for trusts to have this in place so that staff had clear guidelines to act in this event.

Nursing staffing

- Staff were able to describe what level of support each person required. They were able to assess patients' needs and identify the number of staff they required. During our inspection, nurses were allocated one or two patients dependant on the patients level of need. Patients judged at level 2 had either one nurse or shared a nurse with one other patient of the same level. This was in line with the core standards for intensive care units.
- During our inspection band six registered nurses were in charge of the unit. A matron from another area was providing interim senior nurse support which had been put in place two weeks prior to our inspection. The Deputy Director of Nursing also had a responsibility for the unit however neither role enabled them to be based on the unit. This meant there were no supernumerary nurses on any shift on the unit as the identified lead nurse for each shift pattern was allocated patients and part of the shift numbers. This was not in line with the core standards for intensive care units.
- The band six staff were the bleep holders for the hospital as a minimum five nights a week. This was a

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hospital wide role and could require the bleep holder to leave the unit. The additional role further compromised staffing levels. We were told that it was planned to make the bleep holder role supernumerary from August 2014.

- Senior hospital staff and band 6 nurses we spoke with told us HDU would have its full complement of staff by the end of July 2014. The deputy director of nursing told us a workforce review had been completed and they still needed to increase the numbers of nursing staff at the weekends. Documents provided by the trust up to February 2014 demonstrated that they still had nine nursing vacancies, but this included anaesthetics and theatres.
- To achieve adequate staffing numbers in HDU, both bank and agency staff had been used. We looked at the breakdown of staffing requirements for February and March 2014. For the 84 available nursing shifts in February, 36% of them required bank staff and 30% required agency to meet the needs of the patients. For the 98 available nursing shifts in March 47% of them required bank staff and 31% required agency to meet the needs of the patients. The staff told us that they tried to use agency staff that were familiar with the unit.
- We saw that bank and agency staff completed an induction on arrival to their first shift on HDU.
- We observed the handover of a patient from HDU to Ward 2. It was very comprehensive, using the records which had been in use on the unit. The handover took place at the nurse's station as apposed at the patient's bed.
- We did not observe the handover process on HDU, but staff told us when shift changes occurred, staff handed each patients care over to the new nurse responsible for their care.

Medical staffing

- We saw rotas for the medical consultant cover out of hours. Both medical and nursing staff confirmed and raised their concerns about the lack of anaesthetic consultant cover. We were told that, when some consultants were covering HDU at the weekends, they did not come in to review patients at all. They were available to the registrar for telephone support. This practice potentially compromised patient safety and went against the advice within the core standards for intensive care units. We informed the trust of our

findings and we received confirmation from the trust immediate action had been taken to ensure that consultant anaesthetists conducted ward rounds in HDU on both Saturday and Sundays.

- We observed ward rounds which took place daily with the consultant anaesthetist and registrar, but not always with nursing staff. We observed treating consultants reviewing their patients; these took place sometimes with nursing staff but not in every event.
- Consultants told us they would write care instructions in the notes and share information with nurses before leaving the unit. This was not in line with the trust standard operating policy for HDU which required nursing staff, the nurse in charge and a member of the critical outreach team to be present.

Major incident awareness and training

- Bleep holders on HDU had training to address major incidents such as fire safety management. This was a trust wide role to coordinate fire alarm responses.
- The trust had produced a major incident plan, which had been authorised in April 2014. The HDU lead nurse had a specified role to comply with, which involved leading the team and disseminating information about the incident.

Are critical care services effective?

Requires improvement



We found that the HDU service was not as effective as it should be. The service did not use nationally recognised guidelines for adult care, and had not monitored patient outcomes specific to HDU. This made it difficult for the service to measure its effectiveness. The service did not benchmark itself against similar providers to compare outcomes.

The HDU service had a multidisciplinary team in place but missed the opportunity to work together to effectively communicate patients' needs during ward rounds.

Evidence-based care and treatment

- Senior staff we spoke with told us they did not work to nationally recognised guidelines such as NICE or core standards for intensive care units for adult patients. Staff on the unit felt that they were a niche service so not all

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the standards applied to them. However, for the paediatric part of the service, we saw that the trust worked with a local provider to identify guidelines of best practice with a view to implementing them.

- Senior staff told us they did not benchmark themselves currently with other providers that offered a similar service, but that was something they wanted to do in future.
- We saw that policies and procedures were available to staff via the intranet. We were given the printed version on the unit of the standard operating policy for high dependency. However, this particular policy dated 2012 had a number of areas in which the unit was not compliant. This included the supernumerary nurses on shift and professionals present on ward rounds. The standard operating procedure was referenced to and completed in line with Comprehensive critical care: a review of adult critical care services (Department of Health, 2000).
- HDU staff took part in local audit activities to monitor their effectiveness. We saw that nursing staff completed a monthly tracker that included patient incidents and medical staff monitored the number of readmissions and patient transfers to other providers. We saw that meetings took place to discuss the audit outcomes on a regular basis.

Pain relief

- Most of the patients we spoke with confirmed their pain was well-controlled. Those with patient controlled analgesia syringe drivers told us they felt in control. Others told us they could call nurses who responded well.
- One patient said they felt their pain was not well-controlled. We informed the nurse who was responsible for their care who immediately got a doctor to see the patient who explained what they could do for them.
- Pharmacists reviewed the patient's pain relief daily to ensure there were no unwanted drug interactions and to ensure that pain medication was appropriate and available on the unit.

Nutrition and hydration

- We saw patients in HDU being given meals and offered drinks at regular times. One patient we spoke with who needed to remain at 45 degrees told us that staff supported them to drink by offering drinks with straws, or with cups with lids.

- We spoke to staff who said they had regular times to offer drinks and patients could ask in between times. We saw that patients who could drink had cold drinks available next to them.

Patient outcomes

- The HDU did not take part in the Intensive Care National Audit & Research Centre (ICNARC) data collection. They felt it was not reflective of the work they undertook as a specialist hospital.
- The trust participated in national audits for which they were eligible such as the pain database and the national joint registry.

Competent staff

- Band 6 nurses told us they had undertaken additional training to work in HDU, having completed an HDU module.
- Records provided by the trust showed staff completed HDU competency-based training while working in the unit and held post-graduate qualifications in HDU care.
- Band 6 nurses mentored staff of a lower grade. This role included supporting lower grade staff with identified professional development needs. Senior trust staff told us that band 6 staff had protected time to complete this role. Staff told us this did not happen and they had to complete this role while still being responsible for patient care. Staff in mentoring roles told us they were unable to meet regularly with their mentees to assess if they are meeting their training targets. The supervision was done in conjunction with appraisal meetings twice a year.
- Staff received appraisals from more senior staff. This allowed them to discuss their current work and plan for professional development needs. One member of staff told us that they were extremely well-supported by managers and colleagues.
- Documents we received gave conflicting information about the completion rates of appraisals. KPI recordings for HDU in February 2014 indicated 90% of staff had received an appraisal. However, for the same timeframe, other documents received from the trust indicated a 52% completion rate.
- Both medical and nursing staff told us they had opportunities to access the additional training they required to maintain their professional registrations. However, two nurses told us they would have liked more opportunity to undertake courses in the latest orthopaedic techniques.

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- Nursing staff told us they had completed the HDU module post-graduation and felt able to care for the level 1 and 2 patients they had within the unit.
- Also medical staff we spoke to felt able to care for the patients. The clinical director had made contact with a local provider to arrange for 15 consultant anaesthetists to undertake a period of preceptorship training and experience to improve their knowledge and skills.

Multidisciplinary working

- We saw that multidisciplinary team working took place within HDU. We observed physiotherapists and pharmacists on the unit working with patients to support their rehabilitation. We spoke to both of the allied health professionals who confirmed that they did not take part in ward rounds.
- They reviewed the records for each patient and, following their intervention, they would report their updates to the nurse responsible for that patient's needs. If pharmacists were concerned about medications and thought that adjustments were required, they would interact with the consultant anaesthetist. The physiotherapist, in addition to informing nursing staff of their treatment plan, would also write in the patient's notes.
- HDU did not have any service level agreements with other providers. The agreements with other providers were informal. However, during the inspection, we were made aware that a meeting had taken place with another provider to formally accept level 3 patients.
- The trust had a critical outreach team available Monday to Friday 7.45am to 6pm and Saturday 8am to 4pm. They told us, and we saw documents to confirm, that they followed up on patients within 24 hours following discharge to the wards.

Seven-day services

- Medical cover was available out of hours. Staff confirmed that, when they required medical advice, the anaesthetic registrar was easy to access.
- Consultant cover was scheduled for every day. However, we received feedback from staff that some of the anaesthetic consultants, despite being on the staff rota, did not attend in person at the weekend. They were available for consultation via the telephone.
- Following feedback to the chief executive and director of nursing, immediate action was taken to ensure all the consultants would attend ward rounds in HDU on

Saturday and Sundays. Records were subsequently seen at the unannounced inspection to demonstrate this had been implemented. The action has brought the HDU service in line with the core standards for ICU.

- X-ray and pharmacy support were available six days a week and an on-call service was provided out of hours.
- Magnetic resonance imaging (MRI) was available seven days a week.
- Physiotherapy was available at seven days a week.

Are critical care services caring?

Good



We found that patients received a caring service. We saw, and were told consistently, that all interactions with professionals within the unit were respectful and compassionate. Patients' dignity was maintained and they felt at the centre of their care. Patients understood their rehabilitation plans well and their responsibility within it.

Compassionate care

- NHS Friends and Family Test (FTT) results had been consistently better than the England average from December 2013 – March 2014, scoring well, at above 80 for each month.
- Patients and relatives we spoke with felt that the level of care was very good. We received no negative comments about the level of care. We observed staff interactions with patients and relatives and saw they were respectful and appropriate.
- We observed staff interaction with patients which was calm, caring and compassionate. Patients told us they were "very well looked after".

Patient understanding and involvement

- Both patients and relatives told us that they could discuss their treatment plans when they wanted with the medical and nursing staff. One patient told us how well they understood their treatment plan and their medication, because the doctor had taken the time to explain in a way they fully understood.
- All the patients and relatives we spoke with felt they were part of their care. They all understood their rehabilitation plans. One patient told us in detail how medical staff had taken time to explain all their medication as there had been changes since their admission to hospital.

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- Each patient had a named nurse to care for them on every shift. Staff handovers were conducted at the bedside and patients were introduced to the nurse taking over their care.
- Both patients and relatives told us that they could discuss their treatment plans when they wanted with the medical and nursing staff. One patient told us how well they understood their treatment plan and their medication, because the doctor had taken the time to explain in a way they fully understood.

Emotional support

- Counselling services were available to patients in HDU. There was a counselling service which was used by patients and relatives within the unit. We spoke with patients and relatives who had used the counselling services. They confirmed they were provided with the information and it was their decision as to whether they used the service or not.
- Patients told us they felt they could speak to staff about any concerns they had.
- We observed patients being treated with kindness, dignity and respect, while they received care and treatment in HDU.

Are critical care services responsive?

Requires improvement



We considered the level of responsiveness as requiring improvement. The situation with deteriorating patients and consultant weekend cover at the time of the inspection was not managed in a robust fashion. The trust had evidence of staff concerns that had been raised but had failed to act in a timely manner to address it.

Discharge arrangements within the trust were having an adverse knock-on effect on the discharge of HDU patients. This was occurring often enough for us to expect to see some resolution. The trust was trialling a new booking system, but it was too soon to see if this had had an impact on patient flow.

Service planning and delivery to meet the needs of local people

- Arrangements for blood monitoring was undertaken but were not responsive enough. We observed that patients in HDU had blood taken which was then transported to

a laboratory off-site and the results were available in the afternoon. We saw a report of blood collected at 6am, taken to the laboratory by 10.49am and results were available at 1.37pm. This was after decisions to return patients to the ward were taken, and if the results were of concern it could affect the patients discharge from the unit.

- Due to the ageing population and people having co-morbidity, the unit had recognised that they were caring for more patients living with dementia. These patients were nursed as level 2 patients which meant they received one-to-one care the whole time they were on the unit.
- Families had a small room where they could speak in privacy to staff or wait to visit their relative.
- We observed that equipment was stored at either end of the main bay. We saw that curtains were drawn around them if a patient was in the bed next to this area. This was not an ideal situation, but storage space was limited and we saw no detrimental impact for patients.
- There was also a kitchen for families to use. However, there was a family of a patient who had been on the unit for two weeks who were not aware that a kitchen was on the unit for them to use.
- Both male and female patients were treated on the unit in designated single-sex areas. The unit monitored the adherence to single-sex accommodation and recorded that they were not in breach.
- The unit had four side rooms, which were single occupancy, two at each end of the unit; two of them were used for children placed on the unit.
- There was a kitchen for staff to prepare meals and drinks for patients on the unit. We saw this in use by staff.

Access and flow

- The HDU had the physical capacity for 12 bed spaces but planned and delivered care for 10 patients. The bed occupancy rates for HDU were published as 100%. However, during our inspection, we saw that the HDU was not always fully occupied.
- Patient flow was affected when there were delays in discharging patients from the unit back to wards, as this relied upon a bed being available. Staff told us that this happened regularly, especially towards the end of a week. This led to patients being discharged later in the day between 6pm and 8pm.
- Late discharges from HDU impacted on bed availability for patients coming out of theatres. Also when patients

Critical care

returned to the ward later in the day it was out of hours and put them at additional risk due to lower staffing levels at that time on the wards. In most instances, the discharges were made before 6pm but we were informed of occasions when it was as late as 8.30pm when the staffing was at night-time levels.

- We saw occasions when a patient had had an extended stay within the unit because they required a specialist bed from another provider.
- There were some concerns by staff that patients were being transferred from the high dependency unit (HDU) to the ward too quickly and that patients had to be transferred back to the HDU. Total unplanned readmissions in 2013 to HDU were 29, total readmissions to HDU were 40. There had been 15 readmissions back to HDU so far in 2014.
- A monthly report was produced outlining each readmission or transfer which explained the clinical reason for doing so but did not outline if the readmission/transfer could have been prevented. At the time of the inspection, HDU was trialling a new bed booking system, which was working in conjunction with the original system. The new system allowed staff to see how many people were booked. If more than eight beds were needed, the person booking the bed had to speak with senior staff to see how they could accommodate the patient.
- Nursing staff liaised with theatre staff and reviewed theatre lists to ensure that patients likely to need a HDU bed were already booked on the system.

Meeting people's individual needs

- Staff understood the needs of the patients requiring a stay in HDU. Patients and family members told us they had their needs met. All said that staff responded to the call bell in a timely manner.
- Counselling services were available for patients in HDU.
- There was access to accommodation on-site for families to allow them to visit relatives in HDU. We spoke with several relatives who were using or had used the accommodation. They all felt it was a good service and meant they could be close to family members in HDU.
- There was open visiting on the unit which relatives took advantage of.

- A patient was waiting to be moved to another provider. They understood what the delay was and told us what maintenance care they were receiving. They wanted to start their rehabilitation but understood why they needed to be cared for conservatively.
- There was a kitchen for staff to prepare simple meals for patients. We saw that patients who were able to eat full meals were given those prepared in the hospital kitchen.
- Dietician support was provided by another provider. The dietician visited regularly two to three times a week and was available for telephone support.

Learning from complaints and concerns

- The service had processes in place to learn from complaints and concerns.
- Staff told us learning actions were shared at handover and at monthly team meetings. We also saw documentation of incidents of concern and actions agreed and how to disseminate the lessons learned.
- Patient experience can be determined by feedback given to the unit. The HDU KPI report showed the number of complaints received from January 2014 to May 2014 was zero and compliments for the same period were 49.

Are critical care services well-led?

Requires improvement



We found that HDU had a sustained period in the last year during which there had been a lack of nursing management and leadership. The clinical lead for anaesthetics and HDU was newly appointed in spring 2014 and demonstrated commitment and enthusiasm for the service. Nursing staff were demoralised due to the lack of leadership based on the unit which had been ongoing for approximately 12 months. Staff were taking on more senior and managerial roles, but not been given the time to complete them as necessary and still retained responsibility for direct patient care.

Issues regarding governance and risk management were escalated to senior managers but had not been addressed in a timely fashion. The issue of senior staff cover in HDU remained an issue at this inspection. However at the unannounced visit, consultant cover at weekends had been addressed.

Critical care

Vision and strategy for this service

- The lack of nursing management had a negative effect on the vision of the unit. Staff told us they felt disconnected from the overall vision of the trust.
- The clinical director was aware of the issues and reported that they were trying to get senior managers in the trust to act on recommendations. Where the clinical director had autonomy, action could be taken, for example, arranging the 15 preceptorships with another provider.

Governance, risk management and quality measurement

- KPIs were maintained on the unit and reviewed. These were maintained so the unit could demonstrate its performance overtime.
- The KPI's identified elevated risk within the unit; these were identified and escalated, such as the number of incidents. We saw that investigations to understand what learnings needed to be undertaken and shared amongst the staff to further improve the service.

Leadership of service

- We noted that, among the nursing staff, there had been a lack of senior support on the unit. The most senior staff working on the unit was a band 6. Interim senior nurse management was provided by the deputy director of nursing and a band 8 matron. The matron had been covering the post for two weeks and had responsibility for clinical support and the outpatients department as well as HDU.
- The trust had recruited staff to address the management deficiencies; however, they were not due to take up post until July 2014. This lack of senior staff support on the unit had been noted during our January 2014 inspection.
- Staff we spoke with on the unit felt that the lack of senior management had led to a lack of vision and direction for the unit. Senior trust staff told us they recognised this and had put strategies in place to encourage staff to take on more managerial roles, and

this was still ongoing. One such measure was to have the band 6 nurses carry the hospital bleep. We were informed as a result of this measure two red incident forms had been completed as staff felt they needed more support in taking on these roles.

- The trust had tried to recruit some senior medical staff whose roles would be exclusively within the HDU and critical care outreach but had been unsuccessful at the time of our inspection.

Culture within the service

- Staff told us that they offered a good service despite the limitations. They supported each other to meet the needs of patients. We were told that incident reporting had increased within the unit, because staff did not feel they would be at fault and it was used as a continuing improvement tool.

Public and staff engagement

- HDU undertook some staff engagement work, this included regular staff meetings. We saw an example of the staff meeting minutes. The attendance was monitored as part of the KPIs. We saw that, at the April ward meeting, a register was kept of staff attendance and those who had not were required to sign the record when they had read the minutes.
- Staff valued their personal development review meetings and we saw this reflected in the HDU KPI results which showed 90% completion rates for 2014. So, despite staff not having protected time to support each other they were making time to meet this commitment.

Innovation, improvement and sustainability

- New senior staff were due to commence employment in the unit to provide managerial and educational support to staff.
- There were plans to increase the skills and remit of the outreach team to improve the support to the wards in managing patients who become medically unwell.

Services for children and young people

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

Information about the service

The paediatrics department provides a highly specialised surgical service to children, young people and young adults. Many children and young people with complex conditions and serious or multiple co-morbidities, were assessed and treated. Specialist reconstructive surgery for children and young people with complex needs is carried out. There is a strict criterion for admission and the lowest age limit for operations is three years old.

Children and young people were referred to the department to have planned specialised operations to their muscles, joints or bones, usually by their GP or other paediatric services. They were seen before and after their operations at the Paediatric Outpatient Assessment Clinic (POAC). There were over 3,500 outpatient appointments, 1,000 inpatient stays and day case procedures within the service from April 2013 to March 2014.

Prior to their operation, children, young people and their families were seen at the POAC. On or shortly before the day of their operation, most patients arrive on the specialist children and young people's ward, Ward 11. The normal location of POAC and Ward 11 were under refurbishment at the time of this inspection, and Ward 11 was temporarily relocated to the day surgery unit until July 2014. There were 17 beds on the ward. The ward also had one side room for patients who required isolation or who had longer-term needs.

Children and young people were taken to theatre to have their operation. After their operations they shared a recovery area with adults. For those children and young

people who required more clinical support, there were two side rooms within the high dependency unit (HDU) which were prioritised for children and young people when required. There were no intensive care facilities available for children on site. Networks with the Birmingham Children's Hospital for paediatric medical cover was provided through a formal arrangement.

We spoke with 15 children, young people and their parents and 21 members of staff. The staff included medical, nursing, management and ancillary staff. We also observed aspects of the care provided to children and young people and reviewed 10 sets of medical records and care documentation.

Services for children and young people

Summary of findings

Children and young people received safe and effective care from appropriately trained and competent staff. A programme of training was in place which staff confirmed prepared them for their roles and responsibilities. Staff were positive about working in the family care division of the trust and told us they felt supported and valued in their roles. Parents and carers were satisfied with the care and treatment delivered to their children and told us they felt included and involved.

The temporary environment on Ward 11 was cramped with limited facilities, though space and facilities on the refurbished ward, opening in July 2014, appeared to be light, spacious and fit for purpose. There was sufficient equipment available to deliver the necessary treatments.

The care and treatment provided to children and young people was based on national guidelines and directives. Policies and procedures were reviewed regularly and updated as necessary. The care and treatment was audited to monitor the quality and effectiveness and, as a result, action had been taken to improve the service.

Staff were provided with regular and appropriate training and an annual performance development review. There was no process for staff to receive formal supervision throughout the year, but during our discussions with staff we were told the managers were approachable and provided support when required.

Services for children and young people were caring. Children and young people and their parents/carers were treated with dignity and respect. Surveys took place to gather feedback from patients and their families/carers. Interpreter services were available. Staff raised some concerns about waiting times and clinic overbooking in POAC but there was no information collected or available to show this was monitored to make improvements.

The service for children and young people was well-led. Risks were managed at a local and trust level. Staff were confident in the leadership of the children's services at the Royal Orthopaedic Hospital.

Are services for children and young people safe?

Good



The children and young people's services were found to be safe. Incidents were reported by staff and appropriate action taken by the trust. The investigation and learning from incidents was cascaded to staff to reduce the risk of recurrence.

Medical and nurse staffing levels met the assessed care and treatment needs of children and young people and systems were in place for additional staff to be on duty when required.

The standard of cleanliness and control of infection within the children's ward was monitored and staff complied with the hospital's policies and procedures promoting the control of infection.

There were some concerns that the environment on ward 11 was not child friendly but we were made aware of the temporary nature of the arrangement. The ward was due to move back to the refurbished children's ward within a few weeks of the inspection. Resuscitation equipment in the paediatric outpatients was missing essential items which staff were made aware of however no action was taken to address the missing emergency equipment until we raised the matter with senior management.

Incidents

- Between April 2013 and March 2014, 31 serious incidents were reported to have occurred at the trust. Four of these serious incidents related to the care of children and young people. Two were being investigated at the time of our inspection, and two investigations had been completed and lessons were shared among staff. There were no trends among the reported serious incidents.
- Staff reported incidents through the hospital's electronic reporting system. When concerns or serious incidents had been observed, we saw that action was taken within the directorate and staff were able to describe how those actions had improved care provision – for example, following a reported incident regarding a child

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who had developed sepsis following spinal surgery, information sharing during referrals to other professionals and additional training had been put into place for staff.

- The directorate held meetings which took place every three months and were attended by all grades of staff throughout the directorate. Staff we spoke with were knowledgeable about these meetings and were positive about the opportunity they provided for dissemination of information. We saw minutes from the meetings which showed incidents and the investigations and actions had been discussed.
- Staff said they were encouraged to report incidents through the electronic reporting system and were confident they would be able to do so, would be listened to and feedback given to them on any action taken.

Safety thermometer

- We saw the trust's Safety Thermometer metrics was displayed on the wall at the entrance to Ward 11. It was acknowledged that the safety metrics measured were not fully appropriate for use with children however it was an important measure for the trust. The results of the Safety Thermometer showed children were provided with harm-free care and there had been no reported falls, venous thromboembolism (VTE), catheter related urinary tract infections or pressure damage on the ward between April and May 2014
- Information was displayed in the families' room which at the time of the inspection showed that it had been 442 days since an avoidable pressure ulcer was identified on Ward 11.

Cleanliness, infection control and hygiene

- Ward 11 received support from the trust's infection control team who undertook regular audits and provided advice alongside the microbiology specialists to help manage individual cases.
- The trust's annual infection control report for 2013/2014 showed that ward 11 was meeting the trust target of 90% compliance with hand hygiene during monthly audits.
- In the last 12 months the trust reported no cases of meticillin-resistant staphylococcus aureus (MRSA), meticillin-sensitive staphylococcus aureus (MSSA), C.Difficile or bone infections on Ward 11.

- We were told by nursing staff there were very few reported cases of surgical site infections but it was not possible to see reported figures per ward area in order to establish exact numbers.
- Children and young people were swabbed for colonised MRSA at pre-assessment.
- The trust had a 'bare below the elbows' policy for anyone working in clinical areas. We saw all grades of staff observed the policy at all times. Staff told us they would be confident to challenge anyone not complying with the policy and we observed this during our inspection.
- Personal protective equipment, such as gloves and aprons, were readily available for staff to use throughout the clinical areas and we saw these in use.
- Hand-washing facilities and antibacterial gel were available in prominent areas of the ward and staff were observed to use these correctly prior to, and after contact with patients. We observed one member of staff advising visitors to the ward of its location and use.
- Audits were completed to monitor compliance with infection control procedures and the outcomes, which were all good, were displayed on ward noticeboards.
- Equipment was cleaned after it had been used and a label attached to show the date and name of the person who had cleaned it.
- Domestic staff maintained accurate daily cleaning rotas of the bathroom and shower facilities on the ward. A family member we spoke with who had been on the ward for several days, told us they had seen domestic staff regularly cleaning the bed space and surrounding areas between each cubicle and they had "no concerns" about cleanliness on the ward.
- The trust had a specialist bone infection unit that provided specialist support to children who developed infections after their primary surgery.
- Staff told us that data was being gathered to support information in measures regarding blood stream infections to meet the Department of Health's 'Saving Lives' guidance. Monthly results were recorded as 100% through to February 2014. Further data taken since has not been made available to us and it was not explained why the data was no longer being collected or used.

Environment and equipment

- To address our previous inspection findings from December 2012 and July 2013, works to upgrade the environment on Ward 11 and the POAC commenced in

Services for children and young people

January 2014. This included re-modelling the ward area, balcony and the building of two small extensions, one of which would incorporate a new playroom facility and a separate treatment room. Whilst works were ongoing Ward 11 and the POAC were temporarily situated in the day care unit.

- Staff on the ward and at board level acknowledged that the unit where children were being cared for had limitations. There was limited space between each bay, the ward environment was dark, and the ward area was neither child friendly or appropriately decorated. There was a small lounge on the ward for children and young people which had few facilities. The area for family members contained locked storage items for use on the ward. These concerns were identified on the ward risk register and measures to address concerns as a result of this move were taken. However, staff and patients were kept regularly informed about the ongoing work to ward 11, and this area was due to re-open in July 2014.
- Entry to Ward 11 was secured with locked doors. Visitors were required to press a buzzer and verbally request access. We saw that staff checked who the visitors were, and who they were visiting, prior to opening the door for them.
- The trust had an electronic database of all equipment, which provided information about the date of purchase, cost, servicing, and maintenance and where in the hospital the equipment was located.
- Standardised resuscitation paediatric and adult equipment was available on Ward 11, in recovery areas and within the high dependency unit on the ward. We saw a log which showed the equipment was checked daily to ensure it would be ready to use in an emergency.
- We identified that a paediatric resuscitation equipment bag in the POAC did not contain all of the required items. We raised this on three separate occasions with staff within the department, but on returning to the department we noted that action was not taken. The information was escalated to the Director of Nursing and immediate action was taken to replace the resuscitation equipment.

Medicines

- Medicines were stored securely and appropriately within locked cupboards in rooms which had a key pad

entry. Medication which required cool storage was securely stored in fridges specifically for medicines, the temperature of which was checked daily. Records showed the temperatures were within acceptable limits.

- Hospital pharmacists supported staff on the ward. The pharmacy technician visited the ward once a week to check stored medication and restock as necessary. A stock list was held which was amended to reflect current prescribing trends to ensure adequate supplies of appropriate medication were held in the clinical areas. Records were kept of medication returned to pharmacy, either by the ward or pharmacy staff, for example, once it was out of date so there was a full audit trail of medication that had left the ward.
- Monthly audits were completed by the pharmacy team and the ward had been scored 100% each month since December 2013.
- Incident data showed that nine medication incidents had been reported through the electronic system between January and June 2014. However, these had not all resulted in errors being made or harm coming to the child or young person. For example, some incidents were delays in obtaining medication from pharmacy or a delay in obtaining medication for patients to take home.

Records

- We reviewed the medical and nursing records for 10 children and young people on Ward 11.
- Each child or young person had care plans in their nursing notes. These outlined the action staff needed to take to ensure their care needs were met.
- Risk assessments were in place for individual children and young people. For example, to identify those at risk of pressure damage while on the ward and to highlight the risk from venous thromboembolism (VTE or blood clots). Written instructions detailed any action required to reduce this risk.
- We saw records for children and young people with other medical conditions, such as diabetes, were appropriate. Nursing and medical records identified necessary care and treatment.
- When not in use, medical records were stored securely in closed, lockable trolleys near the nurses' stations.
- Theatre records we reviewed were comprehensive and contained clear post-surgical instructions.

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- POAC staff reported they were able to quickly and easily access radiography such as x-ray reports and scans, and laboratory results.

Consent

- Staff we spoke with were knowledgeable about gaining the consent of parents and, in the case of older children, the child themselves.
- Staff were aware of where policies and procedures regarding consent were located and how to access them.
- The records we reviewed showed consent was sought prior to the delivery of care and treatment.
- We observed that staff informed children and young people of anything they were going to do and explanations were given and consent obtained prior to continuing treatment.
- Parents we spoke with confirmed they felt involved and informed about their child's care and treatment.
- Children and young people told us they had been provided with information about their treatment and what would happen next.
- English language leaflets aimed at children and young people to explain the consent process were available in a prominent area on Ward 11. Staff told us leaflets were not available in other languages.

Safeguarding

- Staff we spoke with were confident of reporting concerns to the named nurse for safeguarding and said they would refer issues they were unsure about for additional support.
- The children's services group met each month and reviewed reported incidents to ensure appropriate action had been taken.
- Safeguarding issues were discussed at a local level at daily ward meetings and the action taken and outcomes discussed in safeguarding strategy meetings. Staff were positive about the way these meetings were conducted and that actions would be identified and followed up.
- Safeguarding children training uptake overall of all grades of staff within the paediatric division was:
 - Enhanced level 2: 62%
 - Enhanced level 3: 75%
- A training matrix for ward 11 staff showed 98% had completed level 3 training.

- Safeguarding training at an appropriate level (level 2 or 3 dependant on their role) was provided to all staff every three years in line with national recommendations. Updates in the interim period were provided at the annual paediatric study day.
- The trust had identified that the mandatory safeguarding children's training had been attended by less than 20% of the staff in 2013. Action had been taken to address the low rates through an increased number of training sessions delivered within the ward areas, and by providing regular feedback to the board regarding groups of staff who had repeated low attendance rates including medical staff. Uptake for the training had improved to 65% of front line staff, though it was acknowledged that this was below the trust expected rate of 90%.

Mandatory training

- Training was provided for all grades of staff. Mandatory training took place annually and records were maintained electronically to evidence which training staff had attended. The ward also had a training matrix displayed on the wall of the office to provide a reference for staff and managers.
- The mandatory training included moving and handling, health and safety and safeguarding updates.
- Qualified paediatric staff were also required to attend a paediatric study day and paediatric intermediate life support (PILS) annually. The manager confirmed staff were up to date with their training.

Assessing and responding to patient risk

- We saw evidence that paediatric early warning scoring systems (PEWS), which alerted staff to any deterioration in the child or young person's health, were in use. From the nursing and medical records it was clear that appropriate action had been taken to summon appropriate medical assistance when necessary.
- Staff were made aware of the procedures to follow when a patient's health deteriorated and required escalating. Written information clearly showed staff the parameters for reporting. A system was in place to provide a visual alert on the records of a child or young person who had been identified as requiring additional care or treatment.
- A flowchart to advise staff on steps to take for children who became critically ill was on display in Ward 11.

Services for children and young people

Nursing staffing

- The ward managers told us when reviewing staffing levels; their professional judgement was used and supported by the Royal College of Nursing dependency tool for staffing which was in use on Ward 11.
- There were three trained nurses and one health care assistant on shift between 8am and 8pm and two trained nurses on duty at night. The staffing arrangements at night were slightly below the tool's recommended guidelines for safe staffing. Senior nurses told us that the ward was usually quiet at night and that further nursing staff could be deployed to support children and young people with additional needs if required.
- Staff we spoke with said there were enough staff on duty over the 24-hour period to meet the assessed care needs of children and young people. On each shift a band 6 registered nurse was designated as a coordinator to manage the flow of patients through the ward.
- The nursing staff on the children's ward had a verbal handover at each shift change. We attended one of these handovers and witnessed discussions regarding the care, treatment and discharge plans for each child or young person.
- The two side rooms for paediatric use on the high dependency unit for the care and treatment to children and young people who had complex needs required a higher level of staffing.
- New staff were provided with a full induction period to the children's ward and were given with a named mentor to help them become competent within their role.
- In recent weekly 'quality and safety debrief' meetings held by the director of nursing for all senior nursing staff across the trust, reports regarding the 'short term' sickness and impact on staffing levels were raised. Bank and agency staff were used to ensure posts were covered. We were not made aware of any further analysis undertaken to identify potential causes of this short term sickness.

Medical staffing

- There was a team of five specialist surgical consultants who operated on children, young people and young adults.

- Two new middle grade surgeons had recently been appointed and further recruitment was ongoing in order to increase the number of paediatric surgical interventions to address the failure to achieve the 18 week target.
- Daily ward rounds with consultant paediatric surgeons took place.
- Surgical staff attended the handover at the start of each shift and during the day. We attended one handover and found detailed information was shared between all staff to enable them to treat and care for patients consistently.
- There was paediatric consultant cover on call seven days a week, including out of hours. Junior medical staff we spoke with told us they were supported well and encouraged and felt able to call senior medical staff, including the consultants, at any time they needed advice or guidance though the need to do so was rare.
- We were told by senior managers that there was no locum use amongst the junior and middle grade medical staff between April 2013 and May 2014. However, one junior doctor that we spoke to told us they were a long term locum.

Major incident awareness and training

- We saw an escalation procedure was in place which identified the action staff would take for obtaining additional staff in the case of a major incident or when the hospital had reached capacity.

Are services for children and young people effective?

Outstanding



The complexities of the orthopaedic care required by children and young people accessing the service meant the service did not routinely provide evidence of outcomes. Despite this, there were efforts to proactively audit care. Surgeons worked with the British Society for Child Orthopaedic Surgery (BSCOS) to benchmark outcomes nationally.

Evidence-based care and treatment

- Data had been collected for the Oxford hip scores and are used to measure the outcome after primary surgery for adolescents, though results had not been analysed at the time of our inspection.

Services for children and young people

- Surgeons regularly presented cases to the British Society for Children's Orthopaedic Surgery (BSCOS) to benchmark their practice and were proactive in doing so. Our inspection noted this was best practice.
- Surgical outcomes were scrutinised and changes in practice was evidenced by the surgical teams.
- Paediatric surgeons had led research and contributed to medical journals in 2013 and many had presented cases to peers internationally.
- The lead paediatric surgeon was the audit lead for the hospital and coordinated participation in national audits.
- The trust told us they were working towards establishing compliance with nationally recognised best practice on the treatment for spasticity in children.
- Paediatric assessment tools for nutrition, hydration, risk of venous thromboembolism (VTE), pressure ulcer prevention and management and risk of deterioration, used by nursing staff on the ward followed evidence based guidance for children and young people.
- The anaesthetic lead had recently piloted the use of the paediatric sepsis 6 tool, and this was due to be rolled out for use across the ward in July 2014.
- The trust regularly reviewed compliance with guidance from the National Institute for Health and Clinical Excellence and other bodies.

Pain relief

- The pain team specialists provided direct support to staff caring for children and young people. Some members of the team had specialist training in order to provide specialist paediatric advice.
- We saw paediatric pain charts were in use in the nursing documentation we reviewed.
- The directorate had recently introduced an acute paediatric pain pathway and staff told us how they used this in practice.
- Medication records we reviewed showed clear prescribing of pain relief and the time, route and dose of the medication administered. Monthly medication audits undertaken by the pharmacist team included measures of the provision and effectiveness of pain relief and results showed this worked well.
- Techniques to distract children and young people who were experiencing pain or due to have procedures involving the use of needles were employed by staff, following advice from the ward play specialist.

Nutrition and hydration

- We spoke with children, young people and their families and carers regarding the food provided to them and were told the food was "pretty good."
- We saw that staff presented menus with simple descriptions of the food available for lunch and dinner.
- In the records we reviewed, we saw that food and fluid charts were maintained when required.
- An educational DVD outlining the importance of good nutrition and hydration pre and post operatively was used in the paediatric outpatient department.
- The anaesthetic team conducted an audit of the nil by mouth fasting regime in February 2014 and reviewed 106 case notes. Findings included patients that were 18 and under were fasted of fluids for nine hours on average, above the recommended six hours by the Royal College of Anaesthetists. This meant that children and young people were at higher risk of dehydration. The audit actions did not stipulate specific measures to address this finding for this age group though did state that the admission process would be reviewed to reduce fluid fast times for all patients.

Patient outcomes

- Pre assessment requirements indicated strict criteria for children and young people who attended the hospital for elective surgical procedures. Those who became sick were transferred to the Birmingham Children's Hospital for further clinical input. No children had been transferred post operatively within the year preceding our inspection.
- Rates of revision were monitored by the directorate. Less than 1% of children required revision surgery following their primary operation between April 2013 and March 2014.
- Specialist surgery for the treatment of scoliosis and bone tumours were achieving very good results for patients.

Competent staff

- Reported key performance indicators showed, and staff reports confirmed, that all staff on Ward 11 had received an appraisal in 2013.
- Staff told us that, during their review they had the opportunity to discuss their progress, any difficulties and training requirements with their line manager or during clinical supervision.

Services for children and young people

- Paediatric competency checklists were completed for all nursing staff on ward 11 and all nursing staff on HDU and covered the deteriorating patient, effective communication skills, rapid assessment, pain management and post-operative wound care.
- Staff had access to clinical nurse specialists and link nurses were available to provide advice and support in specific areas such as paediatric spinal deformity, paediatric oncology, Macmillan nurses, tissue viability and infection control. Physiotherapists had received training to allow them to undertake specific procedures, such as spinal injections for children and young people with scoliosis.
- Plaster technicians supported staff during the day to fit and split plaster casts to improve healing. However, at night the only staff able to split casts was the junior surgical doctor on call. This meant there were sometimes delays for this simple procedure as other staff were not trained.

Multidisciplinary working

- We observed staff from a variety of disciplines, including nursing staff, medical staff, physiotherapists, occupational therapists, pharmacist and education staff attend daily multidisciplinary hand over meetings.
- Anaesthetists, occupational therapists and physiotherapists undertook an assessment of most children or young people during their pre-operative assessment
- The trust employed a part time play specialist who assisted staff on all units and wards where children were cared for or treated. During our inspection we identified that an untrained health care assistant was providing play support to children and young people as the play specialist was on maternity leave. It was not clear whether or not the trust had made arrangements to ensure the post was covered by a suitably qualified person to ensure that specialist support and advice for play for children and young people was available.
- The trust provided support to patients with mental health issues, including children and young people, through psychology and psychiatric input.

Seven-day services

- Surgical doctors were on duty during seven days a week. One junior grade surgeon was on shift during the

- evenings and weekends, with support available from one middle grade and one consultant surgeon on call. Staff told us that a junior grade surgeon visited Ward 11 every evening to review patients and support ward staff.
- Medical cover was provided by Birmingham Children's Hospital and was available on call, seven days a week. Children requiring emergency care and treatment were transferred to the emergency department at the Birmingham Children's Hospital.
- Nursing staff told us they had access to senior management staff at all times. The on-call rota was available for inspection and showed cover over the 24-hour period, seven days a week.
- Pharmacy support was available on call seven days a week.
- Therapy services were available Monday to Saturday between 9.00am and 5.00pm.

Are services for children and young people caring?

Good



Services for children and young people were caring. Feedback from children, young people, families and carers was regularly reviewed via surveys.

Communication and information sharing was generally perceived as good by children, young people and families we spoke with. Parents/carers and their children spoke highlight of the service and were positive in feedback about their experiences.

Compassionate care

- Children and young people we spoke with told us their experience had been "excellent, could not be better" and "100/100."
- Parents/carers and families told us that their experience had been "exceptional" and that "staff have communicated very well with us, we have always been clear on what to expect."
- We observed children, young people and their families and carers were treated with respect and dignity. Staff used the curtains around each bed and at windows, and cubicles were screened by a door to promote people's privacy and dignity when staff provided care and treatment.

Services for children and young people

- We observed staff communicated well with children and their families/carers and showed empathy and kindness.
- Parents/carers were able to visit at any time and spend as long as they wished with their child.
- Comments made to the ward by families and friends were displayed on noticeboards and provided information on action taken in response by the trust. The average friends and family test score for ward 11 was 70 which was higher than the trust average. Negative feedback related to the environment, and regular updates regarding the building of ward 11 were provided on the ward noticeboard to update everyone.
- A computer application called the National Paediatric Toolkit™ (NPT) which used an animated character to capture the opinions and experiences of children and young people was used to include younger children in the friends and family test.

Patient understanding and involvement

- We saw named nurses were displayed above each bed.
- Children and young people we spoke with told us staff introduced themselves before they started treatment and explained what they were going to do.
- Staff had access to written information to provide to parents/carers about their child's medical conditions and how to access support groups.
- Parents we spoke with were generally positive in their comments about the communication and provision of information from the medical and nursing staff.
- The trust provided surgical treatment to young people with bone cancers. Ward 11 was supported by the Teenage Cancer Trust which was involved in the refurbishment of the ward location.

Emotional support

- A social worker employed by the Birmingham Children's Hospital provided regular support to young people who were undergoing surgery to treat bone cancer.
- Psychology and psychiatric referral was available for patients at the trust, but these were not specific to children. The Royal Orthopaedic Hospital Bone Tumour Service Support (ROHBTS) group was set up to provide emotional and psychological support to patients, including children and young people, who were receiving treatments for bone tumours. We were not made aware of any specific support services for children in relation to counselling services for children and young people with other conditions.

Are services for children and young people responsive?

Good



Services for children and young people were responsive. Procedures were in place and followed which promoted the flow of patients through the service. This benefitted children and young people as appropriate treatment and care was provided in a timely way. Discharge planning was efficient and included parents/carers and professionals who would support the children and young people at home.

The service was designed to meet the needs of all children, including those with additional needs. Interpreting services were available when required, although they had not always been accessed. Care and treatment from specialist services were accessed when necessary at the Birmingham Children's Hospital. Staff were concerned about waiting times and clinic overbooking in POAC but there was no information collected or available to show this was monitored to make improvements.

Service planning and delivery to meet the needs of local people

- The trust provided surgery for children and young people, some of whom travelled far to access the specialist services provided. Accommodation was available on site, but there were limited facilities for parents to stay with their children on the ward.
- The trust had implemented a strict admission criteria and procedure to ensure that the service provided was safe.
- Where services could not be provided at the trust, children were referred to the Birmingham Children's Hospital.
- There were only four hospital operation cancellations reported since November 2013 for the paediatric directorate.
- When Ward 11 reopens, children and young people will be taken outside of the hospital building, along the patient journey from the ward to theatres. We noted that the length of the patient journey will also be increased and could contribute to delays.

Services for children and young people

Access and flow

- Additional paediatric surgeons had been recruited to deal with an unplanned and unexpected increase in waiting times.
- Children and young people who were seen in POAC or Ward 11 were either discharged home or to another health provider outside of the trust if children or young people had more complex conditions. When children were transferred from the children's ward in a non-emergency situation an assessment was made to ensure a safe transfer. Dependent on the outcome of the assessment, the child would be accompanied by their parent/carer, nurse or doctor.
- Children and young people were operated on every day during the week, and one Saturday every eight weeks.
- We noted that some complex cases and major surgery were undertaken on Friday's. Staff we spoke with expressed potential concern about the weekend staffing cover available to care for children and young people but said they had not witnessed any direct impact in practice.
- We saw that children and young people who were awaiting complex or major surgery were scheduled first on the list.
- Theatre 1 was mainly used for operations on children and young people but there were no designated paediatric theatres. A recent audit by the anaesthetic team showed that eight of the 10 theatres in the trust were used for children's operations. Actions of the audit aimed to address theatre usage so that operations were undertaken in fewer theatre rooms though dedicated paediatric theatres were not yet planned for.
- The trust told us that cancellations and referral to treatment waiting times were monitored in POAC. Since November 2013, there were 8 avoidable cancellations and 38 children and young people waiting for treatment longer than 18 weeks.
- Staff working in the POAC told us that the clinics were frequently overbooked and that waiting times were increasing. This information was not collected or monitored by the directorate or at board level so it was difficult to identify whether there were any particular trends in order for resultant actions to be effective.
- Discharge letters were produced by the nursing and medical staff when the care of children and young people was transferred to other departments or

professionals. For example, to their GP or another hospital trust. Information included the reason for admission, investigations undertaken and any results and/or treatment.

- The recovery area in the theatre department did not have a designated space for children and young people though staff told us that one bay with four beds was used as frequently as possible.
- We noted that some children and young people were seen in adult outpatient clinics for two consultant surgeons.
- Some therapists told us there were at times long waits for specialist equipment, including wheelchairs and seating, which should be available for use once the child or young person was discharged. We found discharge planning included issues with medication and the medicines children would require on discharge home.
- The multi-disciplinary coordinator for the Teenage and Young Adult Service undertook a psychosocial proforma with each patient and this information was shared with staff at the daily MDT meetings.

Meeting people's individual needs

- Children and young people who were due to undergo complex or major operations or who lived a long distance from the trust could be admitted onto Ward 11 the night before a procedure to accommodate their needs.
- Information about the trust was available in a child friendly format on their website.
- Staff were clear on the processes to access interpretation services. Face-to-face interpretation services were available by prior booking and a telephone translation service was available over the 24-hour period.
- Staff sought the advice and support from the on call paediatrician or from specialist departments at Birmingham Children's Hospital for children with specific medical conditions, for example, diabetes, or additional needs such as caring for children with learning disabilities.
- In its temporary location, staff told us the children and young people were allocated to beds by gender and age where possible, though this was sometimes not possible due to lack of bed space. This issue would be resolved once Ward 11 is relocated and will correlate

Services for children and young people

with guidance from the Department of Health that young people often find comfort from being with others of the same gender and age and should be given the choice.

- On a tour of the new facilities we were shown a sensory room for the use of children with additional needs which was planned to be used as a distraction and relaxation room during some procedures.

Education

- Education services were provided by teachers from James Brindley School. Children were able to participate in school as and when their treatment and medical condition allowed.
- Provision for education was planned prior to admission to hospital for elective surgery and there was close liaison with parents and home schools.
- Ofsted rated the service as “outstanding” in its 2008 inspection report.
- We saw a flexible attitude towards the curriculum and to child and personalised learning which meant that children and young people could be taught in a place they chose, including by their bedside in the ward or on HDU.
- There was liaison with schools and home schooling for handover when children and young people were ready for discharge.
- Young people who were planning to take GCSE or AS level exams were provided with specialist tuition if wanted.
- The ward based teacher was a key member of the daily multidisciplinary handover and provided feedback about children and young people’s holistic and educational needs.

Learning from complaints and concerns

- The trust had a policy and procedure to deal with complaints. Initially parents and carers were encouraged to raise any complaint with the senior nurse on duty. A log was made of all complaints and these were reported to the matron. The matron was aware of complaints in the children and young people’s directorate and the action which had been taken in response. This information was disseminated to staff at the children’s services meetings.
- Information was displayed on the ward and in the POAC on how to make a formal complaint. The information directed people to PALS.

- A flowchart detailing guidance for staff to deal with patient concerns was made available in a 2014 patient experience meeting and disseminated to line managers.
- Data provided by the trust showed that four complaints and 11 to the Patient Advice and Liaison Service (PALS) recorded contacts were received between January 2014 and April 2014. All complaints were responded to within the trust expected time frame of 25 working days although the trust also agreed timescales with the complainant dependant on the issues. Trends identified related to the environment on ward 11.
- A recent PALS concern highlighted issues in the administration processes for referrals which have not yet been fully addressed. A child waited over nine months for an anaesthetic opinion as the letter had not been sent to the referring trust. We were not made aware of what actions the trust had taken to address this concern so that similar errors would not occur in the future.

Are services for children and young people well-led?

Good



The children and young people’s service was well-led. Staff were positive about the leadership and management of paediatric services at the hospital. Staff spoke of an open culture and told us they were able to discuss any concerns or raise incidents and stated they were confident they would be listened to.

A system of risk management was in place, with appropriate action taken to reduce identified risks.

Vision and strategy for this service

- Senior staff in the directorate had developed a draft paediatric strategy which focussed on expanding surgical service provision.

Governance, risk management and quality measurement

- Incidents were reported through the trust’s electronic system and were discussed at the risk management meetings, with decided actions recorded. Reported incidents were subject to auditing and a trend analysis completed by the ward.

Services for children and young people

- Risk registers were monitored at a local level. Staff were able to discuss with us the risks identified within their clinical areas and also the action that was being taken to address these.
- Risk assessments were in place on Ward 11 and were reviewed regularly. These identified potential risks and provided staff with direction on how to reduce such risks including health and safety, medication errors and security risks.
- Paediatric service meetings were held. Minutes from the meetings were circulated and actions arising were allocated to individuals to take responsibility for ensuring they were addressed. The actions were followed up at subsequent meetings to ensure a satisfactory conclusion had been reached.
- Paediatric critical care meetings took place regularly. The purpose was to identify areas of heightened risk and best practice. The service has used existing relationships with another provider that specialises in children's care to identify areas of best practice. The minutes of these meetings demonstrated that once an issue was identified, action was slow to follow. For example, it was highlighted in October 2013 that the trust's paediatric transfer policy required updating. Within the minutes of the last available records sent to us, this remained an issue and had not been updated by the minutes in the March 2014 meeting.

Leadership of service

- Nursing staff in all areas spoke of the children's matron who visited the ward and units regularly. All of the staff we spoke with made positive comments about the support they received from their matron including "approachable", "regularly on the ward and available by phone" and "knowledgeable and supportive".
- Staff were positive about their immediate line manager and local leadership within the paediatric department. However, not all staff were aware of the organisational structure within other directorates and how to escalate

concerns. We were told by one member of staff who worked in the recovery ward that they did not know who to raise issues with where concerns had not been rectified regarding treatment for children and young people.

- We talked with management staff throughout the paediatric directorate and found they were enthusiastic and positive about their roles within the trust.

Culture within the service

- Staff we spoke with all said they would be able to raise concerns, would feel listened to and were confident action would be taken. We were told the senior staff were approachable and responsive.
- Staff were aware of the whistleblowing procedures and how to report concerns through the electronic reporting system or in person.
- Staff spoke positively about working at the hospital and the teams they worked within.
- Nursing staff were regularly involved in fundraising to improve the ward. One member of staff had raised over £90,000 within the last year for services for children and young people provided by the trust.


Public and staff engagement

- Patients, families and carers were provided with opportunities to complete questionnaires regarding their views of the service provided. The actions taken in response were available on the ward.
- Regular staff meetings were held for Ward 11 on a monthly basis. Quarterly directorate meetings also took place.
- Staff and children, young people and their families were involved in the consultation and re-design of Ward 11.

Innovation, improvement and sustainability

- The trust had invested in upgrading the environment in both the POAC and on Ward 11 to make and sustain required improvements.

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

Information about the service

Outpatient services were provided on the ground floor and first floor of a newly built and dedicated part of the main hospital. Both floors had waiting areas and there was lift and stair access to the upstairs clinics. Therapy services were located separately on the first floor. The new outpatients' entrance was also the main hospital entrance. Hot and cold beverages, light snacks and confectionery were available from a coffee shop located near to the main outpatients' reception area.

Outpatients saw around 6000 patients in approximately 74 clinics each week. Approximately 80% of patients came from the West Midlands area and 20% were national, from as far as Cornwall and Scotland. Clinics run from 8am to 8pm on Monday, Tuesday and Thursday, 8am to 7pm on Wednesday and 8am to 5pm on Friday. Clinics occasionally opened on a Saturday when demand was high.

Over the two days of our on-site visit we spoke with 30 patients and a further 24 completed our 'tell us about your care' forms that were available in the outpatients department waiting areas throughout our inspection. We also spoke to a wide range of staff at all levels, observed waiting areas of the clinics and interactions between staff and patients. We received feedback from our listening event and staff focus groups. We also reviewed performance information about the trust.

Summary of findings

There were many aspects of the service that were responsive to people's needs. The overwhelming feedback we received from patients was that although the service was responsive, appointments were very often late. We found a variety of information that supported this. Sometimes clinics ran so late they had to be rebooked. Other clinics were cancelled without patients being informed. We also found that the outpatients department was not set up to understand the extent of this or respond appropriately to this.

There was a system in place to report, investigate and learn from incidents. Other aspects of safety such as staffing and training were being properly monitored. The department was clean, hygienic and underwent regular cleaning. There was an effective system to manage patient records. However, controlled drugs were not being checked as they should have been and some equipment had not been checked for electrical safety.

Assessments followed established evidence based treatment guidelines. Competent staffing was supported by an appraisal system and staff from different professional disciplines worked well together. Patients all told us that treatment was effective and met their needs.

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Patients told us staff treated them with dignity and respect and we observed this throughout our inspection. The trust had only just restarted the patient involvement group following a period of inactivity.

There was clear and visible leadership within the department. The outpatients' directorate was also organised into sub divisions so there were clear lines of accountability up to the leadership group and up to the senior management of the trust.

However, the directorate of outpatients and clinical support services was one of seven directorates within the hospital and the work of outpatients stretched across all directorates due to the range of medical outpatient clinics. There was no single body able to take responsibility or a leadership role for the performance of outpatients and nowhere data regarding access, flow and clinic efficiency could be shared, analysed and discussed as a single concern to help improve the patient experience.

Are outpatient and diagnostic imaging services safe?

Requires improvement



There was a system in place to report, investigate and learn from incidents. Staffing levels and training attendance were being suitably monitored and ensured safe levels. The department was clean, hygienic and underwent regular cleaning. There was an effective system to ensure that patient records were retrieved in time for appointments and the department was able to appropriately respond to safeguarding, capacity or consent issues when they arose.

The department had a system for managing and monitoring risks. However, controlled drugs were not being checked as they should have been and the medicines management policy was out of date. We also found that the electrical safety testing of some equipment was not up to date.

Incidents

- There was an electronic incident reporting system that enabled the outpatient managers to receive copies of all incidents that were reported within the department.
- Actions that arose from the reporting and investigation process were actioned by the manager of the sub division within outpatients and monitored by the directorate manager.
- Incidents and trends were discussed in team meetings and were a standing agenda item. They were also reviewed in quarterly performance reviews. The most recent meeting reviewed the whole year's incidents for possible themes and trends.
- The analysis of all incidents that occurred in 2013/14 showed there were six incidents that had been categorised as serious. All had been appropriately investigated. We discussed how incidents were categorised with the outpatients' leadership. This relatively high rate of serious incidents could be attributed to a good culture of incident reporting and analysis.
- Nursing and therapy staff we spoke with knew the reporting process and told us the mechanisms that were in place to learn from incidents. They also told us that outcomes from investigations were fed back to them directly.

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- Therapy staff we spoke with knew about the incident reporting process and told us they received feedback individually and in staff meetings. We were given examples of recent incident learning that had been communicated to them such as resuscitation trolley checks and x-ray delays.

Safety thermometer

- The NHS Safety Thermometer was not used in outpatients but information that related to safety in real time was recorded on an electronic performance 'dashboard' which was monitored by the outpatients' leadership. This included staffing, training, patient feedback, numbers of incidents, falls and infection control checks.

Cleanliness, infection control and hygiene

- We observed a clean and hygienic environment. We also observed good adherence to hand washing protocols although doctors were not observing the trust's bare below the elbows policy.
- Hand rub gel was available in all clinical areas and staff also had individual hand gels. Gloves and aprons were available.
- Cleaning schedules were in place for different parts of outpatients such as the sluice room, treatment rooms and toilets.
- Infection rates were recorded on the electronic data 'dashboard' and reported to the outpatients' directorate meeting. Data showed a zero infection rate in outpatients.
- The dashboard also included infection control data on weekly hand hygiene audits and monthly audits by the infection control link nurse. Data demonstrated compliance with carrying these out but did not show the results of the audits. Three sets of minutes from outpatients' directorate meetings showed that this performance data had been reviewed and did not show any concerning or outstanding actions from infection control.

Environment and equipment

- We observed that equipment had been cleaned and labelled to state this.
- The hydrotherapy pool was safely cleaned and tested. There was also staff training for therapists in relation to evacuating patients from the pool. This was compliant with Chartered Society of Physiotherapy guidance.

- We found that some portable electrical appliances had been checked for safety (the portable appliance testing is known as PAT). However, we also found equipment that had not been tested. For instance, the walking/running machine had not been PAT tested since January 2012. We also saw other equipment (such as air fans) where the PAT test was out of date.

Medicines

- The resuscitation trolley's drugs and equipment had been checked on a daily basis throughout the year although this had not happened for the last few days prior to our inspection.
- Controlled drugs were kept by the department and although these were stored securely there was no record of them being checked. The trust policy stated that controlled drugs should be checked twice daily.
- The medicines management policy was out of date. It should have been reviewed in January 2014.

Records

- Since September 2013 patient files had been stored in one location within the hospital. Prior to this they had been stored in three different places making it more difficult to locate files for outpatients' clinics.
- An electronic tracking system was in place which meant that files were scanned in and scanned out of storage. This enabled staff to locate where in the hospital the file was if it were not in records' storage.
- Work began on retrieving files a week before a clinic session. The first 'pull' of files located approximately 85% of files with the rest found nearer to the time. Staff aimed to achieve 100% success at retrieving all files by the time of appointments.
- We were told that the manager responsible for recording the key performance indicators (KPIs) for records retrieval was on leave at the time of our inspection and as a result the most recent KPIs for how many records were being retrieved for appointments were available. We were shown data from 2012/13 which showed missing files on a monthly basis was between 0.02 and 0.05% of the total.
- If notes were missing a temporary file was made up that consisted of essential details pulled from the electronic notes and recent tests such as blood results.
- A current risk documented on the outpatient directorate's risk register was 'risk of notes and images not being available for the start of clinics'. The register

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stated controls and assurances such as clinics being notified before they started if a file was not available and that the records department would provide a missing notes list for the clinic.

- We spoke with staff who worked to retrieve records for outpatient' appointments. We were told that it was now rare for sets of notes to not be located for appointments due to the combination of files being stored in one central location and the efficiency of the tracking system.
- Both nursing and medical staff told us they were well served by the records department.
- The governance update report from November 2013 showed there was a lack of single unified health record for every patient. There were separate physiotherapy, orthotic and occupational therapy notes which were not filed with main record.
- Actions arising from the patient experience improvement group meeting in May 2014 included a note that a discussion about improving the efficiency of the delivery of medical records for outpatient clinics would take place at the next meeting.
- Files were transported from the records department to a secure area in outpatients in open trolleys although files were covered so patient details could not be seen. They were transported to a secure area within outpatients although we observed unsupervised patient files in open areas near to clinic rooms which patients had access to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of how to respond to people when issues of mental capacity and best interests arose. There was a lead nurse who would be informed and give support.
- The consent policy was available for staff via the intranet. But the policy was out of date. It stated it was last reviewed in 2012 and was due for review in January 2014 but this had not happened.
- Patient consent was taken and recorded in individual clinic sessions. However, in most clinics leaflets and visual material to assist patients' decisions was not available at that time, but afterwards, outside of the clinic room.

- The pain clinic used a tablet computer in sessions with patients to visually explain what treatment options entailed. They had also produced a DVD showing outpatient staff demonstrating procedures. This was given to patients to take away.

Safeguarding

- There were two safeguarding leads within the trust and leads were identified within the outpatients department.
- The directorate manager told us they were confident that staff understood how to recognise and report abuse. We were given examples of this which included when an elderly person came in to outpatients and staff had concerns about the patient's vulnerability. This was escalated by staff and reported appropriately.
- Posters were on display about what steps to take in the event of suspecting someone might be at risk. Staff we spoke with were able to explain how to recognise and report safeguarding issues. There were lead nurses for safeguarding on duty who staff knew they could report or discuss potential safeguarding issues with and gave us examples when this had occurred. However, tissue viability/pressure sores were not seen as potential safeguarding issues to the staff we spoke with.
- The safeguarding policy was available for staff via the intranet. The policy was last reviewed in 2012 so was out of date.

Mandatory training

- The training record for outpatients identified who was up to date with their training and where there were gaps. The outpatients' clinical director monitored staff training in one to one meetings with the heads of each outpatient department.
- The training record showed that training within the department was 95% complete and that most of the gaps could be accounted for because training had been booked or staff were on maternity or sick leave.
- The trust expectation for training being completed was 85%. This had fallen from the previous year from 95% as it was felt this was not achievable.
- There was a different training expectation for clinical and non-clinical staff. There was a core training content for both that included fire safety, risk, incident reporting and information governance.

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- Other modules included infection control, manual handling and resuscitation (intermediate life support, basic life support, hospital life support). Staff were trained in safeguarding adults and children.
- We were told by the outpatients' manager that whether staff needed level 1, 2 or 3 safeguarding children training was decided by the training and development department. Training records we saw did not include levels of either safeguarding or resuscitation training.

Assessing and responding to patient risk

- The outpatients' directorate managed risks through their risk register. Heads of departments within the directorate were responsible for reporting risks within their own division, which were then managed in collaboration with the directorate manager.
- The risk register showed that risks were being managed within this structure. Each stated risk had a named manager responsible and other key elements such as an explanation of the current control to that risk, the adequacy of the control and the progress on minimising/eliminating the risk.
- We were shown examples where risks such as the retention of records had been progressed and how the department had ensured that staff were up to date with their manual handling training.
- The risk register also showed an item where a risk had not been acted on. The emergency buzzer or call system was not able to be heard on both floors. The risk register reported that estates had been informed 'several times about the problem' by the outpatients' leadership but had not acted on this. It was first reported January 2014 and had not been addressed.
- There was a specific pack in pre-operative assessment that incorporated a range of assessment protocols that also identified and managed individual patient risk. For instance, the malnutrition universal screening tool (MUST) was used to identify adults who were malnourished or at risk of malnutrition or obesity. Pressure ulcer risk assessment (Waterlow) and screening for the risk of venous thromboembolism (VTE or blood clots), which were completed by doctors, were incorporated in to assessments.

Nursing staffing

- The lead nurse for outpatients organised the staffing rota. Nurses and healthcare assistants were allocated to

certain clinics depending on their demands. There was a nurse on duty in a supervisory capacity and always a qualified nurse on each of the two floors from where outpatients delivered services.

- Nursing staff told us they felt there were enough staff and that there was an escalation process in place if the service was short staffed or had to cope with increased demand. The hospital used its own bank staff to cover for absences, sickness or to cover large clinics.
- Staff moved around the different clinics so they got experience of different medical disciplines.

Medical staffing

- Medical staffing is managed by individual specialty directorates, such as small joints or oncology. The junior doctors are managed centrally by the Administrative Registrar and Clinical Tutor.
- Each consultant controlled their own clinic template. A senior nurse told us they could influence this based on clinic efficiency and demand although this was informal and not always successful.
- There was no system for covering clinics in the event of something happening at short notice. For instance, we were given one example where a registrar's car had broken down and the service could not provide cover as a backup. Complaints and Patient Advice and Liaison Service (PALS) comments showed that clinics cancelled at short notice or with no notice was a source of patient dissatisfaction.

Major incident awareness and training

- There was a trust wide major incident policy and an emergency planning group that the outpatients' directorate manager sat on. Information was cascaded back to the department. Business continuity plans were in place in the event of certain incidents. For instance, access to areas, fuel shortage and loss of power were mitigated.
- There were specific business plans within the outpatients' directorate. Policy stated that the major incident procedure should be practiced annually.
- Therapists were able to describe clear processes and risk assessment they had in place if the IT system went down.
- Bleep holders had specific training that included taking the lead if a fire occurred.

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Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The department used a standardised assessment pack which followed established, evidence based treatment guidelines. Competent staffing was supported by an appraisal and supervision process. We also found that staff from different professional disciplines worked well together.

Clinics ran from 8am to 8pm on Monday, Tuesday and Thursday, 8am to 7pm on Wednesday and 8am to 5pm on Friday and occasionally at weekends when demand was high. Patients all told us that treatment was effective and met their needs.

Evidence-based care and treatment

- The pain service followed guidelines from professional bodies such as the Faculty of Pain Medicine and the British Pain Society. These were contained in a dedicated folder within the chronic pain service at outpatients.
- There was an assessment pack in pre-operative assessment that incorporated a range of established assessment and treatment protocols such as the MUST to identify adults, who are malnourished or at risk of malnutrition, pressure ulcer risk assessment and screening for the risk of VTE were incorporated in to assessments.
- Pressure ulcers were measured by grades 1 to 4 and followed the European Pressure Ulcer Advisory Panel guidance for measuring pressure ulcers.

Pain relief

- Patients reported receiving pain relief and there was a pain team available.
- There were programmes in place to reduce medicine reliance such as the functional restoration programme.
- All the patients we spoke with were happy with the pain relief they received and that they received it when they needed it.

Patient outcomes

- The service was National Joint Registry compliant. The National Joint Registry was set up by the Department of Health in 2002 to collect information on orthopaedic

procedures and to monitor the performance of joint replacement implants. As a result of analysing information submitted for this purpose the hospital were able to improve knee replacement care.

- Patients in therapies were positive about the outcomes of their treatment. Patients all told us that treatment was effective and met their needs.
- Musculoskeletal physiotherapy used an established European standardised outcome tool as a measure of health for clinical appraisal.

Competent staff

- There was a system of staff appraisal. Staff had their appraisals completed with the member of staff who was a grade above them. For example, the band 6 nurses' appraisals were completed by band 7 nurses.
- Records showed an appraisal completion rate of 100%. We were told that one to one supervision was also occurring between managers and the heads of each division of outpatients although this was not documented.
- The matron told us there was a clinical nurse skills tutor who sat on the medicines management committee. A nurse competency booklet for medicines management enabled nurse learning and competency in a number of areas such as trust medications policy and controlled drugs.
- There was a week's induction for nursing staff followed by a month with mentor support to ensure staff were competent and followed correct procedures.

Multidisciplinary working

- Outpatients was a multidisciplinary department that included pharmacists, therapists, occupational therapists, nurses, medics and business support staff.
- The outpatient department multidisciplinary meetings occurred on trust business and learning days known as 'TBaLD' days. These were patient free days that occurred every other month.
- There was a physiotherapist and occupational therapist linked to the oncology multidisciplinary team and a pathway in to a week's rehabilitation for outpatients. We observed nursing and medical staff had a good rapport with each other. Staff told us they felt they cooperated with one another and worked well together.

Seven-day services

- Staff in therapies told us that due to patient satisfaction survey results they now offered evening appointments.

Outpatients and diagnostic imaging

- Outpatient clinics ran from 8am to 8pm on Monday, Tuesday and Thursday, 8am to 7pm on Wednesday and 8am to 5pm on Friday.
- We were given examples where weekend clinics had occurred on an ad-hoc basis. For instance, within the last year a spinal clinic and a paediatric clinic had taken place on a Saturday.
- Pre-operative assessment clinics also ran on Saturdays if there was a backlog of patients needing to be assessed before surgery.
- We were told that the x-ray department was open on Saturday mornings and the magnetic resonance imaging (MRI) clinic worked a seven-day rota.

Are outpatient and diagnostic imaging services caring?

Good



Care and treatment was provided in a caring and compassionate environment. Patients told us staff treated them with dignity and respect and we observed this throughout our inspection. The trust had only just restarted the patient involvement group following a period of inactivity.

Compassionate care

- We observed a staff culture that was respectful and advocated for patients. Staff offered a caring and protective service.
- Peer support among staff was caring and nurtured a supportive environment for patients.
- We observed staff at all levels being considerate and helpful towards patients including reception staff.
- Patients we spoke with all felt the hospital was very caring and were complimentary about the service.
- One patient told us “this hospital is very caring; I’ve no complaints at all”. Another told us “the consultant has never rushed me”.
- Patients we spoke with told us they felt they had treatments and procedures explained to them. Clinic consultations took place in rooms with the door closed. Privacy and dignity was observed.
- Appointment delays were reported on the information screens within the outpatients’ waiting area. However, patients were not told the reason for any delay. We

observed frustrated patients going to the reception desk to ask why their appointment was delayed. Although reception staff were not able to give an answer they always responded with dignity and respect.

Patient understanding and involvement

- Patients told us they felt involved in their care. We were told “when we go to different departments they tell us about the tests they are going to do and ask if it’s okay to take samples”.
- Patients also told us that relatives or carers were included when they wanted them to be. This included joining them in the clinic rooms.
- Patients told us they had treatments explained to them and felt they understood what was happening because of this.

Emotional support

A counselling service was available for patients and their families.

Are outpatient and diagnostic services responsive?

Inadequate



There were many aspects of the service were responsive to people’s needs and we found a number of examples of this. The overwhelming feedback we received from patients was that although the service was responsive, appointments were very often delayed by over 40 minutes.

Sometimes patients had to be rebooked because the clinic had over-run. At other times, people told us they had turned up only to find their appointment had been cancelled. It is worth noting that 20% of patients were not from the West Midlands area so some had travelled a long way.

Information held by the trust such as comments from patients and risk register entries confirmed this. Staff also spoke about the regularity of late running clinics. However, the outpatients’ department did not fully understand where the ‘hotspots’ might be or have a real grasp of the extent or nature of this because it was not suitably organised, resourced or equipped to understand or respond to issues of quality and efficiency.

Outpatients and diagnostic imaging

Service planning and delivery to meet the needs of local people

- Written notice of a patient's first appointment was accompanied by a leaflet that outlined some practical information such as what to bring with you, directions and the confidentiality policy.
- The appointment bookings office were responsible for booking the clinic time which was then approved by the consultant who, if needed, would add an x-ray request to the appointment. This was arranged by the appointments team to coincide with the clinic appointment.
- Pre booking x-rays was a newly developed part of the service. This came about because patients told the service they had to wait for unreasonable lengths of time in x-ray on the day of their outpatient appointment.
- Patients were called by the appointments team and a letter was then sent out. Patients we spoke with told us they had always received a letter notifying them of their next appointment on time, often within a week of it being booked.
- Complaints and PALS contact information showed long delays in trying to contact the appointment bookings office.
- We were told that the patient administration system had the capacity to send text reminders to patients about their appointments but, in reality, only about 20% of people received these. The trust was looking to providing a text messaging system for this purpose.
- Patients could rearrange an appointment time if it did not suit them. Trust policy stated patients could rearrange appointments twice.
- One patient told us that the time of their appointment coincided with when they had had booked a holiday. They told us the service was understanding and flexible in allowing them to re book.
- We observed two heavy double doors to the right of reception that opened outwards and had to be opened manually in order for patients to access the clinic rooms from the main waiting area. We observed patients who had difficulty walking, some with walking aids and wheelchairs having to negotiate these doors without assistance.
- Rather than the trust funding the alteration of these doors, the service was awaiting a charitable fund to make them more user friendly.
- The outpatients' entrance was also the main hospital entrance. There was no signposting to direct people from this entrance. The hospital welcome desk was much smaller than the outpatients' reception and was slightly obscured because it was to one side. This meant the first place patients usually saw when they entered the building, was the outpatients' reception desk. The welcome desk opened at 9am whereas outpatients' reception opened at 8am.
- There was an electronic booking-in system located by the entrance. Patients could book in by choosing any one of eight languages. We observed very helpful hospital volunteers showing patients how to use this system.
- We observed patients queuing up at the outpatients' reception to ask for directions to other hospital departments. Reception staff told us this was a regular occurrence and sometimes caused a queue.
- At the weekends both the welcome desk and outpatients' reception were closed. Visitors came in to the outpatients waiting area and had no idea where to go because of the lack of staff assistance or signage.
- "I've been coming here 12 years. In the old building there were menu boards which told people where to go. I've been here two years in this new building and it's been an ongoing problem".

Access and flow

- Patients told us that they were happy with the treatment they received but were usually kept waiting beyond the time of their appointment. One patient reported a wait of two and a half hours on one occasion and regularly waiting for 40 minutes beyond their appointment time.
- Complaints and PALS contact information showed that clinics being cancelled without notice and patients waiting in over running clinics were themes. The service's risk register documented 'patients may become aggressive' as a risk and patients not being informed of late running clinics as a cause of this risk.
- Clinics were late running on the days of our inspection. Reception staff told us "delays are normal".
- Appointment delays were reported on the information screens within the outpatients' waiting area although patients were not told the reasons for any delay. We observed patients going to reception to ask why their appointment was delayed. Reception staff were not able to give an answer but always responded with dignity and respect.

Outpatients and diagnostic imaging

- Clinics had a mix of new and follow up patients with clinic templates controlled by individual consultants. However, the lead nurse in outpatients told us they were able to influence most clinic templates by discussing this with individual consultants.
- One consultant booked all of his patients in to the clinic between 8.30am and 10.30am which meant many waited needlessly. This had been flagged up with managers but without success in changing this practice.
- Access and flow within the outpatients department was not being adequately measured. The numbers of clinics that started late, over ran or were cancelled was not known by the outpatients' department.
- The rates of patients who did not attend their appointments and the time between initial referral and treatment were measured by the seven directorates depending on which speciality the consultant belonged.
- Late notice of cancelled clinics was reported to the trust's weekly 'referral to treatment' meeting as was the time it took to get letters out to GPs and patients following consultation. Two consultants told us it took on average two to three weeks for a letter to reach a patient and their GP.
- We were told by outpatients' managers that DNA rates had just begun to be measured as part of outpatient activity although this was in its early days and was measured in pain and musculoskeletal clinics only.
- Outpatient' managers told us they were aware that information could be used more effectively to measure the quality of the patient experience and efficiency of the department but that it required an analyst/informatics resource which they did not have.
- Outpatient clinics were made up from the separate directorates within the trust such as spinal, small joints, oncology and anaesthetics. There was no single forum where performance data could be shared or that could take collective responsibility for the performance of outpatients.
- Reception staff were able to book follow up appointments for patients when this had been advised by a consultant. However, patients told us that appointments were not available for the length of time that had been advised. For instance, where a patient had been advised to book an appointment for three months' time, one was not available for five months.

- We also found that reception staff did not have full access to the booking system which meant they had to contact their line manager to get permission to access this which contributed to delays at reception.

Meeting people's individual needs

- The directorate manager told us there was not a chaperone policy but the lead nurse in outpatients was able to accommodate patients that might be in need of a chaperone. We asked eight patients who attended appointments alone whether they had ever been asked. Half told us they had been asked if they wanted a chaperone although none had taken up this offer.
- The head of therapies and director of operations were not able to tell us if dementia awareness training was mandatory. We were told that outpatients were 'in the process' of training a link nurse for dementia.
- One patient told us they broke a bone that was not detected by another hospital. It was detected at Royal Orthopaedic Hospital through x-ray on a Monday; they were phoned by the consultant with the result the following day and came in on the Wednesday to have a cast fitted.
- We were shown the 'this is me' documents and were told by staff how they would use it. 'This is me' documentation is for people with dementia and informs health and social care professionals know about their needs, interests, preferences, likes and dislikes.
- There was not a routine process for screening for dementia but if it was flagged up as a potential issue with individual cases it would occur.
- Staff told us there was no learning disabilities awareness training. Staff told us they would use the 'this is me' pack if there was a need for learning disability.
- There was a new interpreter service being used following a recent tendering process. There was a feedback system within the new contract. We were told it was accessible out of hours as well as in normal working hours and was available as a face to face service or by telephone. If GPs flagged the need for an interpreter then one could be booked in advance.
- There was an electronic booking in system available to the side of the outpatients' reception desk. It gave patients the option of being able to book in in several languages.
- There was a specific assessment pack in pre-operative assessment that incorporated a range of assessment protocols such as MUST, pressure care and VTE.

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- The pain service offered outreach sessions at GP surgeries in the Birmingham area.
- There was a 'reflection room' located in outpatients. This was a quiet space, usually used by oncology but was available for all to use. The room was used to give sensitive news to patients. Patients were also taken there for confidential conversations or if they were upset or frustrated.

Learning from complaints and concerns

- Complaints and concerns were discussed in the Outpatient and Clinical Support Directorate business meetings. Agendas and minutes showed that complaints were a regular item. It showed that monthly statistics for compliments and complaints were being reported.
- Records showed that for the whole of the directorate in 2013 12 complaints and 30 compliments had been received for the outpatient service alone. The overall Directorate received 35 complaints and 244 compliments in 2013/14.
- Comments communicated to PALS which did not amount to a formal complaint were also reported to this meeting. It also showed individual complaints being discussed for learning.
- Progress on complaint investigations and outcomes were monitored by the outpatient directorate leadership who recorded this on a chart.
- Staff were able to tell us how they reviewed complaints and comments in team meetings.
- The outpatient lead nurse sat down with patients who were frustrated or unhappy with the service. This was to listen and act on their behalf in order to improve their experience of the service.
- The pain service told us they were 'aware and proactive' when it came to unhappy patients and tried to respond to their frustrations in real time.
- A recent innovation had been to create a patient comments and feedback board called 'the voice'. Patients were invited to anonymously write in a speech bubble which was then posted in to a box and displayed with others. Negative comments were displayed along with a response. This was early days and the board was not yet on display to patients.

Car Parking

- Data from complaints and PALS comments showed that car parking was a source of frustration among outpatients. This was confirmed in our conversations with patients.
- We were told that the hospital had recently started to charge for car parking which was expensive. We were told this was made worse when outpatient clinics were late, which occurred on a regular basis.
- We were also told that there were not enough blue badge spaces for disabled patients which would have meant these patients would not have to pay.
- We spoke with the car parking coordinator, who told us there were a total of 246 parking spaces in the hospital grounds, of which 42 were blue badge spaces. There were also one hour passes for physiotherapy and oncology patients and weekly concessionary passes available.
- Patient and visitor parking information leaflets were available around the hospital and detailed car parking information. However, some information conflicted with what we had been told. For instance, it stated there were only 21 blue badge spaces.

Transport

- Patient transport was contracted out to a new private provider in April 2014, following a tendering process. The contract was monitored by the trust's head of facilities.
- Approximately 100 patient journeys were provided each day with an average wait time of forty minutes although patients were given a two hour time window for being picked up. 80% were picked up from the West Midlands area and 20% from a national area that included Cornwall, Scotland and airports.
- Transport was notified of a patient's need for transport two days prior to appointments and transport phoned patients to understand their needs. For instance, how many steps, was there a wheelchair. Some appointments were at very short notice because of a pressing need and the service was able to respond to this.
- We were told that it was rare that transport could not be provided. Patients we spoke with were happy with transport services.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement



There was clear and visible leadership within the department. The outpatients' directorate was also organised in to sub divisions so there were clear lines of accountability up to the leadership group and on to the senior management of the trust.

However, the directorate of outpatients and clinical support services was one of seven directorates within the hospital and the work of outpatients stretched across all of the hospital's medical directorates due to the range of medical outpatient clinics.

There was no single body able to take responsibility or a leadership role for the performance of outpatients or where data regarding access, flow and clinic efficiency could be shared, analysed and discussed as a single concern to help improve the patient experience.

Vision and strategy for this service

- We were told by the directorate manager that 'best care, best hospital, best people' was the trust mission statement and they worked to achieve this by investing in people and their skills.
- When we spoke to a lead nurse and therapist within outpatients they told us the vision and strategy for the trust was 'the five Cs' - care, commitment, communication, competence, courage'. We were told that outpatients was a 'shop window for the rest of the hospital' and as such their commitment to the 'five Cs' mattered. We were later informed that this should indeed be six Cs. Compassion had been left out.

Governance, risk management and quality measurement

- Incident reporting and analysis was taking place.
- The risk register was kept up to date and risks appropriately monitored.
- A number of KPIs that measured quality and risk were collected and collated in to electronic KPI 'dashboard' collating information on a number of key areas: workforce, training, patient experience/feedback, safety,

financial efficiency, infection control and tissue viability. Minutes from three outpatients' directorate performance meetings showed the dashboard being reported on and discussed.

- There were management team meetings within the directorate and monthly KPI performance dashboard meetings which reviewed data. These were also used by the triumvirate of clinical director, directorate manager and matron as a working document.
- Quality measurement in other areas was not being measured. For instance, the numbers of clinics that started late, over ran or were cancelled was not known by the outpatients' department. The rates of patients who did not attend their appointments and the time between initial referral and treatment was measured by other hospital directorates and were not known by outpatients. DNA rates had just begun to be measured by outpatients for pain and musculoskeletal clinics.
- Late notice of cancelled clinics was reported to the trust's weekly 'referral to treatment' meeting as was the time it took to get letters out to GPs and patients following consultation but was not monitored by the outpatients directorate.

Leadership of service

- The outpatients' directorate was led by the triumvirate of clinical director, matron and directorate manager.
- Senior nurses supervised and managed the outpatients department on the ground and told us they were supernumerary to enable this. We also often observed them carrying out routine clinical tasks.
- There was an executive and non-executive board member linked to the outpatients' directorate. The outpatients' manager told us this gave them good and fast channels of communication up to the board. Making an investment in imaging and sharing ideas about a bone infection unit were given as examples of things that had been discussed through this channel.
- Reception staff told us the chief executive came to speak to them every three weeks or so.
- Outpatients and support services directorate meetings occurred on trust briefing, learning and development days known as 'TBaLD' days. These were patient free days that occurred every other month.
- The departments that made up the outpatients' directorate met monthly where information was

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cascaded. The clinical director, matron and directorate manager shared an office and we were told this enabled them to maintain ongoing conversations regarding the directorate's leadership.

- Outpatients and clinical support services was one of seven clinical directorates within the hospital such as spinal, small joints, oncology and anaesthetics. The work of outpatients stretched across all of the hospital's medical directorates due to the range of medical outpatient clinics.
- There was no single body able to take responsibility for the performance of outpatients and no single forum where data regarding access, flow and clinic efficiency could be shared, analysed and discussed as a single concern. This would be with a purpose to improving the patient experience.

Culture within the service

- The directorate manager told us the leadership of outpatients nurtured an open culture in a respectful, professional environment. We were told by the outpatients' managers that a core value of staff was to be professional, forward facing and courteous.
- We observed staff culture that was respectful and advocated for patients. Staff offered a caring and protective service.

Public and staff engagement

- The directorate manager told us the 'patient experience improvement group' had been refreshed in April 2014 after a period of a year when it had not met. Its focus for the year was to consider the whole patient pathway within outpatients. It included how patients were greeted, treated and seen; the entire experience.
- The first meeting was held in May 2014 so it was early days. We were told there were two patient representatives on the group. They had met once since its refresh. There were a number of actions that had arisen from this that included chair layout of the waiting area, the practice of weighing patients in open areas and patient information.
- Patient information leaflets were available in the department which helped understanding of conditions.
- The trust introduced the NHS Friends and Family Test last year. Outpatients scored 47 in the first quarter of 2013-14 which was significantly lower than other parts of the hospital. Satisfaction rose to 87 in the last quarter (January - March 2014).

- Outpatient managers put this down to making a number of improvements to the service in response to issues raised by patients. They included pre booking x-ray slots for outpatient appointments that had meant patients did not have to wait for long periods, retraining volunteer 'welcomers' who assisted patients to check in, clinic staff supporting reception staff in communicating clinic delays, updating the screen which reports on delays and patients now being able to book in to outpatients at their x-ray appointment and being tracked back to outpatients afterwards.
- Feedback from staff meetings, managers' walkabouts and walkabouts by the two trust board members linked to outpatients were given as examples of engagement with staff.
- Staff survey results were broken down in to directorates and were positive for some aspects of outpatients such as 95% believed their role made a difference (91% nationally).
- Other outcomes were not as positive for instance 24% had experienced bullying, harassment or abuse (13% nationally). We were told that the nature of outpatients meant they were 'front facing' and the nature of having a high amount of contact with patients and the public meant they were more likely to face conflict in the workplace. We were also told that managers were taking action on this which was tracked on an action plan. It included supporting staff with conflict situations, ensuring staff were appropriately trained and reporting and feeding back on incidents.

Innovation, improvement and sustainability

- We were told that the new patient experience group came out of the clinical programme board, which was a trust wide initiative with project leads. The board considers initiatives from directorates and decides on their feasibility.
- The rapid assessment service was given as another example of a recent innovation. It had been up and running for a couple of months and was set up in response to surgery being cancelled because patients had not been pre assessed. It updated the existing service and created a new nurse role within the team.
- A recent innovation had been to create a patient comments and feedback board called 'the voice'. Patients were invited to anonymously write in a speech bubble which was then posted in to a box and displayed

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with others. Where comments that were negative had been written they were displayed along with a response. This was early days and the board was not yet on display to patients.

- There was an electronic booking-in system located by the entrance. Patients could book in by choosing any one of eight languages.

Outstanding practice and areas for improvement

Outstanding practice

- The Royal Orthopaedic Community Service provided services within a 24.5 mile radius of the hospital to support the early discharge of patients from hospital.
- The trust had established patient pre-assessment clinics for surgery, which were available at the same time as their outpatient appointment.
- Outreach clinics were held by the ortho- oncologists in Leeds, Sheffield, Manchester, Liverpool, Bristol and Cardiff to improve patient access and avoid patients and relatives or carers having to travel long distances.
- The trust provided pioneering treatments to patients with very complex orthopaedic conditions. Surgeons were using silver coated implants to reduce infection. Other treatments achieving outstanding outcome for patients included the ITAP implant to attach prosthetic limbs and the use of motorised extendable implants for children and young people.
- Surgeons were using computer navigation based on importing CT/MRI scans to develop a 3D model to remove tumours of the pelvis to ensure maximum removal and clear margins to reduce incidence of reoccurrence from 25% to 10%.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must ensure:

- Medicines are managed at all times in line with legal requirements.
 - Equipment is properly checked and maintained in accordance with electrical safety requirements.
 - A chaperone policy is developed and chaperones made available to support patients' privacy and dignity.
 - Confidential patient information and records are not left unsupervised in unrestricted public areas of the outpatients department.
 - Appointments are organised for all clinics to reduce waiting times for patients and improve their experience in the outpatients department.
 - Letters to GPs and other referring bodies are sent out within set timescales to ensure effective communication.
- In addition the trust should ensure:
- Resuscitation equipment is checked in accordance with the trust's procedures and records of the checks are kept.
 - There is managerial oversight of all outpatient department services to ensure the efficient and effective operation of the department and to ensure patients' experiences of care are improved.
 - Discharge arrangements are improved to facilitate early identification and availability of beds for patients admitted on the day of surgery.
 - The implementation of the Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote patients' involvement in their care.
 - When the reception desk is closed, there is visible signage to direct patients and visitors from the main entrance to other departments.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity

Regulation

Surgical procedures
Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.

People who use services were not protected from the risks associated with the unsafe management of medicines because controlled drugs were not checked in accordance with legislation. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.

Regulated activity

Regulation

Surgical procedures
Treatment of disease, disorder or injury

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment.

People who use services were not protected from the use of unsafe equipment as electrical safety checks were not routinely undertaken.

Regulation 16 (1)(a) HSCA 2008 (Regulated Activities) Regulations 2010

Regulated activity

Regulation

Surgical procedures
Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Compliance actions

Regulation 20 HSCA 2008 (Regulated Activities)
Regulations 2010 Records

The registered person must ensure that patient records which may be in paper or electronic form are kept securely. Regulation 20 (2)(a) HSCA 2008 (Regulated Activities) Regulations 2010.

Regulated activity

Regulation

Surgical procedures
Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

Regulation 10 HSCA 2008 (Regulated Activities)
Regulations 2010 Assessing and monitoring the quality of service provision

The provider did not have systems in place to monitor the quality of services in OPD.

Regulation 10(1)(a)(b) HSCA 2008 (Regulated Activities)
Regulations 2010 Assessing and monitoring the quality of service provision

Regulated activity

Regulation

Surgical procedures
Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

Regulation 17 HSCA 2008 (Regulated Activities)
Regulations 2010 Respecting and involving service users

The registered person must, so far as reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users.

Regulation 17(1)(a) HSCA 2008 (Regulated Activities)
Regulations 2010 Respecting and involving service users