The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Quality Report

Russells Hall Hospital, Pensnett Road, Dudley, West Midlands, DY1 2HQ
Corbett Hospital, Vicarage Road, Stourbridge, West Midlands,, DY8 4HZP
Tel: 01384 456111
Website: www.dgh.nhs.uk

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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
Accident and emergency	Requires improvement
Medical care	Good
Surgery	Good
Critical care	Requires improvement
Maternity and family planning	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection as part of the new hospital inspection programme and as a follow up to the Keogh review which took place in 2013. Of the 14 trusts inspected under the Keogh review for the quality and safety of their services, The Dudley Group NHS Foundation Trust was one of only three trusts that were not put into special measures. That review identified concerns regarding:

- governance arrangements
- the need to embed a culture of learning from incidents
- how the trust uses and reviews mortality data
- the system for bed management and patient flows
- embedding patient experience in the organisation's learning and strategy
- staffing levels and skills mix
- safety and equipment checks
- pressure ulcer care.

Before the inspection conducted in March 2014, the Trust was identified in CQC's intelligent monitoring system as a priority band 4 Trust. There are six bands within the monitoring system so this Trust had a relatively lower risk.

We noted that the trust's action plan to address the concerns following the Keogh review had been put into place and signed off.

Our inspection of The Dudley Group NHS Foundation Trust included Russells Hall Hospital, Corbett Outpatient Centre and Dudley Guest Outpatient Centre.

The announced inspection took place between 26 and 27 March 2014, and unannounced inspection visits took place in the two weeks following this visit.

Overall, this trust was found to require improvement, although we rated it good in terms of having caring staff, and effective services.

We saw much support for the trust, both from the public and from the local health economy.

We saw a trust that was a considerable way along its improvement journey and saw many areas of strong development. Whilst some of the core service areas within the trust required improvements in leadership, we found the executive team and the trust board had a clear focus on improvement and as such we rated this trust as good for its overall leadership.

The improvements required by the trust were within the grasp of the trust and its leaders. We were confident that these could be achieved quickly.Key findings related to the following:

- The trust's staff are seen as highly caring by many of the patients we spoke to and praised the staff for 'going the extra mile'.
- The trust's leadership team is seen as highly effective by the staff; and is recognised to be clearly in touch with the experience of patients and the work of the staff.
- Staff value the Dudley Group as a place to work and a team spirit is clearly evident.
- The trust has responded well to the Keogh review in 2013.
- There are a number of areas of good practice in the trust, which should be encouraged. Staff feel able to develop their own ideas and have confidence that the trust will support them.
- The emergency department (A&E) is busy and overstretched. There remain challenges in the flow of patients, but much of this relates to flow across the rest of the hospital. Only a small proportion relates to the emergency department itself.

Summary of findings

- The trust does not always follow its own policy in relation to DNACPR (do not attempt resuscitation) notices.
- The ophthalmology clinics require review to ensure that all patients are followed up as required and that there is capacity for these clinics.
- The trust must review its capacity in phlebotomy clinics as this is seen as insufficient.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The Trust was experiencing an increased number of patients admitted to the ED. This had a negative impact on the Trust meeting the national target of admitting, transferring or discharging patients within four hours of their arrival in the department. We saw when patients arrived by ambulance they were assessed in a corridor, and at times they were kept in this area until a cubicle was free. Staff told us they were aware the practice was not ideal for patients. Patients were observed until they were placed on a trolley, which was as soon as possible after entering the department. The ED was struggling to manage the flow of patients through the department. Much of the challenge related to the ability of the ED to identify beds in the hospital for those patients who needed to be admitted. Delays in moving patients from the ED were impacted by general blockages across the system. This in part also related to the lack of capacity outside the hospital to facilitate a prompt discharge for patients. There were some initiatives in place to avoid unnecessary admissions (where admission isn't clinically required) and to speed up the discharge of patients but waiting times for patients were not improving. The Trust told us they were aware of the key risks within the organisation but there appeared to be no clear communication or action taken between Trust wide managers and the frontline staff within the ED. The reality for the staff of the day-to-day pressure was immense and the staff felt that this was being overlooked. The staff were committed to trying out new initiatives, learning and wanted to improve. They told us senior leaders were less responsive to supporting them. Although there was some monitoring of quality taking place it was not carried out in a structured or formalised way. We found that the ED staff were enthusiastic and caring. Relatives and patients told us they found the staff very kind and caring. Patients told us they felt

safe and they had been informed about their treatment. They told us they would recommend the hospital to friends and family. The ED was running at full capacity.
During our inspection, we found the department staffed with medical and nursing staff in sufficient numbers to meet the needs of patients. We observed patients in the Minors and Majors areas being prioritised or triaged by a 'triage trained' nurse. This process ensured that the most appropriate plan of care was organised to meet their needs. Children were triaged in the separate paediatric department from 11am to 11pm. This meant that they were seen by specialist nurses and doctors during those hours.

Medical care — Good

We found that all of the areas we visited on the medical care directorate were clean and hygienic, which helped to protect patients from hospital-acquired infection. We saw that all areas were well maintained and free of clutter.
We saw that staff had completed mandatory training and received annual appraisals of their performance. All staff received mental health awareness training and de-escalation training had commenced for nursing staff. We found that lead nurses were well informed about de-escalation techniques and challenging behaviour.
We saw that staff received training on how to report incidents, such as falls, and complaints. Staff told us that they received regular feedback on these. We saw that lessons learned from incidents, and actions for any improvements, were discussed in team meetings.
We found that medicines management was safe and patients received timely and appropriate pain medication as needed. We saw that staffing levels had improved and the Trust was in the process of recruiting additional trained nurses and medical staff.
We saw that staff worked in partnership with other colleagues and partners to achieve the right outcomes for patients. Throughout the inspection we observed positive interaction between staff and patients. All of the patients we spoke with said the staff were very good. They told us that they were treated with respect and dignity.

Summary of findings

We were concerned about the delays in the flow of patients through the hospital. We saw that some patients had to wait for long periods and were subjected to multiple moves in the directorate. We are aware that this is an ongoing problem and actions have been taken to improve this situation with the introduction of the frail elderly short stay unit. However, this remains an area of improvement for the Trust.

A dementia care bundle – a small set of evidence-based practices and processes to improve care – had been piloted, but this must be implemented across the directorate to provide the best outcomes for people living with dementia.

We found that the service was well-led. Staff told us that senior management were visible and wanted to know about patients' care. Staff told us that they felt able to raise issues and senior management were approachable and listened to feedback from staff.

Surgery

Good

We visited six wards, the Pre-operative assessment clinic and the Oral surgery department. We also visited the day surgery unit and main theatres at Russells Hall Hospital and the day case unit at Corbett Hospital which included the waiting area, ward and theatre. We observed care provided both pre- and post-operatively at both locations. We discussed the never events – mistakes that are so serious they should never happen – that had occurred in the surgical department with staff in the theatres. We also held focus groups and 121 discussions with nurses, junior doctors, consultants and heads of services.

Services in the surgical department were safe for most patients. There were appropriate systems in place to report incidents and concerns and take necessary actions when needed. The Trust had reported two surgical never events, between December 2012 and January 2014. We found that new procedures were in place to minimise further risks as part of lessons learned from these incidents. The surgical safety checks at Russells Hall Hospital were completed, as per clinical guidance. The surgical department had good adherence to national and professional infection control and cleanliness guidance.

Summary of findings

Patients in all areas of the surgical department complimented staff on their caring approach.
Patients' needs were assessed, and care planned and delivered in line with best practice guidance.
Assessments started in the preoperative assessment clinic and continued during the patients' hospital stay.
Staffing levels had improved and the Trust was continuing to actively recruit staff. Staffing levels were found to reflect patients' needs. There were arrangements in place to check the competency of staff, their training needs and practice. However there was a need to recommence competency checks for staff who worked in the day case unit at Corbett Hospital to demonstrate that safe and appropriate care continued to be provided in this area.
The Dudley Group NHS Foundation Trust was responsive to patient's needs to ensure that they had access to timely treatment. Staff were proud of their achievements to reduce pressure ulcers, improve the management for diabetic patients who had surgery, the reduction in the number of patient falls and the management of patients who had a fractured neck of femur.
We found that the surgical department was well led. There were appropriate leadership arrangements at all levels within the surgical department and staff felt supported by their managers. Staff were committed to reviewing and auditing to continually improve the care and treatment that patients received.

Critical care

Requires improvement

Staff we spoke with did not consistently demonstrate that they knew how or when to report incidents using the Trusts electronic incident reporting system.
We looked at risk registers for each of the services in critical care. We did not find that risks had all been identified or recorded. This meant senior managers within the Trust would not have been made aware of these risks.
The HDU was routinely staffed to less than the full capacity for the number of patients they could accommodate. We were informed that the hospital bed managers used this capacity to "flex" up and down to meet the needs of people accessing the

hospital. We were concerned that the "flex" staffing arrangements in MHDU could place people at risk of unsafe care. We found that senior nurses were spending unreasonable amounts of time covering shifts with agency staff or the Trust's own temporary nurses. Greater staffing continuity could have been achieved if the Trust agreed blocks of time the beds would be used for.

Senior nursing staff advised us of the staffing challenge they were currently facing due to delays in recruitment, sickness and maternity leave. We found that efforts had been made to ensure the continuity of staffing wherever possible. Agency nurses we spoke with reported that they had been inducted to the unit and supported to ensure that they were competent and confident to undertake their role.

People in the high dependency units (HDUs) were not cared for in an environment that promoted their dignity or privacy. There was a lack of general space and poor screening around beds in the SHDU and a lack of toilets and bathrooms in both SHDU and MHDU

The latest Intensive Care National Audit & Research Centre (ICNARC) data showed that patients using the ICU services were likely to have better than expected outcomes, as the rates of mortality were fewer than expected when compared with other similar hospital units across the country.

Patients received a good standard of nursing and medical care. Patients benefited from a service that was caring, effective and well-led by an experienced and competent team.

Maternity and family planning

Requires improvement

We were concerned with some elements of the service regarding safety; specifically that the arrangements for covering shifts were unsustainable and these were putting pressure on the existing staff. Additionally, we saw that categorisation of incidents and recording of data were at times inaccurate. This prevented the service analysing incidents and learning from these. We also saw the quality of data recorded on the maternity dashboard was variable.

The maternity department had failed to meet some of its indicators on the maternity dashboard, for example, elective caesareans had been higher than expected in recent months. The department was

meeting other targets, for example, majority of women booked by 12 weeks of pregnancy – while performance against other indicators varied each month.
We found that staffing levels sometimes fell below the expected numbers and that there had been an increase in the number of staffing-related incidents reported.
We saw that there were processes in place for individual staff members to learn from incidents they had reported or been directly involved with. However, not all incidents were categorised correctly and information did not always flow through accurately to reports and the performance dashboard (an electronic performance reporting and tracking system). Also, the sharing of learning outcomes required improvement.
The women we spoke with were happy with the care they had received. They found the staff to be friendly and helpful and communicated well about their care and treatment.
There was a clear care pathway in the maternity unit, according to women's clinical needs. Women felt that the level of communication from midwives and doctors was good and they felt listened to and well supported.
The layout of the department meant that women and their new-born babies could be cared for in an environment which promoted their privacy during their stay.
We saw that the maternity department had performed well in feedback from patients through the Maternity Survey and that there was a process for handling complaints, although we saw that one complainant had not received an accurate response.
Staff working within the department generally felt well supported by management and thought that they worked in an open and transparent environment.

Services for children and young people

Good

The paediatric department did not have a system in place to monitor performance against targets beyond the basic nursing principles and other Trust-wide targets. We were told that this was under review and that a performance dashboard (a reporting and tracking system) was in the process of being developed.

Summary of findings

We found that staffing sometimes fell below the expected numbers; when this happened, the escalation policy was followed and beds on the unit were suspended.
It was difficult for parents to obtain meals when visiting for long periods of time.
The children and families we spoke with felt staff were caring and supportive. We were told that communication from medical staff was not always consistent, which could cause confusion for patients.
There was a clear care pathway for babies and children according to their clinical need. The unit was modern and nicely laid out which enabled the promotion of people's privacy and dignity. There was a sensory room on the children's ward, with toys. Play workers and a teacher were available.
We saw that there were processes in place for individual staff members to learn from incidents they had reported or been directly involved with. However, the sharing of learning outcomes required improvements.
Staff working within the department generally felt well-supported by management and thought that they worked in an open and transparent environment.

End of life care

Good

We found that improvements were required to ensure patients were always as safe as possible and received care and treatment that met their needs in relation to do not attempt resuscitation (DNACPR) processes. A DNACPR policy and procedure was in place, however, we noted a number of concerns in relation to how this had been implemented.
We noted an occasion where there was no evidence that DNACPR decisions had been reviewed and an occasion when a DNACPR decision had not been endorsed by a consultant within the timescale specified within the Trust's policy, although a discussion with a consultant had previously taken place.
The specialist palliative care team provided support and advice to health professionals working within the hospital and in the community. This ensured a coordinated multidisciplinary approach to end of life

Summary of findings

care. We found that patients who were receiving end of life care without the need for support from the palliative care team also received a good standard of care.
Patients and their families told us that staff were available at the times they needed them and said that personnel were caring, kind and compassionate. We observed staff treat patients respectfully and with dignity.
The services offered by the chaplaincy, mortuary and bereavement services were considered to be excellent.
Staff we spoke with described strong, supportive leadership at Trust Board level and an organisational culture that empowered staff at all levels of the organisation.
Most people told us that the end of life service was responsive to their needs. From patients' care notes we found that patients' healthcare needs were regularly reviewed. Pain relief, symptom management, nutrition and hydration were being provided according to patients' needs. Most patients and relatives we spoke with told us that they felt involved in decisions made about their care and treatment and care records confirmed this.

Outpatients

Good

Most people told us that the services they used were responsive to their needs. However, in some areas of the outpatient department, patients' needs were not being met. There were problems in ophthalmology with the appointments system, overcrowding in the phlebotomy (blood collection) clinics at Russells Hall and Corbett Hospitals and, issues identified with parking provision at Russells Hall.
Overall, patients received a safe service. They were protected as far as possible from harm or abuse. Staffing levels were good and the Trust demonstrated a commitment to ensuring staff were up to date with mandatory training. Managing risk across the outpatient department had not been consistent; information and good practice in relation to slips, trips and falls had not been widely shared across the department.
Treatment was generally effective. We found that patients were satisfied with outpatient treatment. Difficulties with the transport arrangements to and

Summary of findings

from outpatient appointments had been identified and the Trust was working towards their key performance indicator of 95% of patients arriving and leaving the outpatient department on time.
Staff at all three sites, including outpatient services for children and young people, told us some clinics used reminder calls and texts and a partial booking service to achieve good rates of appointment attendance.
We observed good collaborative working within the multidisciplinary team. Examples included nurse-led clinics, clinics led by allied health professionals and multidisciplinary clinics.
Patients said that staff were caring, kind and compassionate. We observed that staff treated patients respectfully and with dignity.
We identified some excellent practice that targeted patients' specific needs in an empathetic manner. This included the Eye Clinic Liaison Officer (ECLO) and the Care of Next Infant (CONI) programme in the outpatient clinic for children and young people.
Most of the staff we spoke with described strong, supportive leadership at board level and an organisational culture that empowered staff at all levels of the organisation.

Requires improvement

Russells Hall Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to Russells Hall Hospital

Russells Hall Hospital is part of The Dudley Group NHS Foundation Trust. It is a medium sized hospital providing services to the population of Dudley, Stourbridge and the surrounding towns and villages. Located in the heart of the Black Country area, it covers a population of around 450,000 people in mainly urban areas.

The Trust consists of Russells Hall Hospital with two smaller outpatient centres, Corbett and Dudley Guest, which are run as one main unit.

The hospital has around 687 beds. It sees around 105,000 inpatients; 500,000 outpatients and almost 100,000 attendances at A&E each year.

The area of Dudley is moderately deprived (83rd out of 326 local authorities, where 1 is the most deprived). Life expectancy is worse than that expected within the England average.

The Trust gained foundation Trust status in October 2008, and was the first Trust to do so in the area.

We carried out this comprehensive inspection as part of the new hospital inspection programme and as a follow up to the Keogh review which took place in 2013. Of the 14 trusts inspected under the Keogh review for the quality and safety of their services, The Dudley Group NHS Foundation Trust was one of only three trusts that were not put into special measures. Before this inspection, the Trust was identified in CQC's intelligent monitoring system as a priority band 4 Trust. There are six bands within the monitoring system so this Trust was a relatively lower risk.

CQC has reviewed the Trust on a number of areas and against all outcomes in the previous regulatory approach to inspection. The Trust has had seven inspections since registration and was last reviewed on 30 July 2013. On all reviews, the Trust was found to be fully compliant with regulations.

Our inspection team

Our inspection team was led by:

Chair: Mr Peter Lees, Medical Director, Faculty of Medical Leadership and Management

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

The team of 40 included CQC inspectors, doctors and nurses with specialist skills and interests in the areas we inspected. There was a pharmacist inspector, people with skills and experience to look at safeguarding and care of vulnerable adults. At least two members of the team also held board level roles in other trusts and were therefore experienced in the wider organisational issues. We had both a junior doctor and a student nurse. Additionally we had two Experts by Experience (people with experience of using similar services who are able to talk to patients to gather their views) and two lay representatives.

The Patients Association was also part of our team to review how the trust handled complaints.

How we carried out this inspection

To really understand a patient's 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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical

Detailed findings

commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Royal Colleges and the local Healthwatch.

We held two community focus groups in early March 2014 with voluntary and community organisations. The focus groups were organised in partnership with Raise, through CQC's Regional Voices Programme. They aim to listen to the views of people who may not always be heard.

We held two listening events, in Stourbridge and Dudley, on 25 March 2014, when people shared their views and experiences of The Dudley Group NHS Foundation Trust.

We carried out an announced inspection visit on 26 and 27 March 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, managers, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out several unannounced inspections in the two weeks following our inspection.

We are grateful to all the patients, carers, members of the public and staff for their honesty and open approach during this visit.

What people who use the hospital say

We spoke to two patient/community focus groups before the inspection which were arranged by CQC partners and held away from the hospital. People at the focus groups reported that they had challenges in accessing outpatients and often experienced delays in the service. People found most problems with the ophthalmology clinics.

We held two public listening events on 25 March 2013 for people of the Dudley and Stourbridge areas to join us in one-to-one discussions about their experiences, one in Stourbridge and one in Dudley. These meetings were well attended and the information shared with our inspectors informed the inspection.

People told us of areas where the care they had received was good and that they were pleased with that care; people also told us of times when (with complex clinical or social needs) they felt the service had let them down.

Letters handed to the CQC inspection team on the day of the visit were highly complimentary about the services that people had received.

We also spoke to many patients and relatives during our inspection within each clinical area we visited. In the subsequent sections of this report we have detailed the comments as they relate to each service.

What other organisations say

We spoke to partner organisations before our visit and saw good relationships between the Trust and partners within the local health economy.

The local Healthwatch were represented at the public listening events we held.

What staff say

During our inspection of the Trust we held focus groups (open meetings for staff to reflect their thoughts and views). We held focus groups for

- Consultants
- Junior doctors
- Senior managers and senior nurses
- Nursing staff
- Student nurses and healthcare assistants
- Midwives
- Allied health professionals
- Non-clinical staff.

In all groups, staff attended and contributed freely. Many of the groups were very well attended (for example, the senior managers group had over 65 people; 55 at the student nurses and 50 people at the non-clinical staff groups).

All staff felt positive about working in the organisation and were very up-beat about the changes made and the direction of the organisation's development.

All of the staff were highly complimentary about the leadership team and particularly praised the Chief Executive for her strong leadership and engagement of the staff.

Detailed findings

The consultants' group praised the strong focus on clinical governance, case review of deaths in the hospital and good team working.

The nursing staff (as well as other groups) felt that the Trust strongly supported staff appraisal and development. Training of staff was perceived to be a priority in the organisation and people spoke about being supported to achieve their potential.

People spoke with passion about being part of a single team and had pride in their organisation.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity and family planning	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good
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 & Emergency and Outpatients.
2. The rating at overall Trust level for the well-led key question is different for the rating for well-led for the location. This reflects the inspection team's view of strong leadership from the executive team, Trust board and the chief executive.

Accident and emergency

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

Information about the service

The emergency department (ED) had a total of 35 trolleys situated throughout the department. There were three trolleys in a resuscitation room, 17 in Majors cubicles (for major injuries), six in Minors (minor injuries) and three dedicated paediatric trolleys. Adjacent to the ED was a clinical decision unit (CDU) where up to six patients were assessed and supported to be discharged back to the community avoiding admission to a ward.

The ED is a 24-hour, seven-days-a-week service. During 2013, the ED saw 98,230 patients.

While in the department, we spoke with 28 staff (qualified and unqualified), including the matron and lead consultant. We also spoke with 24 patients and 11 relatives

Summary of findings

The Trust was experiencing an increased number of patients admitted to the ED. This had a negative impact on the Trust meeting the national target of admitting, transferring or discharging patients within four hours of their arrival in the department. We saw when patients arrived by ambulance they were assessed in a corridor, and at times they were kept in this area until a cubicle was free. Staff told us they were aware the practice was not ideal for patients. Patients were observed until they were placed on a trolley, which was as soon as possible after entering the department.

The ED was struggling to manage the flow of patients through the department. Much of the challenge related to the ability of the ED to identify beds in the hospital for those patients who needed to be admitted. Delays in moving patients from the ED were impacted by general blockages across the system. This in part also related to the lack of capacity outside the hospital to facilitate a prompt discharge for patients. There were some initiatives in place to avoid unnecessary admissions (where admission isn't clinically required) and to speed up the discharge of patients but waiting times for patients were not improving.

The Trust told us they were aware of the key risks within the organisation but there appeared to be no clear communication or action taken between Trust wide managers and the frontline staff within the ED. The reality for the staff of the day-to-day pressure was immense and the staff felt that this was being

Accident and emergency

overlooked. The staff were committed to trying out new initiatives, learning and wanted to improve. They told us senior leaders were less responsive to supporting them. Although there was some monitoring of quality taking place it was not carried out in a structured or formalised way.

We found that the ED staff were enthusiastic and caring. Relatives and patients told us they found the staff very kind and caring. Patients told us they felt safe and they had been informed about their treatment. They told us they would recommend the hospital to friends and family. The ED was running at full capacity.

During our inspection, we found the department staffed with medical and nursing staff in sufficient numbers to meet the needs of patients. We observed patients in the Minors and Majors areas being prioritised or triaged by a 'triage trained' nurse. This process ensured that the most appropriate plan of care was organised to meet their needs. Children were triaged in the separate paediatric department from 11am to 11pm. This meant that they were seen by specialist nurses and doctors during those hours.

Are accident and emergency services safe?

Good

Safety and performance

The Strategic Executive Information System (STEIS) records Serious Incidents and Never Events. Serious Incidents are those that require an investigation. Between December 2012 to January 2014, 168 Serious Incidents occurred at the Trust. 10 were reported to have occurred in ED.

Between June 2012 and July 2013, the trust submitted 1,003 incident notifications to the national reporting and learning system (NRLS); 118 notifications were reported in the emergency department. Ninety three of these incidents were classified with a moderate degree of harm, 21 were abuse (relating to abuse of staff by patients) and four were severe harm."

The Dudley Group NHS Foundation Trust was rated as 'high yellow' or 'low risk' for access to secondary care through ED.

The Trust scored 'worse than expected' in regards to three questions about waiting times in the NHS A&E survey. The Trust had scored better than expected for the percentage of admitted patients who waited in A&E less than 4 hours and trending towards better than expected for two questions.

Staff told us of the clear guidelines for incident reporting. They said they were encouraged to report and were treated fairly when they did, and they received feedback if they requested it. Staff described the process they followed for safeguarding referrals. Through discussion it was accepted that more effective assurance audits could be performed to monitor the referrals from the department.

Monitoring safety and responding to risk

The department was split into two areas: Majors and Minors. Both areas followed clear processes to enable them to run smoothly. The ED had its own x-ray department which assisted in patients' swift diagnosis.

Dependant on their symptoms, patients followed specific care pathways. If a patients was brought in with a

suspected stroke they were taken immediately for a CT scan (computerised tomography) before they were taken to the stroke ward. We saw care pathways in place for sepsis, chest pain and dementia. Children were directed to the specific paediatric area which admitted directly to the children's department.

During our visit we saw that patients were seen by nurses and doctors in a timely manner and relatives we spoke with confirmed this.

We saw that standardised clinical pathways were in use in ED. We reviewed the records of four patients and saw the clinical pathways had been followed. Staff told us that when time allowed they discussed specific cases in order to learn and improve.

Staff had good visibility from the nurses station of all of the patients in the department Patient observation was recognised to be essential for patient safety. Nursing care indicator audits were completed to monitor the activity within the department. We did not see the outcomes from these audits displayed in the department.

The department used the Waterlow risk assessment tool to assess the risk of a patient developing a pressure ulcer. Staff told us they assessed the patients risk if they were waiting for more than four hours in the department. We saw evidence that staff assessed risk in the CDU. We were told that pressure-reducing trolley mattresses were available, but we did not see any in use. One patient, who had remained in the ambulatory emergency care unit overnight, had slept on a trolley with no specialist mattress.

We spoke with two staff about safety in the department. Both said it was a safe department, except for the queue of patients that occurred from time to time in the ambulance-greeting corridor.

We were told about the escalation process, used regularly in emergency situations such as the cardiac arrest, deterioration of patients, or capacity issues within the department.

Systems, processes and practices

Environment

The department was clean, hygienic and tidy. Domestic staff told us they supported the medical staff to keep the area clean. They were fully aware of the infection control responsibilities. All staff adhered to the 'bare below the elbow' policy and were seen to use protective clothing when necessary to reduce the risk of cross-infection. Throughout the department there was a good supply of hand-washing facilities and hand gel dispensers. As part of the patient-led assessments of the care environment (known as PLACE), Russells Hall Hospital scored 97.9% for cleanliness.

We looked at the previous month's infection control audit results undertaken in the department. These were not accurately dated. The results showed safe cannula (tube) insertion results at 10% compliance with their standards, catheter insertion results were 100% compliance with their standards and equipment checks results were 70% compliance with their standards. Following these results no action plan had been written and there was no planned date to repeat the audits so it was unclear what learning had taken place. The recently appointed 'nurse lead' for infection control was now responsible for addressing these issues.

Equipment

We were told that the ED currently had sufficient equipment to run safely and it was maintained appropriately. Equipment was stored away from patient areas which meant the emergency routes were kept clear. The equipment we looked at was clean and in good condition. Equipment storage was managed by the staff, but more storage space was needed; some equipment was seen stored in empty cubicles and non-patient areas.

Staffing

We saw that the staffing levels were monitored through the nurse staffing rotas. The nursing sister provided oversight of this to ensure patient care was safe. Staff absence was covered with permanent staff working overtime or by their own bank of staff and agency staff were rarely used.

The ED staff were aware of the weekly pattern of 'known busy times'. The patients' needs in the department were regularly monitored by the nurse in charge. When the demand within the department exceeded the staffing levels available it was escalated to the senior management on duty.

The emergency nurse practitioner (ENP) led the Minors area within the department. The ENPs were seen as clinical partners who contributed positively to junior

doctors' education. They dealt with on-emergency cases safely as well as swiftly which meant patients spent the least time as possible in the department. And ensured patients

Medical staff cover was overseen by the consultant in charge. There were nine consultants in post, supported by a team of middle-grade and foundation year 2 (FY2) doctors. Consultant cover was provided between the hours of 8-9pm Monday to Friday. Overnight on call was covered by one consultant who also covered clinic between 9am-1pm the following day. On Saturdays and Sundays one consultant covered six hours a day plus they were available through an on call rota. Middle grade cover was Monday to Friday 8am-midnight.There were also 13 FY2 doctors in the department from 7am until 2am every day.

Medicines

The CQC pharmacist inspected the department. We found medicines were managed. We found there was a lack of storage space for the increasing number of drugs that are needed to be stored within the department. Emergency drugs in the resuscitation area were easily accessible. The controlled drugs were checked each morning by two staff.

Learning and improvement

We heard examples of how the ED staff had learned from previous incidents to avoid another occurrence. For example, an incident relating to poor monitoring of a patient resulted in the installation of more monitored trolleys. These trolleys were now in use; however, we saw one monitor had a lead missing and several had missing data packs.

We were told that regular staff discussions took place over morning tea where staff could talk about recent events in ED.

During our inspection, we reviewed 12 sets of patient notes. The documents we saw were dated, signed and legible.

Anticipation and planning

We observed staff safely hand over patients at the end or beginning of each shift. This time was protected to avoid disruption and ensure clear transfer of information was carried out. Senior staff attended a Trust capacity meeting four times a day to monitor and discuss the patient flow through the hospital.

There was a major incident board in the ED displaying action to take should a major incident occur. We were told that training sessions were undertaken to ensure staff were fully aware of the major incident process.

We met and spoke with the ED general manager who told us how they worked with the local clinical commissioning group (CCG) to support people in the community and avoid unnecessary admissions. For example, plans to expand the urgent care centre were in progress to support the ED. This would help support patients before they needed admission via the ED and ensure the most appropriate team dealt with their care needs.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence based findings

We were told that pain control was a main consideration when patients arrived in the department. We saw that the administration of medicine was well managed by the medical and nursing staff. We saw that the effectiveness of the medication was also monitored. Patients we spoke with told us that they had been asked if they were in pain. Those that were in pain on arrival or while in the department told us they had been administered painkillers as soon was practically possible and had been later asked if the pain relief had worked.

Performance, monitoring and improvement of outcomes

There was a clear infrastructure to enable ED staff to contribute to service improvement, but this was not always brought to the senior management's attention or celebrated. For example the team had been working to avoid admissions to hospital by working closely with the multidisciplinary team, discussing the best options for the patient.

Sufficient capacity

The local need for emergency services had outgrown the department, however, the staff made the best of the facilities. We were shown around the department. We saw that a four-bed resuscitation area had been reduced to three beds to accommodate the equipment needed in

Accident and emergency

emergency situations. One of the beds was available for use for either adult or paediatric use. There was a proposal to relocate the area in a larger, more functional space when building plans had been agreed.

We were told that security staff were instructed to support the medical and nursing staff if a patient or relative became aggressive. The Trust had a 'no tolerance' policy to aggression and violence.

Multidisciplinary working and support

We saw many examples of how the staff, with the support of the multidisciplinary team, helped patients back in to the community to avoid admissions. The department social worker and occupational therapist worked closely with the nursing staff to support a safe discharge home. The department had recently employed an experienced community nurse a as 'welfare nurse'. They worked in the CDU but they also monitored people in the ED who may be vulnerable and need support prior to discharge. They told us how their role included talking with community staff, relatives and GPs to ensure that all support was in place prior to the patient returning home.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

The department scored above average in the Friends and Family test between September and December 2013. December 2013 achieved the highest score of 73. The NHS Friends and Family Test is a national test which is used to find out if people attending the department would recommend it to their friends or family.

Patients and relatives we spoke with were all satisfied with the care they received, we heard no negative feedback. One patient told us: "I've had marvellous treatment, brilliant. I can't fault the staff. They have communicated with me so I know what's happening. They're pleasant and speak kindly to me. I would definitely recommend the place to friends".

Private discussions could be held in an assessment room which was located away from the main observation area. This meant people's privacy and dignity was maintained.

Involvement in care and decision making

One relative told us that they had been kept up to date with their mother's condition at all stages. They told us that the doctors and nurses had explained things to them to stop them worrying. They went on to say: "I feel so much better now I know what's happening".

Trust and communication

One patient we spoke with told us how nervous they were about being brought to hospital but the ambulance crew had reassured them. They said: "When I came in to department a member of staff met me and the ambulance crew handed over all my details. I felt myself become less worried, as I could tell I was in safe hands. The staff have been very respectful and so far very kind".

One family we spoke with told us: "The staff are wonderful but very busy. We seemed to be waiting a long time and didn't know what was happening next; the doctor came and updated us".

One doctor was observed to have been rather sharp in response to a patient's question. However, they did go on to support the patient with their request.

Emotional support

Patients we spoke with felt involved with their care. They told us they quickly had their fears alleviated by the nursing and medical staff. One patient told us: "I was in a lot of pain when I arrived but they soon had me sorted, they calmed me down, gave me painkillers and made me comfortable. They gave me undivided attention and were very kind".

We observed a student nurse and healthcare support worker assist a patient with great respect and kindness, maintaining the patient's dignity at all times. The nurse spoke in a gentle, quiet voice, continually reassuring the patient. They ensured the patient had the call bell as they left the cubicle.

We saw staff preparing the relatives' room to greet bereaved relatives. They were compassionate and thoughtful.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Accident and emergency

Requires improvement

Meeting people's needs

Patients who were waiting in the department were offered food and drinks if appropriate to their condition. One patient who was due to go home told us they had a cup of tea and a sandwich before they left the department. The staff told us that volunteers helped out by ensuring that people had their dietary and fluid needs addressed in the ED. When necessary, fluid charts were used.

The staff showed us the recently upgraded relatives' room. They had raised the funds in the department to decorate the room and improve the comfort for relatives.

Three relatives we spoke with told us that it had been difficult to find a car park when entering the ED but they understood that the department was busy.

It was noted that, in the ED waiting room, the television was out of order. Also, of the three available vending machines, two were marked as 'not working'.

We saw a wealth of advice and information leaflets available for patients and relatives to read about medical conditions and access to support in the community.

The resuscitation area had reduced space due to necessary storage. The area was now three bedded instead of four. The ambulance admission area was not suitable when the department was busy. Patients were observed in a narrow corridor. There was evidence on the board reports that general funds were to be spent on new equipment for the Trust including ED environment improvements.

Patients brought in by ambulance arrived in the corridor area adjacent to ED and were assessed by ED staff within the national guideline time of 15 minutes. We observed the cramped and confined corridor space to be in use on four occasions. We spoke with four paramedics who regularly attended the department. They told us that on occasions handing over the patient was delayed due to the department being busy, but generally they had a reasonable turnaround time.

Access to services

Trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the ED. The Trust had struggled to achieve the 95% target and, for several recent months had been below the England average. The lowest was 81.8% in March 2013. Performance did improve but the Trust was still failing to maintain the target and remained consistently well below the England average. The Trust had no patients waiting for four to 12 hours from the decision to admit until being admitted, transferred or discharged.

The department had access to specialist teams, including a mental health liaison nurse, a social worker and access to an interpreter service. Specialist medical advice was sought when necessary through consultant referral. Some patients in the department were awaiting confirmation of investigative test results or a consultation by another doctor.

If required, follow-up appointments were arranged before patients left the ED, or patients were told that appointment details would be sent to them.

Vulnerable patients and capacity

The welfare nurse told us how they supported the department staff to monitor and assess vulnerable patients in the department. With the support of ED staff and the patients' families, patients were, where possible, reassured and returned to their own home safely. Staff told us that they were aware of assessing people's mental capacity and involving families/carers where necessary. We were told that, when necessary, safeguarding referrals were made.

The welfare nurse gave us examples of how the CDU supported patients back in to the community. They had set up a clothes and food bank to enable people to return home in a dignified, safe manner. They told us how they worked closely with local charities and social services, ensuring that social care packages were sufficient and that continual support was available.

Leaving hospital

There was a wealth of patient information available for people returning home – for example, about asthma and falls prevention. The ED used a discharge checklist to help ensure that patients were discharged safely.

Accident and emergency

Learning from experience, concerns and complaints

Action had been taken as a result of two complaints being received about the ED. Staff attitude and behaviours were discussed with those involved and all frontline staff were reminded of the importance of effectively directing the patients to the appropriate department.

Are accident and emergency services well-led?

Requires improvement

Vision, strategy and risks

The Trust has a vision called 'Where People Matter'. The vision was supported by three values: Care, Respect and Responsibility. The aim was to provide the best possible patient experience. The Trust believed the vision and values summed up the journey they were on to achieve their goal of being the best place to receive healthcare, to get things right for every patient, every time and be the best place to work.

The Trust has joined the Ambulatory Care Network in an emergency care trial that was launched in November 2013 and this has been successful in reducing patient admissions.

In January 2014 the board discussed that the Trust had failed to meet the 4 hour ED target. The final outcome was 93.31%. The Trust was disappointed given the hard work of the teams in ED and EAU whose performance had been affected by the ongoing capacity pressures during the winter months.

Governance arrangements

The Trust was taking action to reduce the number of patients who had to be readmitted to the ED. The senior nurse told us that, through improved communication with relatives and social services, planned discharges were being safely arranged.

Nursing staff told us that all incidents were reported through Datix. Datix is patient safety software for healthcare risk management, incident and adverse event reporting. They told us that they didn't always get feedback on the incidents but they would benefit from discussing them in the team, as a learning tool. We were told that staff did get feedback if they asked for it, but was not offered as routine.

The auditing in the department was not systematic and some staff we spoke with were not aware of any auditing being undertaken that was relevant to the ED.

Leadership and culture

The Trust told us they were aware of the key risks within the organisation but there appeared to be no clear communication or action taken between Trust wide managers and the frontline staff. The reality for the ED staff of the day-to-day pressure was immense and the staff felt that this was being overlooked.

Several staff members told us they had not seen members of the Trust board visit the department for them to witness the challenges they faced. However, the chief executive had been visible within the ED and we heard in the past they had taken the patients' drinks trolley around the department and had also made drinks for the staff when the department was busy.

We spoke with staff about leadership in the department. They told us they felt supported by their managers. They told us and we saw that the matron was visible and approachable. Two staff we spoke with told us they felt supported and valued in the team and that they worked well together. The practice development nurse working in the department ensured that the staff learning time was protected and their competencies were maintained.

We spoke with the hospital chaplain who told us they offered support and counselling for staff when they had dealt with difficult situations. They also told us they met with relatives and patients in the ED and CDU when requested.

Junior doctors and student nurses told us they valued their time in ED and felt the training and support was excellent. One consultant told us, "It's a wonderful place with a responsive management team."

Patient experience, staff involvement and engagement

Staff told us that they prided themselves on giving good quality care in the ED. We heard mainly positive feedback from patients and relatives about the care and attention they had received.

The staff told us that, at times, they did feel stressed when the department was full. They felt the staffing levels were sufficient if the flow of patients into and out of the hospital could be improved. They told us that the Trust was aware of their concerns about the volume of patients in the department. They did not feel that they were always supported with the pressures they were under. Inadequate staffing in relation to patient flow/volume was on the risk register since April 2010 and was reviewed in April 2014. An ambulance triage nurse was put in place as mitigation to this risk.

The national 2013 NHS Staff Survey showed a low response rate for the Trust engaging with staff and the Trust was asked to consider more innovative ways of listening to staff views.

We were told that the senior nursing executive team do not visit the ED. However, staff said that the lead nurse and matron were visible and hands-on which was motivating for the department. We saw many examples of good privacy and dignity standards. The patient experience was positive while we were in the department.

Learning, improving, innovation and sustainability

The junior doctors we spoke with told us that their training and support was good. They received training in and out of the department. They told us found working in the ED a great experience. Their only concern they raised related to the flow of patients from the department to the wards due to bed shortages. They felt the department was overwhelmed by the influx of patients being held in the department due to the bed shortage in the Trust. The impact on patient safety was a concern to the staff who had to manage the risk on a daily basis and escalated their concerns when they arose. They told us they didn't feel that they were always listened to by the senior management team.

The staff told us about, and we saw records of, the training programme which assisted staff to maintain their competencies and skills. The specific training in ED was supplementary to mandatory training. We were told that this was not recognised by the head of learning or director of nursing.

A renal colic and fractured femur pain recording tool had been introduced in ED since they had scored low on a previous audit.

We saw that ED reported incidents appropriately.

There were numerous notices in the patient cubicles and in all areas of ED. The clinical noticeboards were hard to access in the staff room. The noticeboards were unstructured, with the relevance of the notices in both clinical and staff areas being unclear and unstimulating. It was unclear whether the numerous notices added to the patient/visitor experience or to staff knowledge.

The ED complaints folder did not contain the response to the complaints or the outcome to be used as a learning/sharing tool. We were told that this would be corrected and used in training in the future.

Medical care (including older people's care)

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

Information about the service

We inspected medical care (including older people's care) at Russells Hall Hospital where we visited six wards (A2, A4, CI, C3, C5, and C7). We also visited the emergency assessment unit (EAU) and cardiology.

We spoke with 42 patients and six relatives over the course of the two-day, announced inspection and the unannounced visit to the hospital out of hours. We listened to patients' accounts of their experiences during the listening events we held in the local community. We reviewed 20 sets of patients' notes. We also reviewed the Trust's performance data.

We spoke with 37 staff in different roles and grades across the medical wards. We observed care and treatment and looked at care records.

Summary of findings

We found that all of the areas we visited on the medical care directorate were clean and hygienic, which helped to protect patients from hospital-acquired infection. We saw that all areas were well maintained and free of clutter.

We saw that staff had completed mandatory training and received annual appraisals of their performance. All staff received mental health awareness training and de-escalation training had commenced for nursing staff. We found that lead nurses were well informed about de-escalation techniques and challenging behaviour.

We saw that staff received training on how to report incidents, such as falls, and complaints. Staff told us that they received regular feedback on these. We saw that lessons learned from incidents, and actions for any improvements, were discussed in team meetings.

We found that medicines management was safe and patients received timely and appropriate pain medication as needed. We saw that staffing levels had improved and the Trust was in the process of recruiting additional trained nurses and medical staff.

We saw that staff worked in partnership with other colleagues and partners to achieve the right outcomes for patients. Throughout the inspection we observed positive interaction between staff and patients. All of the patients we spoke with said the staff were very good. They told us that they were treated with respect and dignity.

Medical care (including older people's care)

We were concerned about the delays in the flow of patients through the hospital. We saw that some patients had to wait for long periods and were subjected to multiple moves in the directorate. We are aware that this is an ongoing problem and actions have been taken to improve this situation with the introduction of the frail elderly short stay unit. However, this remains an area of improvement for the Trust.

A dementia care bundle – a small set of evidence-based practices and processes to improve care – had been piloted, but this must be implemented across the directorate to provide the best outcomes for people living with dementia.

We found that the service was well-led. Staff told us that senior management were visible and wanted to know about patients' care. Staff told us that they felt able to raise issues and senior management were approachable and listened to feedback from staff.

Are medical care services safe?

Good

Safety and performance

All medical wards appeared to be clean. We observed that hand gel was available on all the wards. We noted that staff frequently reminded visitors to use the hand gel provided when entering and leaving the ward. We saw that the nationally recommended bare-below-the-elbow policy was adhered to for cleanliness. We saw staff regularly washed their hands and used protective equipment such as aprons and gloves. Patients who had infections were identified and nursed in side rooms.

MRSA and Clostridium difficile (C. difficile) infection rates for the Trust were within a statistically acceptable range relative to the Trust's size and the national level of infections. We found that audits had been completed to prevent infection. Other initiatives had been carried out by the Trust to look at ways to reduce MRSA and C. difficile and the use of antibiotics. We were told this had led to a reduction in infection rates and saved money by using fewer antibiotics.

Learning and improvement

Staff told us that they had all received training on how to report incidents and were encouraged to do so. They said that serious, untoward incidents were investigated and the results were shared with the affected patient, their relatives and staff. The matron told us that themes from incidents were discussed at weekly meetings and practice had changed at a result of incident reporting. One example of this was where staff had carried out their own fundraising to purchase chair alarms so that staff could be alerted of patient movements. We were told that this had helped to reduce the number of falls.

We checked staff training records and found that mandatory training was ongoing. Staff in the medical care directorate were up to date with the required training.

We checked the minutes from the patient falls report which had been prepared for the falls prevention and management group in March 2014. We saw that, overall, the number of falls in hospital had decreased for the period March 2013 to February 2014 compared to the same period in the previous year. We saw that the highest percentage of

falls by bed number continued to take place on acute and elderly care wards. The minutes showed that this was probably due to the fragility and complexity of patients' illnesses. Further analysis carried out by the falls team showed the reasons for the falls and the learning and action to be taken as a result.

During the inspection, we found evidence of good use of the falls policy in some areas, for example on Ward C6. We saw that a falls care bundle – a special checklist to help prevent a patient from falling while in hospital – was being used across the directorate. As part of the Trust's recent learning from falls analysis, there were now nominated falls nurses on some wards.

From care plans we checked, we found that falls risk assessments were not always completed when required. This meant that patients may be at risk of falling. We saw that the Trust had identified this issue and were taking steps to address this. Staff had the use of chair alarms and other specialist equipment to reduce falls. We asked staff what falls-prevention information was given to patients and they told us that this information was available in the falls care bundle. However, it was unclear how well this was used and explained to patients.

We saw that regular ward audits were carried out, for example, infection control, safety thermometer audits, fluid balance and mealtime audits. We were informed that the results of the audits were forwarded to the director of nursing and monitored accordingly. Results were also copied and put on display in seminar rooms for staff information.

Systems, processes and practices

We discussed staffing with a ward sister who told us that nursing numbers had been assessed using a recognised staffing tool. Staff told us that there had been a lot of staffing pressures in 2013. However, there had been an increase in staff over the last few months. The matron told us that approval had been given for additional spending on staff in response to recent difficulties.

The Trust had also recently recruited extra nurses from Spain, Portugal and Romania. One of the nursing sisters we spoke with on Ward A2 had been part of the international recruitment team. They told us: "It was a fantastic opportunity. I was able to meet nurses who would make an impact and do the hospital justice. It was important that I could assess who I could work with and who would look after my patients well".

We asked about medical staffing. One consultant told us that there was a lack of middle-grade doctors in the hospital and more were needed. Another consultant told us that the Trust had employed more doctors, including one specialist registrar, on the medical team in 2013. A registrar told us that they perceived medical staffing had not been a huge problem, but it had been agreed that an additional registrar was going to be brought in to join the team.

We were told that there was a consultant presence on the wards seven days per week. On the wards, some consultants carried out ward rounds twice per week and daily on the stroke and frail elderly care units.

We discussed patient handovers with staff and saw evidence of detailed written handover sheets. On the wards, handovers for nursing and medical staff took place twice per day. Staffing for shifts was discussed as well as any new admissions, high-risk patients or potential issues.

Both nursing and medical staff told us that, overall, there was good communication between themselves and patients and their families.

Staff were very complimentary about the pharmacy service at the Trust. Staff told us that there was a medicine link nurse, a link pharmacist and a technician on each ward, including the EAU. These staff worked together and also with the acting chief pharmacist at the Trust. The medication link nurse delivered medication training and carried out audits on medicines. We were told that this had helped to increase training for staff and improve their competencies. Staff we spoke with confirmed this.

Throughout the medical care directorate we found that medicines were stored securely and that arrangements were in place to ensure that they were stored at the correct temperature. We saw that there were new locked cupboards for patients' own medicines in the EAU and a patient safety transfer list had been developed so that medicines could transfer with the patient. A senior member of staff on the EAU told us that this had led to a decrease in incidents and had been very helpful.

Medical care (including older people's care)

We were told that there were issues when a person was admitted to the EAU because patients' medication information was not always available. This had led to a high incidence of missed doses. Staff told us that all missed doses were recorded and highlighted as a medication error. An audit by the pharmacy department had identified that 70% to 75% of the cases classified as 'missed doses' were actually not missed and due to medicine reconciliation. This is because medicines were either not brought in with the patient on admission or there was a lack of information available about a person's prescribed medicines. However, we found that the Trust had internal systems in place to try to prevent missed doses occurring.

A recent initiative at the Trust was the development of their own smartphone app for prescribing antibiotics which was available for doctors. This was a useful tool to assist doctors in prescribing the most effective antibiotic treatment, which was a benefit for patients and doctors.

Patients we spoke with told us that they received medication for pain management without delay. One patient said: "I couldn't have any painkillers to start with as I had a head injury, which I understood was reasonable. I have them now when I need them".

We asked nursing staff about access to controlled drugs on Ward C3. We found that one nurse held the key for a 52-bed unit. This nurse could not be located at the time and staff were not sure which nurse had the responsibility for the key on the day. This arrangement could delay a patient receiving controlled drug pain relief.

We saw that care records were in paper format. There was a mixed approach to completing care records across the medicines directorate; some records involved healthcare professionals recording separately, while others included all healthcare documents from all practitioners in the same place. Staff told us that a new IT system had been sourced and this would help to improve consistency of recording.

We found that, overall, care records were well maintained and stored appropriately at the nurses' station. One lead nurse told us that a team had been set up to review documentation such as care planning records to improve consistency and effectiveness of recording.

The deputy matron confirmed that a full documentation audit was carried out every year. The results of this audit were fed back to all the directorate staff and action taken for improvement.

During the inspection, we visited the cardiology unit. We were informed that the telemetry system in the post-cardiac care area was not working. We were told that a new system had arrived and that this would be able to cover more than one part of the hospital. However, the installation was delayed due to renegotiation of the IT contract. Staff told us, and we saw, that this did not have a negative impact on patient care.

Monitoring safety and responding to risk

The deputy matron for older people confirmed that an early warning tool was used to monitor any changes in the health and wellbeing of a patient. The tool identified the steps staff should take when a patient begins to deteriorate. We saw that it was detailed on the back of the observation charts at the end of each patient's bed. Staff explained to us how they escalated any concerns and the steps they took if a patient scored higher than expected during observations.

We looked at charts and saw that staff had escalated concerns correctly. We found that repeat observations were taken within the necessary timeframes and the doctor was kept informed at all required stages.

It is mandatory for all NHS Trusts in England to report all patient safety incidents. An analysis of the data submitted by the Trust revealed that it was reporting incidents as we would expect when compared with other Trusts in England. We found that, between December 2012 and January 2014, slips, trips and falls were the highest reported incident type for the Trust. We found that the Trust had taken action and falls had reduced in most areas in the Trust.

Are medical care services effective?

Good

Using evidence-based guidance

Using the CQC Intelligent Monitoring data, the Trust showed a mortality alert as an outlier for dermatology. At the time of our visit this had already been recognised by the Trust and investigated. This issue was discussed with the medical director. This related to small numbers within the data amplifying the concerns.

The medical directorate used National Institute for Health and Care Excellence (NICE) and other guidelines to keep up to date with the care and treatment they provided. We saw

Medical care (including older people's care)

minutes from monthly quality practice development team meetings which showed that any changes to guidance, and particularly the impact on practice, was discussed. This was confirmed by six medical staff we spoke to. They also agreed that they kept up to date with NICE guidelines and other guidance updates themselves.

Medical staff told us that 'morbidity and mortality' meetings took place every month where individual cases and their care were discussed.

We were told that the results of audits were discussed at various meetings, including matron's meetings, and were then cascaded to staff at staff meetings.

We found specific care pathways were in place which ensured that people received standardised care. These included: sepsis and chronic obstructive pulmonary disease care.

Nursing documentation was located at the end of each bed and was completed appropriately. Care records we checked showed evidence of robust management of nutrition, food diary, pressure ulcer and bowel care.

Performance, monitoring and improvement of outcomes

The Trust had previously had a raised mortality indicator for 'cardiological conditions and procedures'. Current data collected by the Trust shows their mortality has been reduced and it was currently no longer an outlier in national (CQC) monitoring. The Medical Director had led work on resolving this through mortality review meetings and pathway redesign. The Trust was awaiting publication of national data which would confirm their local data collection. When published, these data will be rebased (national normalisation) which will give a clear updated picture.

We checked the standardised readmission rates for the Trust and saw that they compared favourably with national rates.

A summary of the Trust's clinical audits undertaken (including the National Audit of Falls and Bone Health in Older People, Myocardial Ischaemia National Audit Project, National Bowel Cancer Audit, National Audit of Dementia, National Parkinson's Audit and the Sentinel Stroke National Audit Programme) demonstrated that outcomes for patients at the Trust were good. The medical directorate participated in all audits they were eligible for and clinical audit was a clear priority for the directorate.

Multidisciplinary working and support

We found that all wards had input from therapists, dieticians, pharmacists and social workers. Ward staff were extremely complimentary about the support they received from these services.

Staff in the stroke team told us about the positive working relationship they had with a voluntary organisation. They said that the voluntary organisation and their involvement in providing long-term, follow-up support for stroke patients and carers was very good. We found that there was clear handover to the community services, with sufficient provision to do so in a timely way.

On the renal unit, there were two part-time psychologists who worked with patients, relatives and staff. A number of nursing staff told us that the chaplaincy support was very good.

The ward sister on the renal unit gave us an example of where team and collaborative working had brought benefits for patients in the unit. They told us about how the staff from the renal unit had worked with the vascular team to improve outcomes for patients who had renal dialysis. This had involved changes in the way the treatment was administered. The ward sister told us that patients who had already used this type of treatment had played a valuable role in supporting other patients to make changes.

Are medical care services caring?

Good

Friends and Family Test

The Friends and Family Test is a measure of whether those who use the service would recommend it to others. The Trust has scored just above the England average all four months. The response rate for the Trust is higher than England average for two out of the three months. We can see though that the number of responses are ranging from 423 to 641 throughout this period. The Trust can be seen to be performing above the England average for the Inpatient tests

Medical care (including older people's care)

Out of the 21 inpatient wards there were 10 that scored below the Trust average of 80.2. A1 was the ward that scored the least with 44. When questioned none of the wards would be 'extremely unlikely' to recommend to other people.

Compassion, dignity and empathy

Throughout the inspection, we observed positive interaction between staff and patients. All of the patients we spoke with said that the staff were "very good". They told us that they were treated with respect and dignity. One relative said that their family member had come into hospital as an emergency and had an operation. They told us that they had "received very good care".

Another patient told us that the hospital used the 'red tray' system at mealtimes. This is used to highlight patients who nursing staff have identified as those needing extra support with meals and drinks. We spoke with one of the staff who helped patients at mealtimes. The staff member explained how they did this in a dignified and compassionate way.

We asked patients about the availability of drinks. One patient said: "I always have plenty to drink – I can have a coffee at any time I want and the staff do a lot of drinks rounds".

We observed that staff were busy, but we did not find any evidence that patients' needs were not being met. We noted that patients rarely used the nurse call bell and, when they did, they were promptly answered. One patient told us: "My call bell is in my reach at night. When I ring it, they come within minutes. If they're busy, they sometimes ask if I can wait a minute. They always come back within 10 minutes. If it's urgent, like the toilet, they look after me straight away".

Patients told us about specific staff who cared for them and how well they were supported. A nurse we spoke with told us that, if a patient was confused or anxious when leaving hospital, a member of the older people's mental health team would go with the patient in the ambulance to support them.

Involvement in care and decision making

Patients and relatives we spoke with told us that they understood what was happening to them and were able to make decisions about their care and treatment.

Records we checked showed that patients and their families were involved in the care and treatment they received. In one care plan, we saw a record where a relative had made a request for the patient to be discharged to a nursing home which catered for specific cultural needs. This was seen to be taken into account in the discharge planning arrangements.

Trust and communication

One person told us about the comments board that staff had asked them to use. The patient told us that they had used the board to write compliments about the staff and, on one occasion, had made a suggestion for an improvement. They told us that the suggestion had been discussed and staff thought it was a good idea.

Emotional support

A relative we spoke with said: "The atmosphere is very good here, everyone is so pleasant. My [relative] came in as an emergency, they apologised for the delay we had in getting to the ward. They fully informed us of what was going to happen. The liaison between patient and staff is very good".

Are medical care services responsive?

Good

Meeting people's needs

We found that visitors were encouraged and supported with flexible visiting times. One relative said that this was particularly helpful for their relative who was confused and didn't eat well. One nurse we spoke with told us that flexible visiting was really helpful for those people who needed support at mealtimes.

Staff were able to tell us about the specific needs for individual patients. A lead nurse and the matron told us that the patients' psychological needs were taken into account. A breakfast club for patients had been set up and 'pet therapy' was also used to promote the mental wellbeing of patients.

The Trust's older people's mental health team provided support to people living with dementia and also for staff working with these patients. We spoke with a dementia nurse specialist who led a team of four mental health nurses who aimed to see each patient with dementia to assess their mental health needs. They told us that they used the Commissioning for Quality and Innovation (CQUIN) goal for dementia care. This helped to identify

patients with dementia alongside their other medical conditions and prompted appropriate referrals and follow-up after they left hospital. The dementia nurse specialist informed us that the team had achieved 100% for assessments completed in line with the CQUIN improvement target.

The dementia nurse specialist told us that they worked closely with the dementia liaison nurse from the community and the Alzheimer's adviser to ensure a robust care pathway for the patient. They also said that they provided training to staff, for example, on mental health awareness, de-escalation training and physical breakaway training.

We discussed the use of agency staff and the dementia nurse specialist told us that they only used bank (overtime) and agency staff for patients on the ward who required one-to-one support.

During the inspection, we did not see any evidence to suggest that a dementia care bundle was working in practice in the wards we visited. We were told that a trial of a new dementia care bundle had been carried out and was in the process of being audited (other systems were also in use during the trial). We saw four patient records that included a dementia care plan. However, this did not show how each element had been considered or implemented for each individual patient. No behavioural management care plans were seen.

We were told that dementia champions were going to be introduced to offer advice to staff on how to manage patients living with dementia. We were also informed that a learning disability nurse was in post who supported patients with a learning disability throughout their time in hospital. We saw that the Trust had plans to launch a new learning disability strategy in the same week of the inspection. At a public meeting prior to the inspection, we spoke with a person who had a learning disability; they told us that they had been involved in the development of the strategy and was looking forward to the launch.

The matron informed us that the general manager for older people had reviewed the issue of appropriate placements of specialist patients which led to the development of the frail elderly short stay unit. This had been specifically set up to improve outcomes for patients and significantly reduce the time they spent in hospital. We were told that, to facilitate this, there were twice-daily ward rounds and multidisciplinary whiteboard meetings on the unit. The lead nurse for the unit told us that the short stay service was more beneficial for patients. Two patients we spoke with told us that they were being well cared for on the unit.

We were shown a questionnaire called 'Take the time' which had been developed for relatives to complete about their loved ones' care needs. The questionnaire sought information about a person's needs such as communication, mobility, diet/fluids, and hobbies. This information would be useful to enable nursing and medical staff to meet the specific needs of the individual quickly. However, throughout the inspection, we saw few examples where this document had been completed. The lead nurse and ward sister on Ward A2 took immediate action to address this and informed us that, with immediate effect, the questionnaire would be included in the admission pack for patients.

A patient told us that they often went to the breakfast club to meet other patients and to make themselves a drink. They said that this helped them to deal with being in hospital as they could talk to other patients who had the same health condition.

Vulnerable patients and capacity

We were told that all band 7 nurses received training in the Mental Capacity Act 2005 and guidance on the associated deprivation of liberty safeguards. We found that the Trust followed the requirements of the Act and appropriate authority was sought in a timely manner.

All staff had mental health awareness training sessions from the older people's mental health team.

Prior to our inspection, we were made aware of allegations surrounding the inappropriate use of restraint in the Dudley Group, especially on the Russell's Hall site. We were aware that the Dudley Safeguarding Adults Board and the Dudley Clinical Commissioning Group were reviewing these concerns. Following our inspection we saw evidence that the hospital was cleared of any wrong doing.

As part of this inspection we looked in detail at the processes and procedures used by the Trust. We spoke to staff from the security team, nursing staff and the clinical nurse specialist for dementia care. We also looked at training records.

Security staff told us that they had received training in the Mental Capacity Act 2005 and Management of actual or

potential aggression. Records we saw confirmed this. We also saw training records for safeguarding (protection of vulnerable adults), restraint (appropriate uses and techniques) and conflict resolution. The Trust told us that not all of the hospital staff had completed conflict resolution training, but they had plans in place to address this, and provide training to all staff within the next six months.

All of the nursing staff we spoke to told us that they would seek advice from the clinical nurse specialist and would try to de-escalate situations that arose by talking to and reassuring people in the first instance. The security staff told us that "hands-on is a last resort". They told us that they were called to the wards less frequently than they had in the past. Security staff told us they would welcome training around dementia and ward staff may benefit from training around the role of the security team.

We were told, and records showed, that de-escalation training had commenced for nurses. One nurse said that they had completed this training and had found it to be extremely helpful. They said that they had learned a lot on how to keep themselves and patients safe if a challenging behaviour incident occurred. We understood that all nurses will complete this training. One ward sister showed us a copy of the restraint policy and when asked, was well informed about de-escalation techniques and challenging behaviour.

We saw that some people were assessed on admission to see if they needed any assistance from the older people's mental health team. We saw that assessments were completed and referrals were made, where appropriate. The hospital team had some good links with local community services and these supported people upon discharge. Nursing staff told us how they would speak to people's families and try to identify if there were any 'triggers' that may prompt difficult behaviours, so they could be avoided. We saw that there were documents to record these triggers, but they were not always completed.

Access to services

We were told that the older people's mental health team cover working had been increased to seven days per week.

Consultant cover to the wards was also provided seven days a week. A ward sister told us that patients do not have to wait to see a consultant over the weekend as there is a consultant on call to see all new patients.

We visited the EAU and Ward C8 and spoke with the ward sisters. We found that the waiting times for patients in the EAU were an issue. We were told that it was not uncommon for patients to stay 24 hours in the EAU.

The main issue was lack of beds available on the wards and the longest waits were for specialty beds. Anyone waiting for more than 12 hours was highlighted as a risk. Patients were sometimes moved to the short stay Ward C8 rather than a specialty bed as an interim measure. The EAU's ward sister told us that this was a better option for vulnerable patients as it enabled them to be safe and to receive the care they needed. We saw that there was a separate area on the EAU to deal with GP referrals and a facility to deal with conditions appropriate for ambulatory care. This ensured that patients could be seen and discharged on the same day.

Leaving hospital

During the inspection, we visited the discharge lounge. Staff told us that a 'patient safety walk around' had identified the need for improvements to the furnishings in the lounge to create a more homely environment. This was being progressed. The ward sister for Ward C8 confirmed that work was in progress to develop leaflets for patients about what to expect when they were moved to the discharge lounge.

The discharge lounge was supported by qualified nurses to enable patients to have medication for pain management and to have their dressings changed if needed. We were told that patients in the discharge lounge could get hot meals and transport arranged for them too.

Ward C8's ward sister told us that the Trust had listened to the complaints about communication and carer involvement. As a result, they had developed a checklist for the discharge lounge to ensure that patients received the best discharge experience. Recently a falls risk assessment had been added to this checklist.

The matron told us that the discharge lounge was not used for older people due to these patients not being able to sit for long periods. Also, it was decided that confused people would not benefit from using the discharge lounge.

Patients were given cards on discharge, 'Your health after hospital' which included information on who to contact if they had any concerns after leaving hospital. The card also provided general information on their medication and how to raise any concerns or complaints.

Medical care (including older people's care)

Patients were also given 'When you needed us, how did we do?' cards on their day of discharge**.** Feedback received was summarised and recorded in the NHS Friends and Family Test and discussed with staff at ward meetings.

We were told that multidisciplinary team meetings were held daily, including at weekends. This meeting included clinicians, social workers and discharge coordinators. This cooperation helped to ensure that the patients could be discharged in a timely manner.

The acting chief pharmacist told us about a number of initiatives which had contributed to improvements to the discharge process for patients. This included the use of an external pharmacy to supply a home care medicine package for patients. They told us that this was a major improvement to support discharge. There was also a discharge team from pharmacy based on 'C' wards, a prescribing pharmacist on wards A2 and C5 which helped to improve care for patients on the wards and on discharge.

Good communication was seen between teams and other departments – for example, therapy services, pharmacy and dietetics. We also saw care plans which included details of where medical staff had contacted specialists at other hospitals for specific information about a patient. One care plan we saw had a record where a GP had been contacted about the future discharge arrangements for a patient.

Learning from experiences, concerns and complaints

During the inspection we saw that one ward had a comments board for patients to write compliments, comments or complaints. Staff from other wards said they were also keen to implement the system. One patient told us that they had made a complaint on the comments board which had been dealt with.

We asked nine patients if they knew how to make a complaint. Only one patient knew how to do this. Others said that they had not been told how to. We spoke with staff about this. One lead nurse showed us a card which was given to patients in their admission pack. We saw that the card included details on what a patient should do if they had a concern or complaint. We also saw that leaflets about the Patient Advice and Liaison Service were available on wards.

Prior to the inspection, we had been contacted by three people who had made complaints about the service at the hospital. They told us that they were not listened to and their issues were not taken seriously by staff. We asked staff about how complaints made by patients were handled. They told us that they would try to resolve any issue straightaway, but, if this could not be done, they would refer the patient to speak with the matron or they would explain how to make a formal complaint.

We saw that complaints had been discussed at the quality practice development team meeting each month.

Are medical care services well-led?

Good

Vision, strategy and risks

The Trust had a vision called 'where people matter'. We asked individual staff about this and the values that support the vision. All staff we asked said that they knew about the vision and were able to tell us the three values of: Care, Respect and Responsibility. We were also told about the Trust's nursing strategy, 'The way we care' which was introduced in May 2013 as a result of the chief nursing officer's three-year vision and strategy, 'Compassion in practice: six Cs'. The strategy was launched at the Trust in early 2014 and all nurses were provided with pocket-size leaflets which set out to reaffirm the six Cs – care, compassion, courage, communication, competence and commitment.

Governance arrangements

We saw that there were robust governance arrangements in place. Staff told us that the quality practice development team met in older people' services every month and in stroke services every two months. All elderly care consultants, matron, deputy matron, band 7 nurses, therapists and pharmacists were invited to attend. There were also regular directorate governance meetings which took place and were led by one of the consultants on medicine. We were told that these meetings were used to discuss a variety of key topics – for example, current issues, audits, falls for the month, and actions to improve practice. There was a falls group and an orthogeriatric group which met separately to discuss and monitor incidents.

Medical care (including older people's care)

At ward level, risks were discussed at regular ward meetings and at 'huddle board' meetings where staff met in the service for a brief, focused discussion on key issues. Staff told us that these meetings enabled them to discuss in detail those patients who were most at risk.

Staff told us that the practice development nurse prepared a monthly report for senior staff on any issues or trends – for example, complaints, falls and pressure ulcers.

Leadership and culture

Staff we spoke with were clear about the leadership of the senior management team. They told us that senior managers were visible and approachable. Most of the staff were able to give the names of some of the members of the Trust Board. Feedback from staff about the leadership of the Trust was positive and constructive. One ward sister told us about how the chief executive had recently worked on their medical ward with the staff to help them understand the pressures for staff and the experiences of patients. The ward sister said that having the chief executive working on the ward had been highly appreciated by staff. They had asked the chief executive for a specialist piece of equipment to further assist in the care of patients. This was agreed and the ward sister confirmed that the ward had received the equipment as requested.

We asked staff about the leadership at ward level. One ward sister told us: "This is a nice Trust, modern with good support, especially from the matron and deputy matron". Another ward sister told us that they also got a lot of support from other key staff such as the general manager, deputy general manager and the director of support management. They were particularly helpful in unblocking obstacles the ward sister had encountered in daily activities.

All staff were positive about the support and accessibility of their immediate managers. Staff from different disciplines, including ward clerks and support workers, said that they felt they could approach the ward sisters and the matron at any time. Junior doctors told us that they received excellent support from their registrars and consultants.

Staff told us how much they enjoyed looking after the patients and working for the Trust. We observed good team work between nursing and medical staff and professional, positive working relationships with staff from other departments – for example, therapy services.

All the staff we spoke with told us that they had been informed about the CQC inspection. All around the Trust we saw posters which informed staff that there was a CQC inspection taking place. Staff said they felt information about the inspection had been communicated well to all teams. They told us that they had been encouraged by senior managers to 'be themselves' and to 'be honest' during the inspection.

Learning, improvement, innovation and sustainability

Staff told us that they received an annual appraisal of their performance with key objectives set for the year ahead. The appraisal included mandatory training and staff were asked to identify what they wanted to achieve for the forthcoming year before the meeting. Two staff members told us that the Trust was a good organisation for arranging study leave.

We asked about clinical supervision. We were informed that new graduates did undertake clinical supervision, however, more needed to be done to develop a clinical supervision programme for all staff.

In the CQC's Adult Inpatient Survey 2013, the Trust performed worse than other trusts in how people rated the food at the hospital. The Trust had taken a number of steps to learn from this feedback. The matron told us that the Trust had set up a steering group which had been looking at ways to improve the food provided to patients. This involved the group visiting and learning from other Trusts, a trial of other types of food and inviting volunteers to be part of a tasting panel. As a result, new, draft menus had been developed and the matron informed us that these were about to be trialled with patients for their consultation.

Surgery

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

Information about the service

The Dudley Group NHS Foundation Trust have surgical beds at both Russells Hall and Corbett hospitals. Russells Hall Hospital provides: 80 trauma and orthopaedics beds, 30 vascular surgery beds, 69 general surgery beds, 17 ear nose and throat beds, 12 urology beds and 48 day surgery beds. Corbett Hospital has a day case unit with waiting room, theatre and ward area.

Summary of findings

We visited six wards, the Pre-operative assessment clinic and the Oral surgery department. We also visited the day surgery unit and main theatres at Russells Hall Hospital and the day case unit at Corbett Hospital which included the waiting area, ward and theatre. We observed care provided both pre- and post-operatively at both locations. We discussed the never events – mistakes that are so serious they should never happen – that had occurred in the surgical department with staff in the theatres. We also held focus groups and 121 discussions with nurses, junior doctors, consultants and heads of services.

Services in the surgical department were safe for most patients. There were appropriate systems in place to report incidents and concerns and take necessary actions when needed. The Trust had reported two surgical never events, between December 2012 and January 2014. We found that new procedures were in place to minimise further risks as part of lessons learned from these incidents.

The surgical safety checks at Russells Hall Hospital were completed, as per clinical guidance. The surgical department had good adherence to national and professional infection control and cleanliness guidance.

Patients in all areas of the surgical department complimented staff on their caring approach. Patients'

needs were assessed, and care planned and delivered in line with best practice guidance. Assessments started in the preoperative assessment clinic and continued during the patients' hospital stay.

Staffing levels had improved and the Trust was continuing to actively recruit staff. Staffing levels were found to reflect patients' needs. There were arrangements in place to check the competency of staff, their training needs and practice. However there was a need to recommence competency checks for staff who worked in the day case unit at Corbett Hospital to demonstrate that safe and appropriate care continued to be provided in this area.

The Dudley Group NHS Foundation Trust was responsive to patient's needs to ensure that they had access to timely treatment. Staff were proud of their achievements to reduce pressure ulcers, improve the management for diabetic patients who had surgery, the reduction in the number of patient falls and the management of patients who had a fractured neck of femur.

We found that the surgical department was well led. There were appropriate leadership arrangements at all levels within the surgical department and staff felt supported by their managers. Staff were committed to reviewing and auditing to continually improve the care and treatment that patients received.

Are surgery services safe?

Good

Safety and performance

Patient safety boards were displayed in the surgical wards and operating suites we visited. The patient safety boards identified the figures for the previous month on specific areas, such as: the number of pressure ulcers, the number of falls and any incidence of infection. This demonstrated to all patients the safety of the ward or theatre area.

We reviewed 12 patient records across four wards and noted that appropriate assessments had been completed accurately, such as for risk of venous thromboembolism (VTE or blood clots), pressure ulcers, nutrition and fluid needs.

In the records we looked at for those patients who had an operation, consent forms had been appropriately completed. Patients we spoke with confirmed that they had spoken to a doctor who had told them about their operation before they had signed the consent form. Staff applied the Mental Capacity Act 2005 and Code of Practice in relation to capacity and consent.

Learning and improvement

Information we received before the inspection indicated that there may have been be a lack of understanding of incident reporting and/or under reporting of incidents. We discussed this with all the staff we interviewed. All clinical staff we spoke with were aware of the Datix patient safety software reporting system and were confident to report any incidents they deemed necessary. Staff told us that all permanent staff had a log-in identity which enabled them to report the incident. We were told that agency staff were also able to report incidents but there was a perception amongst staff that they had to log in with the assistance of permanent staff. Some staff felt that this may discourage incident reporting. Following our inspection, the Trust told us agency staff could access the reporting system without the need of assistance from permanent staff. Staff we spoke with told us that they were usually informed of the outcome of the incident they had reported. Latest data from the NRLS sets the Trust overall among the top 25% (of medium sized acute Trusts) in the country for reporting incidents.

Surgery

Surgical specialties accounted for 14.8% of the total incidents reported by the Trust to the National Reporting and Learning System (NRLS) between June 2012 and July 2013.The Trust reported two Never Events between December 2012 and January 2014. We discussed these with relevant medical and nursing staff and reviewed the follow-up investigation reports and findings. New procedures were put in place to minimise further risks as part of lessons learned from the Never Events. Nursing staff in the day case units and theatres showed us the new flowchart with revised procedures that have been implemented since the Never Events were highlighted. The action plan for the most recent Never Event was scheduled to be completed by the end of March 2014.

Systems, processes and practices

We observed that there was signage throughout the hospital raising awareness of hand hygiene and prevention of infection. Hand gels were available at the doors onto each ward or department, in corridors and at the end of each patient's bed. The hospital was in the top 20% across the country for staff having hand-washing materials available. There were monthly checks on hand hygiene to ensure that staff continued to comply with the Trust's policies. This had minimised the risk of cross-infection.

We saw several items of equipment checked, including alternating pressure mattresses, resuscitation equipment and medicines fridges. All equipment we inspected was regularly checked by staff. We saw that weekly checks confirmed that the resuscitation equipment had been inspected and emergency medicines were available. This meant that equipment and medicines were available and accessible when needed.

We noted that largely World Health Organisation (WHO) surgical safety checks were completed, as per clinical guidance in the records we looked at. The Trust had undertaken monthly audits in all surgical areas and it was a positive to see that both the records and the actual checks were witnessed by the team carrying out the audit. We observed WHO safety checks in the main theatres and day case theatre at Corbett Hospital. The checks we saw in the main theatres at Russells Hall were undertaken correctly.

It is important to check the competency of staff to ensure they have the skills and knowledge necessary to provide safe and appropriate care. At Corbett Hospital day case unit, we were told that the majority of nurses had many years of experience working at the hospital. The team leader told us that nurses' competency checks had previously been undertaken, and a need for the checks to recommence had been identified, particularly for new areas of surgery. We noted that this related to the recording and checking of competencies rather than a lack of competencies within the staff groups. Staff we spoke with told us that competency checks were undertaken in all other areas we visited. Assurance about staff competency is important to ensure that patients receive safe and appropriate care and treatment.

We reviewed the staffing establishment of the ward areas we visited and noted that the funded posts met the needs of the service in line with best practice guidance. Staff we spoke with told us that staffing was much improved. They told us that, if they had a patient who needed one-to-one care, this was supported by senior staff. Staff told us that, although patients' needs and dependencies may vary, they considered that the staffing arrangement usually met patients' needs.

Nurses we spoke with told us that all new staff received a Trust induction followed by a department/ward induction. We also saw records to demonstrate that agency staff and student nurses had received induction to the ward.

On some wards, we saw that additional 'huddles' were carried out at the ward board, highlighting patients at risk. Staff told us that this extra get-together ensured all staff were aware of the ward safety status, which may have changed during the shift. The 'huddle' discussed changes to patients' conditions, such as falls, and any changes to elective surgery.

Monitoring safety and response to risk

The Trust monitored its performance with the use of the NHS Safety Thermometer – a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The Safety Thermometer provides indicators such as catheter and urinary infections, new pressure ulcers and harm following falls. The Trust performed favourably when compared against other similar Trusts. The ward sister on Ward B4 told us how the number of pressure ulcers had decreased since the introduction of a bundle of patient care packages called 'skin bundles' to protect people from the risk of pressure ulcers.

The Trust had identified that improvement was needed to ensure that diabetics who were having operations received

their medication as defined by best practice guidance. We saw that there were protocols in patients' notes which identified medication required, dependent on blood sugar levels. Staff we spoke with confirmed that this system was working well and had ensured that patients received appropriate and timely treatment and medication.

Staff on Ward B2 said that they were proud of improvements made to reduce the number of falls, both within the surgical unit and throughout the hospital. The ward sister explained that all falls were reviewed and when needed lessons learned were shared throughout the hospital. The impact of this had been that the number of falls with harm had decreased within the surgical directorate and the wider hospital.

Anticipation and planning

The Trust had reported difficulties in recruitment. An overseas recruitment programme had commenced and a number of qualified nurses had been employed by the Trust to increase staffing numbers. The wards and department we visited were aware of this. Staff we spoke with on surgical wards and theatres talked about the difference this would make, as many shifts were currently covered by bank (overtime) or agency staff.

Are surgery services effective?

Good

Patients' needs were assessed, and care planned and delivered in line with best practice guidance. Assessments started in the preoperative assessment clinic and continued during the patients' hospital stay. These assessments were undertaken in a timely manner.

Staff, equipment and facilities

Ward sisters and senior staff at Russells Hall Hospital told us about the positive support provided by the practice development nurse who assisted them to ensure that nurses received the training they needed and that their competence was checked.

Monitoring and improvement of outcomes

A range of national clinical audits were completed, such as the fractured neck of femur audit. Staff told us that the Trust had performed well in this audit. Staff told us about initiatives that they felt had contributed to this which included a dedicated 'hip fracture suite' (which specialised in the care of people with fractured femurs), appointment of a specialist hip practitioner nurse and an orthogeriatrician (a doctor who works in close co-operation with orthopaedics and has a focus on care of the elderly and rehabilitation).

Nursing staff told of improvements that had been made with the availability of an orthogeriatrician. Nursing staff showed us records of a detailed assessment that was undertaken on all elderly patients. This meant that patients were assessed for other conditions such as dementia and had access to coordinated care and treatment.

The Trust had an established hip practitioner service that had been in place for eight years. When the hip fracture was confirmed, the hip practitioner nurse ensured that all required checks and tests were undertaken in readiness for the patient to go to theatre. The hospital performed well when compared with other similar Trusts and ensured that those patients who were fit for surgery had their surgery within 36 hours of their admission to hospital.

Using evidenced-based findings

The surgical division monitored mortality rates and took actions where required.

Sufficient capacity

Staff told us that there was sufficient bed capacity on the surgical wards for surgical patients. They said that if surgical patients were admitted elsewhere in the hospital staff were made aware and they would ensure the person was transferred to a surgical bed as soon as one was available. However, medical outliers in surgical beds reduced this capacity and led to surgical patients, in turn being accommodated in inappropriate wards.

Multidisciplinary working and support

During our observations on the ward, we noted that that there was an effective system in place to discuss a patient's care and treatment – at least daily – and that this included consultants, doctors and nurses and integrated multidisciplinary ward rounds.

Surgery

Are surgery services caring?

Good

Compassion and dignity

We received many comments from patients and relatives regarding both clinical and medical staff over the time of the inspection, and only one was negative. We were told by patients and relatives that staff were responsive to their needs, were kind and caring and respected their privacy and dignity. One patient told us: "They always ensure I am covered up and always knock before they come in". One relative said: "The staff have all been marvellous, they are all kind and compassionate and have given us time and privacy at such a difficult time".

Involvement in care

All the patients and relatives we spoke with said that they had been informed about the treatment they needed and mostly said they been involved in these decisions. One relative told us: "I cannot fault them. They knew how worried I was about my husband and let me stay with him all day and kept checking I was alright".

We observed that people with a learning disability requiring dental treatment were able to go to theatre in their own clothes. Staff told us that they were flexible and that they could either walk to theatre or be taken on a trolley and they could be accompanied by a relative or carer. Relatives we spoke with also confirmed this. One relative told us: "My daughter was frightened of the mask last time she had surgery. I explained that to the doctor who told us that she will just have the 'magic cream' on and won't have to have the mask over her face until she is asleep. I can go with her to theatre. They have been very good".

Trust and communication

The hip fracture service ran a relatives appointment system. This ensured that the family of all patients who were admitted with a fractured neck of femur were kept informed of their family member's injury, proposed treatment and prognosis.

Are surgery services responsive?

Good

We saw that wards and bays were single-sex to provide privacy and dignity. Staff in day theatres told us that, as they only had one main ward area, lists were booked either for males or females to facilitate greater dignity for patients.

Meeting people's needs

Medical staff told us how the Trust used a system of 'hot clinics' for identified conditions. Staff explained that these clinics gave patients who needed to be seen quickly the next available clinic appointment. Staff explained that, for certain urology and vascular conditions, this meant that patients could be treated as outpatients and then followed up at home and did not have to come into hospital.

Access to services

The Department of Health monitor the proportion of cancelled elective operations. This can be an indication of the management, efficiency and the quality of care within the Trust. The Trust was meeting the target for patients to receive an operation within 28 days following cancellation and also for the proportion of patients whose operation was cancelled

Vulnerable patients and capacity

We observed that the service was responsive to the needs of people with a learning disability. While we were in the day surgical unit at Russells Hall hospital staff told us that they had a list for people who had a learning disability and required dental treatment under a general anaesthetic.

Leaving hospital

We saw that discharge planning commenced when the patient was admitted. A discharge date was identified and planned for by the multidisciplinary team. Senior nurses told us that delays to discharge occurred as take-home medicines, most frequently medicines for low-level pain, were not available in a timely fashion.

Learning from experience, concerns and complaints

Staff we spoke with explained that patient and relative feedback, particularly around complaints and concerns, were readily encouraged and we saw documented evidence of this. Written notes of ward meetings showed us that patient histories were discussed, as well as learning from complaints received.

Surgery

Are surgery services well-led?

Good

Vision, strategy and risk

The Trust has a nursing strategy 'The way we care' which is demonstrated by the 'six Cs' of nursing: Care, Compassion, Competence, Communication, Courage and Commitment. The Trust told us that this strategy was informed by feedback from more than 600 nurses, midwives, clinical support workers and community nurses. Nurses we spoke with were able to tell us about the 'six Cs' and the positive impact on patients. We welcomed this initiative, but consideration should be made for this strategy to be used for all staff who work for the Trust.

Clinical staff told us about improvements made following learning from Never Events and other incidents within the Trust.

Governance arrangements

During our inspection, we saw information boards containing governance information, informing patients, staff and visitors of results from clinical audits. We found that, on most wards we visited, there was a robust organisational structure lead by a matron, ward sister and nurse in charge. Ward managers told us that appraisals occurred annually and staff confirmed this.

Leadership and culture

All the nurses we spoke with said that they were proud to work for the Trust and felt well supported by their ward manager and matrons. Staff told us that, following media interest about the Trust, the chief executive had held forum meetings with all staff and promoted a positive view about the Trust. Nurses we spoke with told us this had raised staff morale and promoted a positive impact on patients' care and treatment.

All staff we talked to also spoke highly of the chief executive. Staff told us that the chief executive had met with them on the ward or within the department. One ward sister said: "I have worked here for 15 years and she is the first chief executive I have met. She is both approachable and respected by the staff".

The sister and staff at the day case unit at Corbett Hospital spoke positively about the meeting they had with the chief executive. One staff member said: "She was approachable and listened to us. I could definitely go to her if I had any concerns".

Patient experience, staff involvement and engagement

We saw good evidence of team and multidisciplinary working in the areas we inspected. We were informed and saw that daily consultants' rounds were taking place and, on one orthopaedic ward, a specialist care of the elderly consultant had been employed and was wholly based there.

We found during our visit that patients who were admitted to surgical ward with a fractured neck of femur received appropriate pain relief. However, we found that two patients did not. One patient was initially admitted to a medical ward with another problem and another patient, who had taken pain relief at home before their admission, had a delay in receiving further pain relief.

Learning, improving, innovation and sustainability

The Trust demonstrated learning from Never Events and incidents and there was a positive reporting culture in place. We were told about forward planning for patients' safety. The management team told us there were plans in place to undertake a root cause analysis investigations of grade 2 pressure ulcers to ensure that, whenever possible, pressure ulcers were identified and actions taken to ensure that patients' conditions did not deteriorate.

We asked staff about improvements that had been made. Consistently staff told us that staffing ratios had improved and engagement opportunities with the chief executive increased. Improved incidents reporting, sharing information about and learning from incidents was also reported.

Critical care

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

Information about the service

The critical care department at Russells Hall Hospital comprised six beds in the intensive care unit (ICU), eight surgical high dependency unit (SHDU) beds and six medical high dependency unit (MHDU) beds. The ICU delivered care to mainly adult patients with life-threatening illnesses.

The unit occasionally cared for children who required intensive care prior to being collected and transferred to a specialist children's unit. The hospital provided a critical outreach service to support the care of critically ill patients on wards across the hospital.

During this inspection we talked with nine patients, six relatives and 14 members of staff, including doctors, nurses, physiotherapists, house-keeping staff and students on placement. We asked them about their experiences of receiving care and working in critical care. We observed care and treatment and looked at care records. We looked at records of meetings, staff rotas and performance information about the Trust.

Summary of findings

Staff we spoke with did not consistently demonstrate that they knew how or when to report incidents using the Trusts electronic incident reporting system.

We looked at risk registers for each of the services in critical care. We did not find that risks had all been identified or recorded. This meant senior managers within the Trust would not have been made aware of these risks.

The HDU was routinely staffed to less than the full capacity for the number of patients they could accommodate. We were informed that the hospital bed managers used this capacity to "flex" up and down to meet the needs of people accessing the hospital. We were concerned that the "flex" staffing arrangements in MHDU could place people at risk of unsafe care. We found that senior nurses were spending unreasonable amounts of time covering shifts with agency staff or the Trust's own temporary nurses. Greater staffing continuity could have been achieved if the Trust agreed blocks of time the beds would be used for.

Senior nursing staff advised us of the staffing challenge they were currently facing due to delays in recruitment, sickness and maternity leave. We found that efforts had been made to ensure the continuity of staffing wherever possible. Agency nurses we spoke with reported that they had been inducted to the unit and supported to ensure that they were competent and confident to undertake their role.

Critical care

People in the high dependency units (HDUs) were not cared for in an environment that promoted their dignity or privacy. There was a lack of general space and poor screening around beds in the SHDU and a lack of toilets and bathrooms in both SHDU and MHDU

The latest Intensive Care National Audit & Research Centre (ICNARC) data showed that patients using the ICU services were likely to have better than expected outcomes, as the rates of mortality were fewer than expected when compared with other similar hospital units across the country.

Patients received a good standard of nursing and medical care. Patients benefited from a service that was caring, effective and well-led by an experienced and competent team.

Are critical care services safe?

Requires improvement

We found patients within the critical care service would benefit from improvements made to the service.

Learning and improvement

Staff we spoke with all demonstrated a strong commitment to improving and developing the critical care services. Nurses confirmed that they were part of local and national specialist groups, where innovations in the field of critical care were shared.

We saw notes of meetings where improvement and quality issues were discussed. Minutes did not always confirm that staff appreciated the value of such activities to patients or their own practice, but considered them necessary for regulatory purposes.

Systems, processes and practices

Staff we spoke with did not consistently demonstrate that they knew how or when to report incidents using the Trusts electronic incident reporting system. We looked at the systems in place to ensure that an investigation and learning always followed a critical incident. Nursing staff were able to share some examples of clinical incidents and how these had been investigated and the actions taken. Medical staff we spoke with, and records we looked at, showed that staff had responded quickly to critical incidents but that the system for reviewing and learning from the incidents was not fully embedded into medical practice.

Medical staff acknowledged the importance of learning from incidents, however when we looked at minutes from the Critical Care Quality and Practice meetings we found there was no formal system in place to learn from audits, incidents or complaints in order to improve outcomes and experiences for patients using the service. However, we noted from our interviews with medical leaders in the department there was a willingness to introduce a more formal system in the future to ensure learning did take place.

ICU had identified an issue with capnography for patients who need the support of a ventilator to breathe (a way of checking carbon dioxide levels to see that the ventilator is working effectively). The Trust were experiencing problems

in using capnography with patients on humidified ventilation. We saw the Trust were taking steps to address this and would encourage the sharing of information on this to resolve the problem quickly. There was a plan to increase the availability of capnography at each bed-space.

We found that the patients who had been assessed as needing to wear anti embolism compression stockings were not always wearing these. However, we found there were concerns about the assessment paperwork which could have been misleading for staff not familiar with working in the area. This could have placed people at risk not being fitted with compression stockings.

Monitoring safety and responding to risk

We spoke with staff about risks they had identified in the areas they worked. We looked at risk registers for each of the services in critical care. We did not find that risks had all been identified or recorded. This meant senior managers within the Trust would not have been made aware of these risks. We would expect to see all risks within a critical care unit escalated so mitigating actions could be put into place.

Anticipation and planning

The HDU was routinely staffed to less than the full capacity for the number of patients they could accommodate. We were informed that the hospital bed managers used this capacity to "flex" up and down to meet the needs of people accessing the hospital. We were concerned that the "flex" staffing arrangements in MHDU could place people at risk of unsafe care. We found that senior nurses were spending unreasonable amounts of time covering shifts with agency staff or the Trust's own temporary nurses. Greater staffing continuity could have been achieved if the Trust agreed blocks of time the beds would be used for.

Senior nursing staff advised us of the staffing challenge they were currently facing due to delays in recruitment, sickness and maternity leave. We found that efforts had been made to ensure the continuity of staffing wherever possible. Agency nurses we spoke with reported that they had been inducted to the unit and supported to ensure that they were competent and confident to undertake their role.

Are critical care services effective?

Good

We found that patients benefited from a service that was effective.

Using evidence-based guidance

The latest Intensive Care National Audit & Research Centre (ICNARC) data showed that patients using the ICU services were likely to have better than expected outcomes, as the rates of mortality were fewer than expected when compared with other similar hospital units across the country.

Monitoring and improvement of outcomes

We found that electronic records maintained by nursing and medical staff were regularly reviewed and updated to ensure that patients were receiving the most effective care possible.

Nursing staff told us of actions they had taken to ensure the best possible outcomes for patients and their families. These included working to promote continuity of staffing for the patient. Staff and relatives we spoke with, and staff records we viewed confirmed, that, as far as possible, the same nurse would support the same patient on consecutive shifts during their stay in the unit.

We were informed that, each year, staff from the unit had undertaken specialist training to develop their skills in caring for critically ill patients. Staff explained how this learning had been shared among the team to ensure current best practice was maintained in the unit. However, we were informed that "patient diaries" (a recent development to help people rehabilitate after a long period of being sedated or unconscious) were not currently in use within the unit.

Multidisciplinary working and support

We spoke with staff from medical, nursing, housekeeping and professions allied to medicines (such as physiotherapists) during our inspection. We found that staff from all areas were proud of the service they offered and largely attributed this to the close multidisciplinary working within the department. We saw examples of good practice which included a department phoning ICU to make them aware that an unusual test result had been

emailed to them. This ensured the relevant staff saw the result at the earliest opportunity and ensured that the patient's care and treatment was reviewed in the most timely manner.

We were informed that medical staff from specialist teams did not always maintain an active role in their patient's care when in critical care. We also identified that there was no formal system to ensure patients admitted by an acute physician were handed over to the appropriate medics on their discharge from ICU. We identified that strengthening this relationship between staff in ICU and the relevant specialist team could improve the handover and effective transfer of care when people are ready to be discharged from ICU.

Are critical care services caring?

Good

Patients benefited from a service that was caring and compassionate.

Compassion, dignity and empathy

We observed – and patients and relatives we spoke with confirmed – that people were always treated with care and compassion. All the patients we met had been supported to undertake their personal care to a high standard, and people (including people who were unconscious) appeared to be clean, fresh and comfortable. A patient told us, "I can't speak highly enough about it here". An example of the many positive comments we received from relatives was, "Without exception I cannot fault the care of the doctors and nurses here. My relative's care has been exceptional". We saw staff greeting patients and their families every time they approached them and we heard staff encourage people in a way that was respectful and appropriate to the person's age.

Involvement in care

We heard nursing and medical staff explaining to patients who they were and what they needed to do before they commenced a procedure. We heard staff reassuring and encouraging people during our time on the units. Patients we spoke with knew the reasons for their treatment and were aware of the possible next steps. Visitors we spoke with praised the staff for ensuring they were kept up to date in their relative's care and treatment. Staff explained that some relatives liked to be involved in the hands-on care of the patient and, where possible, they enabled this.

Trust and communication

Throughout our visit we observed that each patient's confidentiality was maintained at all times. We saw staff discuss or hand over patient information in a discreet manner so they could not be overheard. People's records were stored securely, and both electronic and paper care records we viewed had been completed in detail and with respect for the patient.

Emotional support

We observed staff providing emotional support to both patients and visitors throughout our visit. Staff we spoke with were aware of the hospital chaplaincy services and of local religious leaders within the community. Critical care staff also had details of bereavement support services for relatives of patients who had died. This ensured patients and their relatives had access to appropriate pastoral and spiritual support.

Are critical care services responsive?

Requires improvement

We found that services in Critical Care required improvement.

Meeting people's needs

We found that the critical care service monitored and reviewed people's welfare on a regular basis to ensure that changes to people's care or treatment were identified and actioned in a timely way.

Facilities were not available for patients who were less dependent; particularly for those who remained on HDU, but would have been able to be transferred to a ward if beds were available. This meant that those patients lacked interesting things to do during the day which would have a negative effect on direct care and welfare of patients within the unit.

We identified that the screens used in ICU and SHDU were not effective in protecting people's privacy and dignity. On some occasions we also observed staff peep over and

around the screens without making people aware they were there. The unit staff had also identified problems with the screens and were looking at ways to improve the situation.

We were shown copies of information booklets given to patients and relatives receiving critical care. These answered some frequently asked questions and informed people about how they could be involved in their care. One leaflet showed the uniforms staff wore, with a description of their grade. This was a way of helping people feel more comfortable in the critical care environment.

Information supplied by the hospital identified that the demand for beds in ICU and HDU sometimes exceeded supply. We found the Trust was using the critical care outreach team to support critically ill patients on wards until a dedicated critical care bed was available. The Trust also operated a "flex" system to staff additional critical care beds. Due to the pressure on beds across the hospital, there were times when some patients stayed on the HDU unit when they were ready for discharge to a ward. While flexing in this way can be convenient for patients we were concerned about the toilet and bathroom facilities for patients within HDU areas for patients who were more able. These facilities were a single joint toilet/bathroom for multi-sex use. This meant that if one patient was showering (which may take longer if patients are physically less able or hampered by drips etc.) the toilet facility was effectively out of use for a significant time period.

Access to services

There was a clear admission protocol for patients needing critical care. This ensured the unit only took on patients who needed their services. Critical care supported people from all parts of the community and we found there were facilities to support people who were physically disabled and required support to move and mobilise. There were facilities or arrangements in place to support people of all ethnic, cultural and religious groups. Staff also described how they had provided appropriate support for people of all sexual orientations to ensure that patients could have privacy with their partners.

Vulnerable patients and capacity

Some patients were unable to understand or be involved in the planning or delivery of care due to the severe nature of their condition. In these instances we found that staff applied the Mental Capacity Act 2005 and Code of Practice in relation to capacity and consent.

We looked at the facilities to support people who communicated in a language other than English. We were informed that there were staff working in critical care who could speak a variety of languages, we saw this happening on two occasions during our inspection. Staff could also request the support of an interpreter or use a phone system called Language Line to ensure patients and their relatives were as fully involved as possible.

On occasion, children were cared for in the ICU prior to their transfer to a local unit specifically for children. We found that staff had been trained in care issues specifically relating to children, and staff demonstrated a robust understanding of the issues relating to caring for children in an adult care environment.

Leaving hospital

The majority of patients were discharged from the ICU into a HDU bed, and from HDU to another ward bed within the hospital. We were informed that people were unlikely to be discharged straight home due to the complexity and severity of the condition they would have been treated for in the ICU. This step-down approach ensured that patients were well enough and stable within their condition prior to being moved, which in turn reduced the likelihood of them requiring readmission in the future. Information booklets given to patients and their relatives also informed them about how to adjust to life at home following discharge from hospital.

Learning from experiences, concerns and complaints

All staff we spoke with were aware of their role in ensuring they listened to the experiences, concerns and complaints of patients and their relatives. Staff gave practical examples of times when they had listened, acted on and resolved a concern at the time it was raised. Staff were also aware of how to escalate a concern to more senior staff, and how to refer people to the hospital's complaints department. Senior nurses explained how learning or action taken as a result of patient and relative feedback was shared within the unit.

Are critical care services well-led?

Good

This aspect of the service required improvement.

Critical care

Vision, strategy and risks

The Trust had a published vision, and we saw posters displaying this in all of the critical care areas we inspected. Staff of all grades and disciplines demonstrated passion for the work they did and dedication to provide the best possible service for patients. Staff spoke positively about the senior sisters and matron, but were less well informed about the nursing management beyond this. Some nurses we spoke with described feeling supported locally but "isolated" from the Trust, and wider Trust initiatives. Senior doctors reported favourably about the medical management and leadership within the Trust. Notes we read of medical meetings showed that open and challenging discussions regularly took place around risks and strategy for the department.

Quality, performance and problems

The Trust had recently introduced "huddle boards" around the hospital. These were whiteboards displaying staffing and quality information about each unit and were a way the Trust was being open with patients, relatives and staff about the operation of the unit. Staff we spoke with acknowledged the value of displaying this information but identified that it was hard for critical care staff to actually gather around the board due to the high care needs of their patients.

Leadership and culture

We identified that both medical and nursing leadership within the critical care department was strong. Staff we spoke with were clear about the line management arrangements, and told us they felt supported both personally and professionally. Comments from staff included: "I'm proud to say I work here," and," I have never felt alone or unsupported". Nurses we spoke with told us they increasingly felt they had a voice. This meant staff felt they could speak out and their views would be taken into account.

Junior doctors we spoke with praised the support they had from their senior medical team. They reported having an induction onto the unit, and being trained and assessed to use the specific department equipment. They reported that they were able to access the support of a senior doctor if they needed it. This ensured that staff were supported and patients had competent staff treating them at all times.

Patient experiences and staff involvement and engagement

The Trust offered patients and their families the opportunity to comment on the care given and give feedback in the NHS Friends and Family' test. The departments had reviewed feedback and displayed the level of satisfaction on their huddle board for visitors to the unit to read. This meant that current feedback on the performance and people's experience of the ward was available to all.

Staff we spoke with explained that formal staff meetings were difficult to arrange due to the intensive nature of supporting patients in the unit and the "long day" working pattern. (Staff working long day's work fewer, but longer days each week to promote consistency of care.) Senior staff explained that they overcame this is far as possible by providing detailed patient handovers each shift to ensure that staff remained as up to date with ward- and Trust-wide issues as possible.

Learning, improvement, innovation and sustainability

We found that staff spoke openly with each other and doctors we spoke with explained how they appreciated being able to think through treatment options for patients with their peers. Nursing staff told us how they were encouraged to challenge each other's practice in a constructive way. This approach ensured that patients benefited from innovative and improving medical practice.

We found that staff were able to undertake both formal and informal learning and development. We were told that ward-based information-sharing sessions were sometimes delivered by staff to their peers. Staff also had the opportunity to attend mandatory and clinical training to ensure that their practice was as safe and as effective as possible. Staff who were responsible for leading other staff or shifts identified the need for more managerial/ leadership training. Staff at this level reported being satisfied with their clinical training but described occasions where they felt they had lacked the skills or experience to deal with a management issue.

Maternity and family planning

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

Information about the service

The maternity unit at Russells Hall Hospital, Dudley, delivered 4,800 babies in the last 12 months.

The maternity unit is located within the women and children's health department and includes an antenatal clinic, early pregnancy unit, day assessment unit, triage, labour ward, midwife-led unit and an antenatal & postnatal ward. Women with high risk pregnancy attend the hospital antenatal clinic at Russells Hall; the an early pregnancy unit (EPU) is for women between six and 20 weeks pregnant who are experiencing difficulties.

The day assessment unit is attended by women over 20 weeks pregnant who have complications of pregnancy. Women attending the maternity unit are triaged (have their care assessed) by a midwife and directed to the most appropriate facility.

Russells Hall Hospital has a designated labour ward as well as a midwife-led unit, the latter for low-risk women. The antenatal and postnatal ward is combined and consists mainly of single rooms.

Community midwives are aligned to a GP practice and are employed by the maternity service to provide both antenatal and postnatal care for women and their babies & provide a home birth service.

We visited all areas of the maternity unit and talked to midwives, support workers, the obstetricians, senior managers, women attending the antenatal clinic who had recently given birth.

Summary of findings

We were concerned with some elements of the service regarding safety; specifically that the arrangements for covering shifts were unsustainable and these were putting pressure on the existing staff. Additionally, we saw that categorisation of incidents and recording of data were at times inaccurate. This prevented the service analysing incidents and learning from these. We also saw the quality of data recorded on the maternity dashboard was variable.

The maternity department had failed to meet some of its indicators on the maternity dashboard, for example, elective caesareans had been higher than expected in recent months. The department was meeting other targets, for example, majority of women booked by 12 weeks of pregnancy – while performance against other indicators varied each month.

We found that staffing levels sometimes fell below the expected numbers and that there had been an increase in the number of staffing-related incidents reported.

We saw that there were processes in place for individual staff members to learn from incidents they had reported or been directly involved with. However, not all incidents were categorised correctly and information did not always flow through accurately to reports and the performance dashboard (an electronic performance reporting and tracking system). Also, the sharing of learning outcomes required improvement.

Maternity and family planning

The women we spoke with were happy with the care they had received. They found the staff to be friendly and helpful and communicated well about their care and treatment.

There was a clear care pathway in the maternity unit, according to women's clinical needs. Women felt that the level of communication from midwives and doctors was good and they felt listened to and well supported.

The layout of the department meant that women and their new-born babies could be cared for in an environment which promoted their privacy during their stay.

We saw that the maternity department had performed well in feedback from patients through the Maternity Survey and that there was a process for handling complaints, although we saw that one complainant had not received an accurate response.

Staff working within the department generally felt well supported by management and thought that they worked in an open and transparent environment.

Are maternity and family planning services safe?

Requires improvement

We found that improvements were needed to ensure women and babies consistently received care that was as safe as possible.

Safety in the past

The maternity department had systems in place for recording and monitoring performance. A dashboard was used to rate performance against key indicators. Performance was colour coded as red, amber or green to enable management to see at a glance areas which required improvement.

Historically the maternity department had issues with capacity. The department was 'stretched' due to the number of women choosing to have their baby at Russells Hall Hospital following a restructuring of maternity services within the local health economy. This had put pressure on staff and placed women's safety at risk. The maternity department at Russells Hall Hospital had to divert women to other local maternity departments on a number of occasions for periods of 12 hours at time. There was an escalation policy to manage this.

Data provided to us prior to our inspection indicated that services had been suspended on five occasions but that women had not been diverted during any of the suspensions. However, we found one reported incident of a woman in labour who had been diverted to another hospital and this had not been recorded on the dashboard. This meant that information presented to the committee using the dashboard was not representative of all events.

Safety and performance

Management from the hospital held discussions with the clinical commissioning group (CCG) and agreed a strategy to improve the service and safety of care offered to women and their babies by reducing the number of women who attended the department by repatriating women to their designated local maternity department.

We were told that this reduction in capacity had improved the care provided to women significantly. Since this agreement, there had been very few occasions when the maternity department had needed to suspend its services.

Maternity and family planning

There had been no service suspensions during January and February 2014 in data available during our inspection.

The Trust used the monthly dashboard to monitor a number of other targets, including activity, escalation, quality and governance as well as risk management. However, some targets on the dashboard were not yet being monitored, for example, the number of consultant hours on labour ward and attendance of staff at specialist training. This meant that a full picture of the department's performance could not easily be monitored at committee meetings.

The maternity dashboard was used to monitor the number of deliveries each month against a target of 380; if deliveries exceeded 400 this was flagged as a risk. However, we were told by management that the number of deliveries was capped for the year at 4,900. This meant that the targets on the dashboard were not accurate and that the target needed to be reviewed. We discussed this with management who agreed the target being monitored was too low and needed to be revised.

We saw that the hospital had recently had an increase in the number of elective caesareans during January and February 2014, reaching 14.2% and 14.7% respectively, compared to the England average of 10.7%. The Trust had set a target of 9% or less of all women to have an elective caesarean section and had only achieved this for three out of 11 months during 2013/14; exceeding the England average for seven of the 11 months. We were told that an audit had not yet taken place because the Trust had only seen a significant increase during the preceding two months.

The number of midwives assigned to a supervisor was below the 1:8 national recommended level, which meant that supervisors had a manageable number of midwives to supervise.

The target for the number of third and fourth degree tears suffered by women had also been met for most of the 11-month period.

We saw that the induction of labour was much higher than the agreed target each month. We were told that this had been reviewed but that the report had not been finalised and therefore was not available for review.

Other key indicators were monitored in accordance with the 'saving lives' initiative. We saw that catheter care had been poor during the summer months but that an action plan had been developed and a new care bundle produced, and performance had improved significantly in November and December 2013.

The birth-to-midwife ratio had been calculated based on case mix (the variation in case complexity) and ratio recommendations. The calculation recommended a ratio of 1:32.2 (one midwife to 32.2 births). We noted that the target monitored on the monthly dashboard was 1:33, however, the ratio monitored was the number of established posts rather than staff actually in post; the dashboard did not consider vacancies such as maternity and sick leave, which meant that it was not able to be used effectively to provide a full and accurate picture of staffing levels for planning or to present to committee meetings. The national workforce planning figure for birth to midwife ratio is 1:28 (Guidance published by Royal College of Obstetricians and Gynaecologists 2007, including the Royal College of Midwives state 'The minimum midwife-to-woman ratio is 1:28 for safe level of service to ensure the capacity to achieve one-to-one care in labour').

It was the perception of most of the staff we spoke with that there were not always adequate staffing levels. There is a national shortage of midwives and we were told that positions were advertised promptly following resignations. There was a constant cycle of resignation and recruitment and we were told that the department regularly recruited to ensure the vacancy rate was kept as low as possible. The department did not use agency midwives and reliance was largely placed on midwives already on the establishment to work additional shifts. Midwives we spoke with told us that they were often tired and that they (those who had previously indicated they may be on the nursing bank) received texts on their personal mobiles to advise when a shift needed covering (regardless of how many shifts they had recently worked or how recently they had completed a shift. Midwives told us that this made them feel guilty and they felt pressure to work a shift.

We reviewed training records and found that the women and children's department overall had achieved 77% compliance with their attendance at mandatory training sessions. The data provided were not separated by department or staff group. It was noted that some mandatory training courses were below 75% attendance, notably, diabetes management, resuscitation for paediatrics (neonatal resuscitation was above 80%),

safeguarding children (intermediate) – although over 90% of staff had completed the safeguarding at foundation level. Training for venous thromboembolism (blood clots) had also been poorly attended and mental health awareness had the lowest attendance rate at 20%, although this training had only been introduced during 2013/14.

A report on training attendance had been prepared for the directorate's risk management meeting in January 2014 and an action plan had been developed to improve attendance.

Learning and improvement

Incidents were reported using an online tool. Staff told us that they reported incidents they were involved in or witnessed and that they were confident in using the system and were encouraged to report incidents as they occurred.

The staff we spoke with told us they had learned from incidents once the investigation had been completed. They said they received direct feedback via an automatically generated email once the incident was closed. Some staff told us that lessons were also learned through group emails.

There had been no recent Never Events (mistakes so serious they should never happen) within the maternity department. There were 23 serious incidents reported by the maternity department over a six-month period between September 2013 and February 2014.

We reviewed the summary report of serious incidents for this period. Of the 19 closed risks, the summary reported that nine required no action as appropriate care had been provided. We requested the root cause analysis report for one of these incidents and found that there was an agreed action and learning point but it was unclear whether this had been followed up.

For the remaining 10 incidents, all had recorded actions; five included an action to share lessons with groups of staff, four via email. We were shown evidence of one of these emails as an example and another one via the maternity department monthly newsletter, 'Chatter'. However, we saw that the monthly newsletter for March was 98 pages long. We spoke to 18 midwives, and 17 told us that they had not read the newsletter because it was too long; one midwife had skimmed through some of the pages. We understand that this may have been due to an editing error. One incident had an action point that a supervisory and management investigation should be undertaken, but the incident was closed prior to receiving the outcome from any such investigation. The other five incidents did not record an action to share lessons learned when it would have been appropriate to do so.

We were told about a complaint which had been received regarding a serious clinical incident. We found that the incident had not been reported until about six weeks after the receipt of the complaint. The complainant was given assurances that all relevant documentation had been completed, although the incident investigation had shown that one document had been completed in error. This suggested weaknesses in the system of checks prior to surgery. We also noted that the incident was categorised as high risk but did not feature on the serious incident report.

Systems, processes and practices

We observed that the design and layout of the department was conducive to providing care to patients in accordance with their needs. The department was visibly clean on the day of our inspection. All women in established labour were cared for by a midwife in a side room and we were told that women received one-to-one care while in established labour.

There were separate side rooms on the postnatal and antenatal ward for most of the women, although there were some shared bays. One of the delivery rooms had been set up as a bereavement room as required; this room had additional space and was located at the end of the corridor so that a bereaved family would not have to walk past new mothers.

We saw that all necessary equipment was available within each of the rooms and we were told by staff that equipment was always available and well maintained. We observed that the resuscitation trolleys contained all the necessary equipment.

Most of the midwives told us they thought there were insufficient staff and the department could become overwhelmingly busy at times. We were told that the maternity department did not use agency staff and that all bank (overtime) staff – with the exception of two – were also established staff. This meant that vacant shifts would be covered by existing midwives; the Trust did not have an additional pool of midwives they could contact to cover vacant shifts.

Maternity and family planning

The maternity managers' meeting minutes for February 2014 reported that the maternity unit vacancies had been taken up by staff increasing the hours worked. We were told by management that the number of hours worked by midwives was not monitored and, therefore, it was not possible to determine whether individual midwives worked excessive numbers of shifts. We did not see that the limited pool of midwives available to provide cover had been considered as a risk by the Trust or that it was being managed effectively.

We were told that the maternity unit staffing structure was fairly fluid and that midwives could be moved around the department as required according to demand. If there was insufficient staff, midwives would be asked to cancel study leave or would be relieved from non-clinical duties. The midwives we spoke with told us that when the unit was short-staffed, a text would be sent to all available bank midwives (via their personal mobile phones) informing them and asking if they were able to cover the shift.

This was also evident through review of the women and children's risk management meeting held in January which reported that there had been an increase in staffing and workforce issues from 25 in April 2013 to 69 in December 2013.

Community midwives also told us that it was their perception that they were short-staffed due to vacancies, maternity leave and long-term sickness.

The maternity managers' meeting minutes for February 2014 stated that vacancies and absences had caused some difficulties with cover. There was no evidence that discussions took place on how this could be improved.

The midwives we spoke with had a good understanding of safeguarding arrangements. They were able to tell us what would concern them about a child or vulnerable adult and how they would act on those concerns, by following the hospital's safeguarding policy.

The maternity department worked closely with the local authority and other external organisations to identify in advance any unborn babies who may be at risk either locally or from geographically further afield.

The maternity department had its own 24-hour per day security personnel and access to the department could only be gained via intercom. Electronic baby tagging was provided as standard and women were offered a choice of using this service.

Records stored within the reception area of the inpatient maternity department had been identified as a risk on the directorate's risk register. Issues around confidentiality and fire had been identified. An action plan was in place and works were due to commence the week following the inspection. However, we observed that patient records on the antenatal clinic were not stored securely. Records were stored in unlocked trolleys close to the reception desk. We were told that the reception desk was always manned and that records were never left unattended. We were told that a risk assessment had been completed but we were not provided with evidence of this.

Monitoring safety and responding to risk

The women and children's health department had a risk register which was regularly monitored and updated. The register was regularly presented and discussed at the directorate's risk management meeting. The register contained a detailed description of the risk as well as controls in place and action required to reduce the risk. The risk register was discussed at relevant departmental meetings and we were told that high risks were transferred to the Trust-wide risk register to ensure that they were reported and discussed at executive level. We discussed the risks and were told about action being taken – for example, alteration work was planned for the reception area to improve the storage and security of records and there were also changes being made to improve the phlebotomy service.

Anticipation and planning

The maternity department had a separate escalation policy to cope with capacity or staffing issues. The plans set out responsibilities and actions to follow. The number of expected deliveries was monitored each month according to the delivery dates recorded for women who had attended the antenatal department. We were told by management that this was used a tool to ensure adequate staffing resources were available.

Maternity and family planning

The maternity unit was open 24 hours a day, seven days per week. We were told that, in the event of staffing or patient capacity issues, the service would be suspended in accordance with the escalation policy. There were four levels of functionality within the department:

- level 1 – maternity services are fully operational with normal patient flow and there are appropriate staffing levels
- level 2 – early signs of capacity/staffing compromise requiring additional management support
- level 3 – serious capacity/staffing compromise requiring temporary unit closure with diversion arrangements to other hospitals
- level 4 – serious capacity/staffing compromise requiring 'suspension of services' but unable to divert women to other hospitals.

According to the maternity dashboard, levels 3 or 4 had been reached on eight separate occasions during an 11-month period, April 2013 to February 2014 inclusive. We found there were discrepancies between the data on the dashboard and a staffing report relating to the number of times the service was on level 3 or 4 alert due to staffing and capacity (we noted that this was an error and was changed while we were on site). The dashboard also reported that there had been no women diverted to other units as a result of the department temporarily suspending its services; however, we identified a reported incident in September 2013 where a woman had been transferred to another hospital but this data had not filtered through to the dashboard. The Trust amended this while we were on site.

We were told that staffing was monitored throughout the day. A daily staffing sheet was used to record staff allocations; we were told that the maternity unit worked with a minimum of 15 midwives. One of the midwives was the shift leader and their role was supernumerary. Midwives were allocated across the department according to demand.

The escalation and staffing report for maternity midwife managers' meeting prepared for 17 February 2014 reported that, during the three-month period November to January 2013, 26 shifts had been staffed by more than 15 midwives and 114 had been staffed by fewer than 14 midwives. However, there was no written explanation and the available data lacked detail, particularly for the number of births during these shifts; lack of this information fails to make sense of the numbers for the services planning purposes. Therefore, the receiving committee would not have been able to determine whether shifts were adequately staffed according to the number of women who attended the department, or whether the unit was over or under staffed.

We were told by some of the midwives that they frequently worked with fewer than the required number of midwives and it was their perception that the department could become very busy at times. We reviewed the incident data for a six-month period and saw that 282 staffing incidents had been reported; 39 reported that midwife numbers were between 10 and 12; a small number of incidents did not report the number of midwives on a shift; and the majority reported there were 13 to 14 midwives who had worked.

A review of the minutes for the women and children's risk management meeting held in January 2014, reported that there had been an increase in staffing and workforce issues from 25 in April 2013 to 69 in December 2013.

Staff told us that handovers were undertaken twice daily. Handovers involved midwives and clinicians and focused on individual patient information as well as any general issues, for example, staffing. We observed one of the handovers and found that suitable information was transferred between staff to ensure patient safety.

Are maternity and family planning services effective?

Good

Using evidence-based guidance

An annual clinical audit plan had been developed for 2013/14. The plan was Trust-wide and audits were listed by directorate and speciality. There were 14 audits scheduled for obstetrics for the year.

We were provided with a copy of a clinical audit for management of multiple pregnancies and found that the rationale and methodology were clearly defined. We found that recommendations were detailed and an action plan had been developed for implementation. However, we noted that not all recommendations were supported by an action and recorded actions did not specify a timeframe. There was also no evidence recorded of the completion of agreed actions.

Maternity and family planning

We saw that the department had introduced a log to monitor new guidance from the National Institute for Health and Care Excellence (NICE) to ensure that the department incorporated and followed national recommendations. NICE guidance featured as a standard agenda item on the directorate's governance committee meeting.

We saw that targets had been developed, based on national guidance and these were monitored monthly.

Monitoring and improvement of outcomes

The maternity department monitored a range of targets, set internally, nationally or by the CCG. Targets monitored were recorded under relevant headings, activity and escalation, escalation quality, governance and risk management. The maternity dashboard was reviewed at the monthly directorate's governance meeting. We noted that some indicators had been identified as needing an audit due to an increase in risk level.

We reviewed a sample of indicators and found that the data reported could not always be relied on. This was due to various reasons – for example, there was a target of 380 births per month, with births or predicted births rising above 400 causing a red alert. The figure of 400 births a month would take the annual total to 4,800. We raised this issue with management because the cap for the annual number of births was actually 4,900. Management agreed that the monthly target needed to be revised and increased accordingly. Minutes from the directorate's governance meeting in December considered retrospectively how data was used; it noted that the predicted births for October had exceeded 400 and that data for this target should be available three months ahead and we saw evidence this had been actioned. However, the committee had failed consider whether the target used was adequate as identified during the inspection.

Unexpected admissions to the special care baby unit were not measured or monitored on the department's dashboard, yet this incident type was the most frequently recorded serious incident for maternity. However, the Trust overall rate of neonatal admissions and readmission was in line with the national average.

The maternity department also reviewed a sample of records each month to ensure women and their babies had received the expected standard of care and that this had been documented – for example, pain management, infection control and nutrition, among other things. For March 2014 the department had achieved 95% compliance overall, with five indicators falling below 80%, including documentation of prescriptions for intravenous fluids and falls assessments for women who had an epidural.

We looked at outcomes for women and their babies. The rate for elective caesarean sections and other forceps deliveries was slightly higher than the England average but readmissions to the maternity unit, perinatal mortality, neonatal readmissions and puerperal sepsis and puerperal infections were all in line with England averages. 62.3% of babies were born by a normal delivery.

Sufficient Capacity

There was a clear staff reporting structure at operational level within the maternity department. We were told that shifts were always led by a band 7 midwife. Concerns could be reported to the lead midwife and escalated to the matron or general manager if required. We were told that there was a site manager who could be contacted in the event of an emergency out of hours, and that concerns could be escalated to the on-call duty manager if necessary.

We were told that staff had annual appraisals. The staff we spoke to told us they felt supported by management and found their appraisal a helpful process. We were shown evidence that 81% of staff within the directorate had completed their appraisal for 2013.

The staff we spoke with told us that they were satisfied with the training they received and that it supported them in their role.

We were told that staff completed training on all medical devices used within the department. However, the records showed that only a small percentage of staff had completed the relevant training.

Multidisciplinary working and support

Women attending the maternity department received care from midwives, midwife assistants as well as obstetric medical staff and anaesthetists. We were told that the team worked well together. Midwives told us that they could access medical staff for advice if necessary and that women wanting an epidural were responded to promptly by the anaesthetist and any delays were only caused by prioritising any emergency surgery needed.

Maternity and family planning

The maternity department had trained a number of midwives in specialist roles, for example, diabetes, substance misuse, vulnerable women and safeguarding, among other areas. This meant that all midwives had a person to contact for advice if needed.

There were also feeding assistants allocated to the postnatal ward to provide women with support and guidance on feeding their baby. This freed up time for midwives and midwife assistants to concentrate on other aspect of care for women and their babies.

We observed a handover between shifts and found that this was well attended by obstetricians, midwives, student midwives and anaesthetists. Information shared between staff was adequate to ensure patient safety.

There was a clearly defined care pathway for pregnant women presenting in the emergency department.

Are maternity and family planning services caring?

Good

We found that women and babies experienced appropriate care and support.

Compassion, dignity and empathy

The women we spoke to told us that staff were caring and compassionate and that their requests were responded to and this was supported by our observations.

Using the CQC Survey of Women's Experiences of Maternity Services 2013 (Labour and Birth Data) shows that the Trust is performing the same as other Trust's for two of the three areas of questioning in the survey. Under the headings of 'Care during labour and birth' that the Trust is performing the same as other Trust's for two of the three areas for questioning. They are performing better than other Trust's in relation to 'Care in hospital after the birth'. The comparison to the 2010 results reflect that the Trust is showing an upward trend in one of the eight questions asked, 'Thinking about your care during labour, were spoken to in a way you can understand'. This showed a 0.5% increase compared to 2010.

Involvement in care

Women told us how they felt listened to and were in control of the care they received and that doctors and midwives communicated well with them. For example, one woman told us how she had wanted to use the birthing pool and so this formed part of her birthing plan and was available during her labour. Women told us that pain relief was explained to them and they felt in control of the pain relief they received. They told us that information on breastfeeding was helpful and that they had felt well-informed about the options available to them.

Patients attending the maternity department received regular meals and were provided with breastfeeding and/or bottle feeding support in accordance with their wishes.

Women and their partners had the opportunity to have a tour of the maternity department prior to checking in. Weekly breastfeeding support sessions were also available and a monthly session was available for grandparents, designed to help them to support their daughters in looking after their babies.

Patients could access an interpreter service if they were unable to communicate in English, and a number of the staff were able to speak a second language to provide support if needed.

Trust and communication

The women we spoke with were satisfied with how staff communicated with them during their time in the maternity department. We observed positive interactions between staff and women.

We observed that patient records were written in a clear and concise manner. Care and treatment required was well-documented and consent had been obtained as required.

Are maternity and family planning services responsive?

Good

We found that the maternity department was responsive to people's needs at outpatient stage and during inpatient stays.

Meeting people's needs

The maternity department is set up to provide care for women according to their assessed level of risk. A midwifery-led unit is available for low-risk women and is within close proximity to the labour ward which sees a

mixture of low- and high-risk women according to the level of demand. Women who are induced currently give birth on the labour ward, although this is under review, with a view to allowing some of these women to give birth on the midwifery-led unit, in accordance with women's individual care needs.

The department has two theatres, one theatre is used for routine elective caesareans and the second is used as an emergency theatre. Staff told us that the theatre arrangements worked well and that if there was a second emergency, the elective list would be delayed, but all women scheduled to have a caesarean remained on the theatre list for that day.

There were clearly defined pathways for women to ensure their needs were met.

Staff regularly checked on women and their babies to ensure that they received care and support.

Women also had support and advice from feeding experts to assist and advise them in feeding their new-borns.

Most women received their care in a side room. One of the side rooms had two beds, with curtains available to ensure women's privacy could be maintained; assessment areas also had curtains which could be pulled round as required.

The staff and women we spoke with liked the layout of the maternity department; it meant people could be cared for in privacy.

Women were provided with information and leaflets at antenatal appointments as well on the inpatient ward. Information was available about the different birth options available and if an elective caesarean was planned, information was provided during the outpatient appointment.

Vulnerable patients and capacity

The department provided a service to a diverse population; people who were unable to speak English could be supported by an interpreter service if required. We saw that there were patient information leaflets available in four different languages.

We spoke with staff about safeguarding policies and procedures. The staff we spoke with all talked confidently about how to recognise the different types of abuse and what they would do if they suspected a vulnerable person may have been subject to some form of abuse.

Staff were also aware of the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.

We reviewed training records and found that only 20% of staff had completed training in mental health awareness. However, this was a new training course and had only been introduced in 2013. An action plan had been developed to improve attendance at training. We saw that there was a clear pathway for vulnerable women and a policy for making assessments on women's mental health both during pregnancy and as part of their postnatal care.

Access to services

The maternity unit was open 24 hours a day, seven days per week. We were told that, in the event of staffing or patient capacity issues, the service would be suspended in accordance with the escalation policy. (This is detailed above in the section on 'Safety and performance'.)

It was reported in the dashboard that suspensions had not resulted in women being diverted. However, from review of the incident report for September 2013 to February 2014, it was noted that one woman had been diverted due to capacity issues when the department temporarily suspended service. The incident had been categorised as 'no harm'; this meant that management would not be aware through committee reporting structures that anyone had been diverted to another hospital as a result of the suspensions.

Leaving hospital

We were told that discharge arrangements worked well and that a number of midwives had been trained to undertake the paediatric discharge assessments. This had improved the discharge process and reduced the delay for babies being discharged from the unit because they did not need to wait for an assessment from a paediatrician.

Learning from experiences, concerns and complaints

Women attending the maternity department had a range of options they could follow to provide feedback about the care and treatment they received.

Patients could also make a formal complaint or contact the Patient Advice Liaison Service to provide feedback or for help to make a complaint.

The complaints-handling process followed the Trust's policy and was devolved to individual directorates to

investigate. Complaints were monitored and discussed at meetings and we saw evidence that this had taken place. During the quarter October to December 2013, the maternity department received a total of nine complaints.

This number was included as an agenda item at the women and children's risk management monthly meetings. However, individual complaints were not discussed and nor were themes or trends.

Are maternity and family planning services well-led?

Requires improvement

We found that the service was not well-led because governance systems and processes were not followed to ensure information was consistently accurate or meaningful.

Vision, strategy and risks

The staff we spoke with did not know what the department or Trust's vision was.

We saw that the directorate had developed a business plan covering a three year period; this was updated annually and was under review at the time of our inspection.

We were provided with a copy of the most up to date version which although covered a three year period up to 2015. The plan reflected on the vision for the previous year, looking ahead planned to build on these strengths to continue to improve the quality of care. The plan had not considered how the department would develop in 2014/15. The plan discussed agreements regarding restricting the number of women delivering at Russells Hall Hospital up to 2013/14 but not how capacity would be managed beyond this. This meant that the strategy for delivering high-quality care for women was out of date and had not forecast for the year ahead. We were told that this was in the process of being redrafted for 2014/15 but this meant that forward planning was not happening in advance.

A risk register had been developed which was reviewed at the directorate's risk management committee on a regular basis. However, the process for identifying and recording risks was not sufficiently robust.

Risks were categorised according to severity, based on the likelihood and impact a risk may have if it materialised. Significant risks were transferred to the Trust-wide risk register.

We noted that there were some good examples of risk identification, description and monitoring. However, through the inspection process, we were told about some issues which had not been recorded on the register – for example, that staffing levels were not always adequate, leading to an increase in the number of incidents being reported due to inadequate numbers of staff per shift.

The department only had two midwives to contact to cover shifts and agency staff were not used. This meant that the same midwives were used to cover substantive vacant shifts. The staff we talked to told us they often felt tired and received texts on their personal mobile when they were off-duty which made them feel pressured to working additional shifts.

Quality, performance and problems

The directorate used a dashboard to monitor clinical performance and governance.

The dashboard specified targets under a series of headings and was used to holistically monitor performance across the department.

Actual performance was colour-coded red, amber or green according to the level of risk posed. The dashboard was monitored at the monthly women and children's governance meeting.

From our review of the dashboard we noted some errors or omissions in the data when compared to other information provided to us, for example:

- The monthly target for the predicted and actual births did not correspond to the number of births the Trust was contracted for. This meant that the Trust appeared to be exceeding the target when they were within range.
- The birth-to-midwife ratio differed to the ratio calculated and recommended following an assessment of staffing and case mix.
- It was also not clearly stated on the dashboard that the ratio used was based on establishment rather than actual staff available.

- The dashboard reported that there had been no women diverted to other hospitals as a result of temporary suspensions of service, but we saw one incident reported in September 2013 which had resulted in a woman being diverted to another hospital.
- The number of times the maternity department had reached level 3 or 4 of its escalation policy according to staffing or patient capacity issues differed to information presented in a separate staffing report.

This meant that the quality of the data reported in the dashboard could not be relied on.

We also noted on the dashboard for April 2013 to February 2014 that there had been an increase in the number of elective caesareans during January and February, reaching 14.2% and 14.7% respectively, compared to the England average of 10.7%. The Trust had set a target of 9% or less of all women to have an elective caesarean section and had only achieved this for three out of 11 months during 2013/14; the Trust had exceeded the England average for seven of the 11 months. We asked if an audit had been undertaken to understand the reason for this and were told that an audit had not yet taken place because the Trust had only seen a significant increase during the preceding two months.

We noted that one of the complaints we reviewed which was classed as a high level of risk and had been investigated with a root cause analysis had not featured in the serious incident report. We were told this was because, although the incident was of sufficient significance, there was no specific category for it to be entered against. This meant that the serious incident summary report did not contain details of all incidents which meant that, from a governance perspective, full information was not available of all serious incidents which had occurred during a given period.

We saw that unexpected admissions to the neonatal unit were mostly recorded on the maternity department's serious incident report, but that on two occasions these had been reported on the paediatric serious incident report. This meant that this type of serious incident was split across two reports and therefore a full overview of the precise number of incidents of this type was not accurately reported.

We were also provided with a copy of a clinical audit as an example of audits which took place, however, the clinical audit provided had not been listed on the clinical audit plan for the year. This meant that auditing resources may not have been allocated appropriately because staff may have undertaken audits which had not received prior approval.

Leadership and culture

The department had a clearly defined accountability structure. Lead or specialist midwives reported to either the matron or head of midwifery, who in turn reported to the general manager for the directorate a well as the clinical director and relevant executive director. However, the structure did not define reporting lines for medical staff, with the exception of the upward reporting for the clinical director.

Staff told us that that they felt well-supported and were able to share concerns as they arose, either through whistleblowing or incident reporting. Staff told us that the lead midwives and matron were all very approachable.

Patient experiences, staff involvement and engagement

Staff told us that they felt supported by and listened to by management and that their line manager, the lead midwives and matron were all very approachable.

Patient feedback was sourced through the NHS Friends and Family Test as well as comments received and reported on as part of the matron's quarterly update. We saw that patient feedback was listened to. An example displayed on the maternity department huddle board reported under the heading, "You said, we did" stated that comments had been received regarding the comfort of chairs for people supporting their partners in labour; the department had responded by purchasing improved seating.

In February 2014, there had been 108 compliments and one complaint. This was also reported on the board and available for staff and women and their partners/visitors to review.

Staff were given positive encouragement from management within the department which promoted good team working. This included sharing compliments from women and their families with staff.

Services for children and young people

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

Information about the service

The paediatric department have at Russells Hall Hospital, Dudley is set up to care for babies, toddlers and adolescents. The paediatric department is located within the women and children's health department and has a separate neonatal ward, level 2 (with its own intensive care and high dependency beds). The children's ward has separate bays for younger children and adolescents where possible. There is also a separate mixed-age bay for under 18s attending the unit for surgery. There are two high dependency beds on the unit which can be increased to three according to demand. There is a paediatric assessment unit (PAU) operational from 8am until 8pm every day, situated within the department. There is an outpatient department for paediatrics and a specialist outreach nursing team.

We visited all areas of the maternity service and talked to midwives, support workers, the clinical director, senior managers, as well as women attending the antenatal department and women who had recently given birth.

Summary of findings

The paediatric department did not have a system in place to monitor performance against targets beyond the basic nursing principles and other Trust-wide targets. We were told that this was under review and that a performance dashboard (a reporting and tracking system) was in the process of being developed.

We found that staffing sometimes fell below the expected numbers; when this happened, the escalation policy was followed and beds on the unit were suspended.

It was difficult for parents to obtain meals when visiting for long periods of time.

The children and families we spoke with felt staff were caring and supportive. We were told that communication from medical staff was not always consistent, which could cause confusion for patients.

There was a clear care pathway for babies and children according to their clinical need. The unit was modern and nicely laid out which enabled the promotion of people's privacy and dignity. There was a sensory room on the children's ward, with toys. Play workers and a teacher were available.

We saw that there were processes in place for individual staff members to learn from incidents they had reported or been directly involved with. However, the sharing of learning outcomes required improvements.

Services for children and young people

Staff working within the department generally felt well-supported by management and thought that they worked in an open and transparent environment.

Are services for children and young people safe?

Good

Overall, we found that services for Children and Young People were safe

Safety in the past

Nursing care indicators were monitored each month. We reviewed a sample of records looking at staffing levels, patient observations, pain management, falls, tissue viability, nutrition, medication and infection control. We saw that, for March 2014, overall, paediatrics had scored 93% compliance, which was an improvement since December 2013. Particularly low scores were achieved for completion of nutritional assessments, pain status, as well as obtaining the signatures of two nurses when administering medication.

We saw that the nursing care indicators were monitored at the directorate's risk management meeting. However, the minutes for January 2014 reported lower than expected performance and there was no recorded action for how this could be improved.

We were told that the department could become busy at times and that sometimes admissions to beds were suspended in accordance with the department's escalation policy as required.

We saw examples where the neonatal unit had temporarily suspended admissions due to lack of staff and the children's ward had closed some beds on a number of occasions. However, the Trust did not collect data on the number of babies or children diverted to other hospitals as a result of the temporary suspensions. This meant that the impact of the risk had not been effectively monitored. We were informed that the hospital worked closely with other hospitals to ensure that these patients were received and cared for at another hospital.

Learning and improvement

Staff we spoke with told us that they reported incidents they were involved in or witnessed using an online tool. Staff told us they were confident in using the system and were encouraged to report incidents as they occurred.

Staff told us they had learned from incidents once the investigation had been completed. They said they received direct feedback via an automatically generated email once the incident was closed. Some staff told us that lessons were also learned through group emails.

There have been no recent Never Events (incidents so serious they should never happen) within paediatrics. There were 11 serious incidents reported by the paediatric department between April and December 2013 inclusive. We reviewed a summary of these serious incidents and found that there were no common themes. However, it was noted that two incidents related to unexpected admissions to the neonatal unit which occurred in September and October 2013. We saw that the maternity department serious incident report, listed a total of 11 unexpected admissions to the neonatal unit between the period September 2013 and February 2014, however, the incidents in the paediatric report were different to the incidents in the maternity report. This meant that there was a lack of consistency in reporting and this may have affected trends being picked up and accurately monitored.

Actions were taken following serious incidents, although we noted that, for one serious incident, responsive action did not address the entire issue – the incident involved a saturation machine not working, and there was no action recorded regarding use of equipment.

Where actions had been identified, it was not always clear how information had been shared with groups of staff. The actions for some incidents (but not all) recorded that findings should be shared with staff, and we were shown an example of this, but it was not always clear from the recorded action how learning had been communicated.

Systems, processes and practices

We observed that the design and layout of the department was conducive to providing care to patients in accordance with their needs. The department was visibly clean on the day of our inspection. We saw that there had been an incident reported around infection control in the past, but there were no ongoing issues.

We saw that there were bays and separate side rooms. The department also had a sensory unit which was used for young babies and for other children with specific needs, for example, visual impairment.

We were told by staff that equipment was always available and well maintained. We observed that the resuscitation trolleys contained all the required equipment.

Staff thought that staffing was adequate, although said the department could become busy at times. We were told that there was a high use of agency nurses on the department but that the same agency personnel were used to ensure continuity wherever possible. We were told that this meant the budget was often exceeded but that patient safety came first.

We were told that staffing was monitored throughout the day. A daily staffing sheet was used to record staff allocations; we were told that the paediatric unit worked in accordance with safe staffing levels and that, if there were insufficient numbers of staff, this would be reported as an incident and the unit would be suspended in accordance with the department's escalation policy.

Staff told us that handovers were undertaken twice daily. Handovers involved a nurses and clinicians and focussed on individual patient information as well as any general issues, for example staffing. We observed one of the handovers and found that suitable information was transferred between staff to ensure patient safety.

Monitoring safety and responding to risk

The women and children's health department had a risk register which was regularly monitored and updated. The register was regularly presented and discussed at the directorate's risk management meeting.

The register contained a detailed description of the risk as well as controls in place and action required to reduce the risk. The risk register was discussed at relevant departmental meetings and we were told that high risks were transferred to the Trust-wide risk register to ensure they were reported and discussed at executive level. We discussed the high-level risks which predominantly focused on staffing and patient capacity issues.

Anticipation and planning

The paediatric department had an escalation policy to cope with capacity or staffing issues. The plans set out responsibilities and actions to follow. There were four levels of escalation. Level 1 being normal activity through to level 4, extreme pressure.

Services for children and young people

The neonatal and paediatric units were open 24 hours per day, seven days per week, although the PAU and day surgery beds were operational between specified hours.

We were told that there had been no suspensions for the paediatric department.

We reviewed incidents for the period September 2013 to February 2014 inclusive and found that, for the neonatal unit, there had been a total of 19 incidents reported where staffing levels were inadequate. We saw that, on six of these occasions, it was reported that the unit had closed due to staffing levels not meeting the British Association of Perinatal Medicine (BAPM) guidelines for staffing. The incident reports did not state whether babies had been diverted to other units as a result of the temporary suspension of admissions. The remaining 13 incidents reported insufficient staff; some stated that BAPM staffing requirements had not been met. However, the incident summary did not report whether the incident had resulted in a temporary suspension of the unit.

There was a total of five staffing incidents reported for the children's ward for the same period, however, some of the incidents lacked detail as well as action taken. Two of the incidents reported that beds on the ward had been closed, although one did not state how many beds. Three of the incidents did not state what action had been taken in response to the shortage of staff.

This lack of detail meant it was not clear whether adequate action had been taken and whether patients were able to be cared for with safe staffing levels.

Are services for children and young people effective?

Good

We found that the care children received was effective.

Using evidence-based guidance

An annual clinical audit plan had been developed for 2013/14. The plan was Trust-wide and audits were listed by directorate and speciality.

We reviewed the clinical audit for paediatric pneumonia and found that the rationale and methodology were clearly defined. We found that recommendations were detailed and an action plan had been developed for implementation; however, the target completion dates had not yet been reached. It was noted that this clinical audit had not been included in the clinical audit plan for the year. This meant that auditing resources may not have been allocated appropriately because staff may have undertaken audits which had not received prior approval.

We saw that the department had copies of national paediatric and regional neonatal guidelines. We were shown example of pathways for children and saw that this followed nationally recognised guidance.

Most of the parents or carers we spoke to were satisfied with the care their children had received, although some parents commented that there was differences in guidance offered from the different medical staff they spoke to, which they found confusing.

Monitoring and improvement of outcomes

The paediatric department did not have any specific departmental targets or measures. We were told that a dashboard was being developed to allow departmental performance to be monitored.

We saw that nursing care indicators, risks and incidents were monitored and discussed within the relevant nursing groups.

The department's nursing care indicators were monitored each month by selecting and reviewing a sample of records. This included an analysis of staffing levels, patient observations, pain management, falls, tissue viability, nutrition, medication and infection control. We saw that for March 2014, overall, paediatrics had scored 93% compliance, which was an improvement since December 2013. It was noted that particularly low scores were achieved for completion of nutritional assessments, pain status, as well as obtaining the signatures of two nurses when administering medication. We saw that an action plan had been developed to improve performance against targets.

Other key indicators for the neonatal unit were monitored in accordance with 'saving lives' initiative. We saw that the unit had fully met all indicators throughout the year. This included catheter care, reducing ventilation and enteral feeding, for example.

The patients and families we spoke with told us how they had received pain relief as necessary and that their pain had been controlled as far as possible.

Services for children and young people

Staff, equipment and facilities

There was a clear structure for reporting within the paediatrics and neonatal unit at operational level. We were told that the shift for each unit was always led by a band 7 nurse. Concerns could be reported to the lead nurse and escalated to the matron or general manager if required. We were told that there was a site manager who could be contacted in the event of an emergency out of hours, and that concerns could be escalated to the on-call duty manager if necessary.

We were told that staff had annual appraisals. The staff we spoke to told us they felt supported by management and found their appraisal a helpful process. We were shown evidence that 81% of staff within the directorate had completed their appraisal for the year.

The staff we spoke with told us that they were satisfied with the training they received and that it supported them in their role.

Multidisciplinary working and support

Children and babies who attended the paediatric or neonatal received care from dedicated children's or neonatal nurses, healthcare assistants, as well paediatricians, play therapists and surgical staff from the relevant speciality.

We were told that the team worked well together, although, there were issues with accessing specialist advice from the speech and language therapist. The therapist was employed by the community and provided support to other hospitals and so there was no cover when that person was on leave. This meant that there could be long delays in getting advice and support. This had been identified as a risk on the directorate's risk register and the Trust was in the process of negotiating a formal contract to improve the level of cover. We were told that there had not been any adverse patient incidents as a result of the therapist not being available.

There were play assistants on the paediatric ward and a teacher was available to support school-aged children. The parents and children we spoke with told us they were happy with the support provided by these personnel.

We observed a handover between shifts and found that this was well attended and that information shared between staff was adequate to ensure patient safety. This ensured staff on each shift had the necessary knowledge to support patients under their care.

Are services for children and young people caring?

Good

Children who attended the department received care and treatment from staff which met their needs.

Compassion, dignity and empathy

The families we spoke with told us that staff were caring and compassionate and that their requests were responded to; this was supported by our observations. Discussions between staff and patients were undertaken at their bedside, side rooms were available for some, others had their privacy and dignity respected because there was a partition between beds and curtains could be pulled round as required.

Involvement in care and decision making

Patients and their families told us how they felt listened to and were in control of the care they received. They felt that doctors and nurses communicated well with them, although some relatives told us there were differences in the information they received from different personnel and this was confusing.

Trust and communication

The families we spoke with were satisfied with how staff communicated with them during their time on the paediatric or neonatal units. We observed positive interactions between staff and patients.

We saw that there were information leaflets available for patients and their families about treatments.

We observed that patient records were written in a clear and concise manner. Care and treatment required was well-documented and consent had been obtained as required. Although, we noted that not all professionals engaged in completing the healthcare single inter-professional record (a single record of all healthcare professionals interaction with patients).

Services for children and young people

Are services for children and young people responsive?

Good

The service is responsive to meeting children's needs.

Meeting people's needs

The paediatric and neonatal units were set up to provide care for children and babies according to their assessed level of need. A paediatric assessment unit was located within the department – although this was not operational 24 hours a day, the number of hours operational was within national guidance. However, the department had prepared a business case to extend the opening hours.

The department had its own high dependency unit (HDU) and this could be for up to three children. The main hospital had an intensive care unit (ICU) and this could accommodate children for a short period of time. If children required a long stay in ICU, arrangements were made for the child to be transferred to another hospital once sufficiently stable to do so.

Children and babies requiring surgery were cared for within the children's ward and specialist surgical teams came to the ward to make necessary assessments.

We were told that discharge arrangements worked and that when the department became busy, all staffing groups worked as a team to expedite discharges as appropriate.

We were told that patients could access an interpreter service if they were unable to communicate in English, we were also told that a number of the staff were able to speak a second language.

The design and layout of the department promoted privacy and dignity for children and curtains were used to separate beds and provide a private area to receive care and undertake assessments.

The staff and women we spoke with liked the layout of the paediatric department; it meant people could be cared for in privacy.

It was difficult for parents or carers to access meals after 2.30pm because the canteen was closed after this time and the ward did not provide extra meals.

We were told that when children with learning disabilities attended the department their parents were relied upon to communicate with the child. We were told by some staff that they had not received training in the use of Makaton, (a language programme designed for individuals who could not otherwise communicate efficiently) and that this would be helpful, particularly when children's parents or carers were not on the ward.

Access to services

The paediatric ward and neonatal unit were open 24 hours per day, seven days per week. Although the PAU and community outreach team operated within specific time periods. We were told that, in the event of staffing or patient capacity issues, the service would be suspended in accordance with the escalation policy. There were four levels of functionality within the department from normal flow through to extreme pressure. The women and children's risk register included a risk for the suspension of admissions to the paediatric or neonatal department due to capacity or staffing issues. We were told that there had been no occasions when the department had officially closed but that admissions to beds were suspended in accordance with the department's escalation policy as required.

We saw examples where the neonatal unit had temporarily suspended admissions due to lack of staffing and the children's ward had closed some beds on a number of occasions. The Trust did not collect data on the number of babies and children diverted to other hospitals as a result of the temporary suspensions. This meant that the impact of the risk had not been effectively monitored. We were informed that the hospital worked closely with other hospitals to ensure that patients were received and cared for at another hospital if needed.

Vulnerable patients and capacity

The department provided a service to a diverse population. People who were unable to speak English could be supported by an interpreter services if needed, and we saw that there were patient information leaflets available in four different languages.

We spoke with staff about safeguarding policies and procedures. They all talked confidently about how to recognise the different types of abuse and what they would

do if they suspected a vulnerable person may have been at risk. We saw some good examples of appropriate referrals being made to social services or police being called in response to incidents that had happened.

We reviewed training records and found that only 20% of staff had completed training in mental health awareness. However, this was a new training course and had only been introduced in 2013. An action plan had been developed to improve attendance at training.

We were told that the team for adults and children were contacted to support people with mental health needs if needed and that they responded promptly.

Learning from experiences, concerns and complaints

Patients and their families who attended the neonatal or children's wards had the opportunity to provide feedback on the care they had received. We saw that a comments board was available in each ward with pens and cards for people to record their feedback. We saw that all comments reported in the quarterly action plan were positive, with the exception of one – the action and response for this was recorded and displayed on the patient information board in the unit.

Patients could also make a formal complaint or contact the Patient Advice Liaison Service to provide feedback or facilitated to make a complaint.

We were told that complaints were responded to following Trust policy. The complaints-handling process was devolved to individual directorates to investigate. Complaints were monitored and discussed at meetings and we saw evidence that this had taken place. During the quarter October to December 2013, the paediatric inpatient department received a total of three complaints, the outpatient department one complaint; there was no information provided on the number of complaints received about the neonatal unit.

We saw that the number of complaints received was included as an agenda item at the women and children's risk management monthly meetings. Individual complaints were not discussed and themes or trends in complaints were not identified.

We saw that the number of compliments and complaints received during the previous month was also reported on the board and available for children and their families and visitors to review.

Staff were given positive encouragement from management within the department which promoted good team working. This included sharing compliments from children and their families with staff.

Are services for children and young people well-led?

Good

We found that the service was well-led, although to drive improvement, performance indicators needed to be monitored and reported on.

Vision, strategy and risks

The staff we spoke with did not know what the vision for the department or the Trust was.

We saw that the directorate had developed a business plan covering a three-year period; this was updated annually and was under review at the time of our inspection.

We were provided with a copy of the most up-to-date version covering the period up to 2015. The plan reflected on the vision for the previous year, looked ahead to build on these strengths continue to improve the quality of care. The plan had not considered how the department would develop in 2014/15, although we were informed that the priorities for the coming year were being worked on.

The business plan stated an intention to continue a service-wide review for a number of priorities, including renegotiating the neonatal contract, best practice tariffs for three specialist areas, development of a virtual ward, improving the services for PAU and community arrangements. We were told that the business plan priorities were discussed at one-to-one meetings with service leads, commissioner meetings and at operational meetings (which we saw evidence of).

A risk register had been developed which was reviewed at the directorate's risk management committee on a regular basis.

Risks were categorised according to severity, based on the likelihood and impact a risk may have if it materialised. Significant risks were transferred to the Trust-wide risk register. We noted that (with the exception of data on suspension and transfer) there were some good examples of risk identification, description and monitoring.

Quality, performance and problems

The paediatric department had not established a systematic monitoring tool to review monthly performance against targets. We saw evidence of some monitoring – for example, for nursing care indicators, complaints and incidents – however, the department had not established a dashboard to bring together and monitor targets. We were told that the directorate planned to devise a dashboard to monitor targets.

We saw that clinical indicators were monitored for nursing care and saving lives.

Nursing care indicators were monitored each month. A sample of records are reviewed which look at staffing levels, patient observations, pain management, falls, tissue viability, nutrition, medication and infection control. We saw that for March 2014, overall, paediatrics had scored 93% compliance which was an improvement since December 2013. It was noted that particularly low scores were achieved for completion of nutritional assessments, pain status as well as obtaining the signatures of two nurses when administering medication.

We saw that the nursing care indicators were monitored at the directorate's risk management meeting, however, the minutes for January 2014 reported lower than expected performance, but there was no recorded action as to how this could be improved.

An annual clinical audit plan had been developed for 2013/14, the plan was Trust-wide and audits were listed by directorate and speciality.

We reviewed training records and found that the women and children's health department overall had achieved 77% compliance with their attendance at mandatory training sessions. The data provided was not separated by department or staff group. It was noted that some mandatory training courses were below 75% attendance, notably, diabetes management, resuscitation for adults and paediatrics (neonatal resuscitation was above 80%), safeguarding children (intermediate) – although over 90% of staff had completed the safeguarding at foundation level. Training for venous thromboembolism (blood clots) had also been poorly attended and mental health awareness had the lowest attendance rate at 20%, although this training had only been introduced during 2013/14.

A report on training attendance had been prepared for the directorate's risk management meeting in January 2014 and an action plan had been developed to improve attendance.

Leadership and culture

The department had a clearly defined accountability structure. Nurses and healthcare assistant's reported to the lead nurse for either paediatrics of neonatal unit; the lead nurses reported to the matron who, in turn, reported to the general manager and director of nursing. However, the structure did not define reporting lines for medical staff, with exception of the upward reporting for the clinical director.

The staff we spoke with told us that that they felt well supported and were able to share concerns as they arose, either through whistleblowing or incident reporting. Staff told us that they felt well-supported by the lead nurses and matron and that these personnel were very approachable.

Patient experiences and staff involvement and engagement

Patient feedback was sourced through use of a comments board in both units. Comments received and reported on as part of the matron's quarterly update. We saw that patient feedback was listened to – an example displayed on the paediatric department comment board reported under the heading, 'You said, we did' stated that a comment had been received about the bad taste of medicine and that the child had been advised how to deal with this to make the situation better.

End of life care

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

Information about the service

The Dudley Group NHS Foundation Trust's end of life service included palliative care services as well as inpatient and outpatient treatments for symptom and pain management. End of life care was also delivered by frontline staff on other wards throughout the hospital.

The Trust had a specialist palliative care team, led by consultants in palliative care medicine and specialist palliative care nurses. Palliative care was provided across all wards at Russells Hall Hospital, five days a week, with access to specialist advice out of hours and at weekends. The palliative care team provided direct patient care where palliative needs could not be met by the hospital team. The team also provided training and support to medical and nursing staff and was involved in developing and implementing patient end of life care pathways.

The bereavement service included a Trust-wide, multicultural chaplaincy service to support people during end of life care. This included providing practical and emotional support to families after the death of a relative.

We visited an oncology ward, two surgical wards, two medical wards, the emergency department, the coronary care unit, bereavement and mortuary services and the multi-faith centre.

We spoke with two patients and seven relatives throughout the wards and departments we visited.

We spoke with 22 staff, including a palliative care consultant, palliative care nurse specialists, junior and senior nursing staff from general surgical and medical wards and the emergency department, junior doctors, a chaplain, a bereavement officer and a mortuary technician. We observed care and treatment throughout the areas we visited and looked at 17 medical and nursing care records.

We received comments from our listening events, from people who contacted us about their experiences and from staff focus groups. We also reviewed the Trust's performance data.

End of life care

Summary of findings

We found that improvements were required to ensure patients were always as safe as possible and received care and treatment that met their needs in relation to do not attempt resuscitation (DNACPR) processes. A DNACPR policy and procedure was in place, however, we noted a number of concerns in relation to how this had been implemented.

We noted an occasion where there was no evidence that DNACPR decisions had been reviewed and an occasion when a DNACPR decision had not been endorsed by a consultant within the timescale specified within the Trust's policy, although a discussion with a consultant had previously taken place.

The specialist palliative care team provided support and advice to health professionals working within the hospital and in the community. This ensured a coordinated multidisciplinary approach to end of life care. We found that patients who were receiving end of life care without the need for support from the palliative care team also received a good standard of care.

Patients and their families told us that staff were available at the times they needed them and said that personnel were caring, kind and compassionate. We observed staff treat patients respectfully and with dignity.

The services offered by the chaplaincy, mortuary and bereavement services were considered to be excellent.

Staff we spoke with described strong, supportive leadership at Trust Board level and an organisational culture that empowered staff at all levels of the organisation.

Most people told us that the end of life service was responsive to their needs. From patients' care notes we found that patients' healthcare needs were regularly reviewed. Pain relief, symptom management, nutrition and hydration were being provided according to patients' needs. Most patients and relatives we spoke with told us that they felt involved in decisions made about their care and treatment and care records confirmed this.

Are end of life care services safe?

Requires Improvement

We found that improvements were required to ensure patients were always as safe as possible when receiving end of life care.

Learning and improvement

All grades of medical and nursing staff throughout the wards and departments we visited told us that they had undertaken training about end of life care. They told us that they were satisfied with the level of training they had received and that they had a good understanding of end of life care in order to provide safe care.

Staff stated that they were encouraged to report incidents and received direct feedback on the outcomes. Arrangements were in place to share information about lessons learned with the team. For example, minutes of team meetings during which incidents were discussed, were sent to staff members who had been unable to attend the meetings. This would reduce the risk of a similar incident occurring again.

Systems, processes and practices

We asked staff about staffing levels within the wards and departments we visited. None of the staff we spoke with raised concerns about staffing levels. We noted that temporary agency and bank (overtime) nursing staff were used to cover periods of annual leave, sickness and vacancies. Systems were in place to ensure that the appropriate skills mix of staff was provided, for example, for the administration of chemotherapy treatments. This maintained patients' safety by ensuring that staff were available to provide care and treatment in a safe and competent manner at all times.

Patients and their families told us that staff were available at the times they needed them. A patient on a medical ward told us, "The nurses are great, they answer my call bell promptly".

All of the staff we spoke with told us they were up to date with their mandatory training and had received an appraisal within the last 12 months. This meant that staff were supported by the Trust to deliver care and treatment safely and to an appropriate standard.

End of life care

Patients told us that they received their medication at the times they needed them. No concerns were raised by the pharmacist inspector in relation to the management of end of life medicines.

End of life care guidelines were in place. Medical and nursing staff spoken with had a good understanding of these. All staff spoken with throughout the wards and departments we visited were able to tell us which patients had a DNACPR decision recorded.

A DNACPR policy and procedure was in place, however, we noted a number of concerns in relation to how this had been implemented. We looked at a total of 17 DNACPR documents throughout the wards and departments we visited. This included patients who were and who were not receiving palliative care. We noted that discussions between medical staff, patients and their relatives around care and treatment during end of life care was not always clearly documented within patients' notes. From our discussions with patients using the service, and from reviewing their care records, it was not clear whether they had been involved in the DNACPR decision. We brought these issues to the attention of the Trust's executive team on the day of our inspection and the medical director took immediate action.

We noted an occasion where there was no evidence that DNACPR decisions had been reviewed and an occasion when a DNACPR decision had not been endorsed by a consultant within the timescale specified within the Trust's policy, although a discussion with a consultant had previously taken place.

During our inspection we noted that DNACPR decisions had been reviewed at each hospital admission and in most instances patients and/or their relatives had been involved in this decision process. The relative of a person receiving end of life care told us that they had been fully involved in this decision. They told us that they knew all of the facts, events had been explained to them and the reasons why cardiopulmonary resuscitation would be futile.

The Trust's policy in relation to the DNACPR process identified that discussions about decisions made must be recorded in patients' records and reviewed regularly. It was of concern that two patients told us that their views on their care and treatment had not been taken into consideration while planning their care. This was further evidenced while reviewing their healthcare records, as details of discussions held with them had not been recorded. In one of these cases, the patient was also concerned that their family had not been involved in the decision either. We brought this to the attention of the Trust for immediate action.

We found that not all DNACPR decisions had been reviewed regularly. One patient told us that they did not agree with the decision made and that their health had improved since the initial decision had been made. The patient told us that they wanted all treatment available and that they felt that they could not challenge the doctor's decision for a DNACPR.

Monitoring safety and responding to risk

We looked at the Trust's risk register. This identified that a number of nursing vacancies existed on speciality medicine wards. This had resulted in a high use of temporary agency staff. We found that this was the case on a number of the wards we visited. However, as identified on the Trust's risk register, plans were already in place to recruit nurses from overseas into the vacant posts. In addition, the Trust had assigned a staff member to oversee the use of agency staff. Part of this person's role was to assess the competencies of agency staff and arrange that they completed the Trust's induction training to ensure that they had the skills to work in a safe manner.

However, a relative told us that they had raised a concern that an agency staff member had not been familiar with a certain piece of equipment used. We brought this to the attention of the lead nurse on the ward. They confirmed that they had already been made aware of this concern and actions had been taken to address this. The outcome was that the agency staff member had undertaken the relevant training.

Anticipation and planning

When a patient was deemed to be reaching their end of life, the palliative care team was contacted to support the patient and the staff with the development of an individualised care plan. To ensure patients' safety within the coronary care unit, we noted that an additional document had been included in patients' notes to identify that they were receiving palliative care.

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Anticipatory end of life care medication to relieve symptoms was appropriately prescribed and medical staff had a good understanding of the prescription guidelines. This meant that these medicines could be administered without delay when they were needed.

Within the mortuary, additional safe storage capacity had recently been obtained. This included specialist equipment for bariatric (obese and morbidly obese) patients.

Infection prevention

We found that all of the wards and departments we visited were clean and tidy. We observed staff regularly washing their hands and using hand gel between patient consultations. Visitors were also encouraged to use hand gel on entering and leaving the wards. A patient told us "It is very clean here, my room is cleaned every morning".

Within the oncology ward (C4) we noted that MRSA screening had been undertaken for patients admitted to the ward. Isolation facilities were available as needed and infection control audits were undertaken each month. The most recent audit undertaken in February 2014 showed that the ward had achieved 100% compliance in all areas assessed. This included hand-washing facilities, hand-washing techniques and commode audits. Details of the findings of the audits and infection rates were on display in the ward areas that we visited.

Are end of life care services effective?

Good

Patients benefited from a service that was effective.

Using evidence-based guidance

The Trust incorporated new research and best practice into patient care. In line with national guidance, the Trust no longer used the Liverpool Care Pathway for end of life care. The Trust was implementing the AMBER care bundle (this is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encouraged staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen), initially as a trial on Ward C5 and then throughout the Trust. Key staff had undertaken training about this and plans were in place for training to be disseminated throughout the Trust. We spoke with a nurse who spoke highly of the recent training they had received and felt that the revised care pathway would have a positive effect on both patients and their families.

Monitoring and improvement of outcomes

Nursing staff told us of actions they had taken to ensure the best possible outcomes for patients and their families. These included working to promote consistency of staffing for the patients in their care. Patient handovers were undertaken from one staff team shift to the next. This included verbal and written communications about patients who were receiving end of life care. This meant that important information about patients' care and treatment would be relayed from one staff team to the next.

Palliative care nurses and doctors were actively involved in the training of all staff in end of life care. This training was also incorporated into the care support workers induction programme and newly qualified nursing staff's preceptorship practical experience and training programme. Staff were also trained in caring for people after they had died, to preserve their dignity, in line with national guidelines.

Sufficient capacity

The palliative care team was available from 9am to 5pm Monday to Friday, excluding Bank holidays. Outside these hours, specialist palliative care advice was provided by the on-call medical team at a local hospice. Medical and nursing staff did not raise any concerns about accessing advice and support from the palliative care team.

From tracking the care of patients receiving end of life care without the need for specialist palliative care support, we found that care received was of a consistently good standard. We spoke with the family of a patient who was receiving end of life care within a general surgery ward. They told us that, although their relative was not being cared for on a specialist palliative care ward, they could not fault the care received by all staff involved in the care.

Multidisciplinary working and support

The palliative care team provided specialist advice, support and education to healthcare professionals, patients, carers and families. We spoke with medical and nursing staff from the palliative care team and they told us that they were proud of the service they offered. Staff throughout the wards and departments we visited spoke highly about the

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palliative care team. They told us that they were available for advice and support at the times they needed them. Multidisciplinary ward rounds were held regularly so that all professionals involved in patients' care could discuss any changes needed to care and treatment plans. Multidisciplinary team meetings were also held regularly.

Staff told us that the success of the palliative care service was due to close links with all health and social care professionals involved in patients' care, both within the hospital and in the community. For example, there were close links with the community hospices and specialist community nurses. Within the palliative care team, psychological and emotional support was provided by a psychologist and spiritual support was provided by the chaplaincy services.

Equipment

Staff throughout the wards and departments told us that they had sufficient equipment to treat patients receiving end of life care. We saw that patients on end of life care pathways received medication through a syringe pump (to control the amount of medication given) and that these were regularly available for use. Staff told us that training was provided prior to new equipment being used to ensure it would be used in a safe manner.

Are end of life care services caring?

Good

Patients benefited from a service that was caring and compassionate.

Compassion, dignity and empathy

Throughout our inspection we observed patients being treated with compassion, dignity and respect. All of the patients we met and observed had been supported to undertake their personal care to a good standard, and people appeared to be clean and comfortable. We saw that call bells were answered promptly and patients and relatives told us that staff were kind and caring. A patient told us, “The nurses have been great. They go the extra mile and show compassion. They are considerate and thoughtful”. Relatives told us, “My husband calls the staff his angels, they have been so kind,” and, “All staff are lovely, they bend over backwards to make sure my daughter has the best care”.

Within the ward areas we visited, arrangements were in place so that patients at the end of their lives were nursed in private facilities. However, staff told us that a lack of side rooms within the critical care and emergency departments did not uphold patients’ privacy and dignity at this time. Staff within the emergency department also raised concerns about the route through the department that deceased patients had to travel to reach the mortuary.

The services offered by the mortuary and bereavement services were considered to be excellent. The facilities, which included a separate waiting area and viewing rooms, had recently been refurbished and decorated to a good standard. Arrangements were in place for viewings of the deceased out of hours and patients of all faiths were respected and catered for. A viewing area was also provided within the emergency department and this had been recently refurbished.

Care provided by the bereavement and mortuary teams was compassionate and caring. We spoke with a bereavement officer, chaplain and mortuary staff. We found that they were very knowledgeable and proactive in seeking ways to make the bereavement process easier and as caring as possible, putting bereaved families at the heart of their work.

Involvement in care and decision making

Most patients and relatives we spoke with told us that they felt involved in decisions made about their care and treatment and care records confirmed this. A relative told us, “My husband and I have been fully involved in decisions about care and treatment. My husband chose to stay here rather than go to a hospice. The staff gave him the choice and he’d rather stay here because he knows all the staff”.

Patients and relatives told us that they had been given the opportunity to speak with the consultant looking after them and that staff were available to answer any questions that they had at any time. Senior nurses within the ward areas also told us that they had an open door policy for patients and relatives who wished to speak with them. A relative told us, “The staff are always willing to chat to me”.

We spoke with the family of another patient who was receiving end of life care. They told us that they had been involved in their relative’s plan of care and had been asked for their views about the treatment the patient received.

Relatives’ rooms were available in all of the areas we visited. This was so that more sensitive conversations could

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be undertaken in private. Normal visiting time restrictions were waivered for relatives of patients who were at the end of their life. We spoke with one family who told us that staff had supported them well and had made arrangements so that they could spend as much time at the hospital as they wanted to.

Arrangements and facilities were in place so that family members could be fully involved in caring for patients following their death. Staff had undertaken training about the importance of this.

Trust and communication

We observed good interactions between staff, patients and relatives. We observed staff greet patients and their families every time they approached them and we heard staff encourage patients in a way that was respectful and appropriate to their age. Throughout our visit we observed most staff discuss or hand over patient information in a discreet manner so they could not be overheard.

One relative told us that they welcomed the honest and open communications they had received from the medical team. They also told us that they were treated with respect during communications. They told us "When we received bad news, the consultant was very careful how he spoke. He thought carefully about what he said and made sure that I was present during the discussion". However, during our listening event a person told us that their family had a different experience to this; they had not felt that the doctor had spoken in a compassionate and caring way. Junior doctors told us that they had undertaken training about how to discuss end of life care with patients and their families.

Emotional support

Patients' spiritual needs were met by the chaplaincy team. This consisted of a team of chaplains, covering a range of religions and a team of volunteers who worked closely with the chaplaincy team to provide pastoral support for patients. There was further access to all faiths and members of the community faith groups. Extremely positive feedback was provided by staff working at the Trust in support of the chaplaincy service. The chaplaincy service was also extended for staff to use if they needed support at particularly difficult times. The hospital's prayer centre included a prayer room, chapel and the peace garden. People of all faiths and beliefs were welcome to use these facilities.

Following the death of a patient at the hospital, the team of bereavement officers liaised with medical staff to coordinate the provision of essential documents. They met with families in the bereavement suite within a private area of Russells Hall Hospital. The Trust had produced an information booklet for bereaved relatives and details about external bereavement services were readily available. Information for relatives about practical arrangements, such as registering a person's death, was also available. The Trust's chaplaincy services also offered listening and pastoral care and gave advice on funeral arrangements.

Are end of life care services responsive?

Good

We found that improvements were required to ensure patients received a service that was responsive to their needs.

Meeting people's needs

From patients' care notes, we found that patients' healthcare needs were regularly reviewed. Pain relief, symptom management, nutrition and hydration were being provided according to patients' needs. A patient told us, "I am impressed how the nurses monitor what I eat and what I don't eat. The nurses are fully aware of my needs". A relative of a patient receiving end of life care told us, "Nurses are very good with pain control, they come round with pain medication promptly".

Palliative care multidisciplinary team ward rounds and meetings were held regularly. This was in order to monitor and review patients' health on a regular basis to ensure that changes were identified and any adjustments to care or treatment needs actioned in a timely way.

Patients and relatives were involved in making decisions about their preferred places of care. This was clearly documented in patients' care records. Patients were also fast-tracked to get funding to facilitate the right home care package or nursing home, depending on their wishes. A bereaved parent spoke highly of how staff had supported the family to ensure that their child died in their preferred place of care.

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Where patients required a burial or repatriation within 24 hours of their death for cultural or religious reasons, the hospital had systems in place to recognise that this would be required and so they could release people for burial in a timely way.

Access to services

Patients, relatives and staff told us that access to the palliative care team was good. Medical and nursing staff told us that end of life care beds were managed at a local level and that there were no concerns about admitting patients from clinic or from home. A family told us that they had used the service for a number of years and their relative had always been able to be admitted to hospital when they needed to. Arrangements were in place so that patients who had received chemotherapy treatments within the past 90 days had open access to the oncology assessment unit.

Arrangements were in place so that early referrals to the palliative care team were made. Following referral, patients were reviewed by the palliative care team in a timely manner, on the same day. We noted in one patient's notes that they had been assessed by the palliative care specialist nurse within one and a half hours of referral. This included a full assessment of the patient's holistic care needs and arrangements in place for the patient to be discharged from hospital to a place of their choice. Patients were also reviewed by the palliative care team during outpatient clinics at the Trust's three hospital sites.

Staff told us that interpreter services were available at the times needed. They also said that access to the chaplaincy service was good.

Vulnerable patients and capacity

From speaking with staff, it was evident that they were aware and sensitive to the needs of end of life patients in their care. They recognised that this group of patients were particularly vulnerable at this point in their life.

Some patients were unable to understand or be involved in the planning or delivery of their care. In most of these instances we found that relatives had been consulted about the person's wishes in relation to the care and treatment they received. Staff told us that independent advocates were sought should a patient not have relatives available to be consulted in decision making on their behalf.

Leaving hospital

Arrangements were in place to ensure patients' rapid discharge from hospital to their preferred place of care. Staff told us that the discharge process worked well and delayed discharges were prevented. A coordinated approach to this included good communications with all staff involved in patients care from both within the hospital and the community. We found that this had been clearly documented in patients' notes. On discharge, a letter was sent to the patient's GP and other people involved in their care, for example, district nurses, detailing the events of the hospital admission and care, treatment and support to be provided in the community.

Relatives we spoke with did not raise any concerns about delays in patients' discharges. A patient who was due to be discharged the day after our inspection told us, "An occupational therapist has been involved and all equipment is ready for when I go home. The hospital have arranged an ambulance for me, ready for my discharge home tomorrow".

We noted that electronic patient discharge planning boards had been implemented throughout the wards and departments we visited. A fast-track discharge checklist had also recently been implemented on the wards.

Learning from experiences, concerns and complaints

All staff we spoke with were aware of their role in ensuring they listened to the experiences, concerns and complaints of patients and their relatives. Staff gave us examples of times when they had listened, acted on and resolved a concern at the time it was raised. Staff were also aware of how to escalate a concern to more senior staff, and how to direct people to the hospital's complaints process.

A patient told us about their recent experience, having made a complaint about the care and treatment they received. They told us that they had been able to access information about how to raise a complaint from the Trust's website. They said they received an automated email response from the Trust to acknowledge their complaint, however, they were surprised that the Trust had not visited them on the ward in person to acknowledge their complaint.

Senior nurses explained how learning from, or actions taken in response to, complaints received was shared with the staff team.

End of life care

Are end of life care services well-led?

Good

We found that improvements were needed to ensure that people benefited from a service that was well-led.

Vision, strategy and risks

The Trust had a published vision, and we saw posters displaying this throughout Russells Hall Hospital. All the staff we spoke to were passionate about end of life care and the importance of this for ensuring the best patient experience as possible. They told us that quality and patient experience was seen as a priority for the Trust Board and was everyone's responsibility.

The Trust was part of a national programme to transform and improve end of life care. In 2013 the Trust decided to change end of life care. An end of life project was implemented and plans are in place for this to be completed by March 2016. This includes the introduction of the AMBER care bundle end of life care pathway. An end of life steering group was set up and this group meet regularly.

Governance arrangements

A range of audits were undertaken in relation to monitoring the quality of end of life care. This included audits of syringe pump usage and the quality of record keeping. However, since the Liverpool Care Pathway had ceased in 2013, the Trust were unable to advise us of how many of the 1,657 deaths that had occurred at the Trust from February 2013 to January 2014 had involved patients who had been eligible for end of life care. The palliative care team told us that there was currently no measure for this however plans were in place for this to be addressed.

The most recent clinical coding palliative care audit was undertaken by the Trust in January 2014 following a recommendation identified in the Keogh action plan dated July 2013. The outcome of the audit was that two out of the 88 patients who had been coded for specialist palliative care during their in-patient episode of care in November 2013 had been coded incorrectly as receiving palliative care.

Quality, performance and problems

The Trust's Specialist Palliative Care Multi-Disciplinary Team Operational Policy was agreed in June 2013. This outlined the aims and objectives of the palliative care service to provide a co-ordinated approach to patient's care.

The Trust had recently introduced "huddle boards" around the hospital. These were white-boards displaying staffing and quality information about each ward and department, for patients, visitors and staff to view. These were a way the Trust was being open about the quality of services they provided. We observed this being used to handover important information to the staff on duty.

Palliative care multi- disciplinary team business meetings were held regularly. This involved Consultants in Palliative Medicine, Clinical Psychologists, Occupational therapy, Clinical nurse Specialists and the Multi- Disciplinary Team Co-ordinator.

Leadership and culture

Staff commented on positive changes in the culture at the Trust and described a Trust that listened to and involved front line staff. They told us that they were encouraged to speak up and contribute their ideas. They told us that they felt that they could easily raise concerns about patients or system failures. All medical and nursing staff, when asked, told us that any concerns they had about end of life care could easily be fed back to the Trust Board and that end of life care was a priority.

We identified that both medical and nursing leadership within staff teams involved in end of life care was strong. Staff we spoke with were clear about the line management arrangements, and told us they felt supported within their job roles. This included emotional support from the chaplaincy teams at the times their job roles had become particularly challenging. Staff told us that they were aware of the Trust's whistleblowing policy and that they felt confident that they would raise any concerns with their line managers if needed.

Patient experiences and staff involvement and engagement

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment. This is part of the NHS Friends and Family Test. The Trust encouraged patients and their families to participate. We noted that

throughout all of the wards and departments we visited, information about feedback from these surveys was on display for patients and their visitors to read. For the inpatient Friends and Family Test, the Trust had scored just above the England average compared to other NHS Trusts for the period September 2013 to December 2013. The specialist oncology ward scored highly in relation to the number of people that would recommend the ward to their family and friends.

The palliative care team also assessed the quality of their service by the Trust's own palliative care team patient questionnaire. The results of the audit taken from a sample of patients under the care of the Trust's palliative care between December 2012 and March 2013 showed that the vast majority of patients were satisfied with the service they received, with 86% of patients who responded stating that the palliative care team input was helpful and 95% saying that the team had answered any questions they had.

Staff told us that the Trust's communications team fed back information obtained from patients' experience each month. Arrangements were in place so that all staff were advised of any new feedback by discussions at staff meetings and information displayed on the wards' 'huddle boards' for people to read. The lead nurse on the oncology ward told us that they predominantly received positive feedback in support of the service provided in their area. They told us that they looked for any themes of concerns and fed this back during 'essence of care' meetings. This meant that actions could be taken to address any concerns identified. For example, as a result of recent patient experience feedback, a trial was currently underway to ensure that call bells were answered within 30 seconds. Information advising patients and visitors about this was on display in Ward C4.

Learning, improvement, innovation and sustainability

Core members of the palliative care multidisciplinary care team had undertaken specialist training, for example, in relation to advanced communication skills and palliative care degree modules. Staff within the ward areas we visited spoke highly of the training offered to them in relation to end of life care. Staff also had opportunities to attend mandatory and clinical training to ensure their practice was safe and as effective as possible.

Staff told us that they had training opportunities for future career development. For example, plans were in place for hospital nursing staff to work alongside nurses at a local community hospice to look at therapies being used there.

Information about end of life care was available on the Trust's intranet for staff to access. This included information about guidelines on medication for end of life care.

Staff we spoke with told us that team meetings were held regularly. They said that any updates or changes in relation to the provision of end of life care was discussed during these meetings.

Outpatients

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

Information about the service

The Dudley Group NHS Foundation Trust provides outpatient services from three separate sites: Russells Hall Hospital, Corbett Hospital and Dudley Guest Hospital. We inspected the outpatient services over two days. We inspected six of the outpatient clinics for adults and one of the outpatient clinics for children and young people at Russells Hall Hospital, five of the outpatient clinics at Corbett Hospital and the outpatients department in its entirety at Dudley Guest Hospital.

Over the three sites, we spoke with 29 patients, seven relatives and 24 staff.

We received comments from our listening events, from people who contacted us about their experiences and from staff focus groups. We also reviewed the Trust's performance data.

Summary of findings

Most people told us that the services they used were responsive to their needs. However, in some areas of the outpatient department, patients' needs were not being met. There were problems in ophthalmology with the appointments system, overcrowding in the phlebotomy (blood collection) clinics at Russells Hall and Corbett Hospitals and, issues identified with parking provision at Russells Hall.

Overall, patients received a safe service. They were protected as far as possible from harm or abuse. Staffing levels were good and the Trust demonstrated a commitment to ensuring staff were up to date with mandatory training. Managing risk across the outpatient department had not been consistent; information and good practice in relation to slips, trips and falls had not been widely shared across the department.

Treatment was generally effective. We found that patients were satisfied with outpatient treatment. Difficulties with the transport arrangements to and from outpatient appointments had been identified and the Trust was working towards their key performance indicator of 95% of patients arriving and leaving the outpatient department on time.

Staff at all three sites, including outpatient services for children and young people, told us some clinics used reminder calls and texts and a partial booking service to achieve good rates of appointment attendance.

Outpatients

We observed good collaborative working within the multidisciplinary team. Examples included nurse-led clinics, clinics led by allied health professionals and multidisciplinary clinics.

Patients said that staff were caring, kind and compassionate. We observed that staff treated patients respectfully and with dignity.

We identified some excellent practice that targeted patients' specific needs in an empathetic manner. This included the Eye Clinic Liaison Officer (ECLO) and the Care of Next Infant (CONI) programme in the outpatient clinic for children and young people.

Most of the staff we spoke with described strong, supportive leadership at board level and an organisational culture that empowered staff at all levels of the organisation.

Are outpatient services safe?

Good

Safety in the past

At Corbett Hospital we inspected the urology clinic. The Trust risk register identified the risk to patients from not having assurance of the competence of healthcare professionals in the administration of intravesical chemotherapy (a chemotherapy drug, usually mitomycin C or MMC). The Trust had addressed this and now had three registered nurses at Corbett Hospital who were competent to provide this service. This showed the Trust had taken action to reduce or remove the risks identified in the risk register.

We spoke with a nurse working in the urology clinic. They were competent to administer MMC and perform cystoscopies and worked to guidelines defined by the British Association of Urological Nurses (BAUN). This enabled them to work collaboratively with the medical staff for the benefit of patients attending the urology clinic.

Learning and improvement

Staff we spoke with over the three sites identified slips, trips and falls as a risk within the outpatient department. This had not been identified by the Trust in the information we received prior to the inspection.

At Russells Hall Hospital the lead nurse told us of a fall that had occurred the week prior to the inspection. At Corbett Hospital the clinical services manager told us of two falls, both resulting in the patients being admitted to the emergency department that had occurred within the last 12 months. Both of the falls at Corbett Hospital occurred within the same area of the outpatient department; one incident was likely to be linked to the reason the patient was attending the clinic.

Staff we spoke with told us that all slips, trips and falls were entered on Datix – patient safety incidents healthcare software system. However, we were unable to access information about these three falls at the time of the inspection. Both the lead nurse and the clinical services manager told us that all slips, trips and falls were investigated in line with the Trust policy and that shared learning would take place at team meetings. Staff we spoke with confirmed this.

Outpatients

At Dudley Guest Hospital, a member of staff we spoke with in the rehabilitation clinic told us that all new patients received a physical and social assessment that included the use of the Otago Exercise Programme – a programme used to prevent falls in older adults.

Most of the staff we spoke with told us they would not always be aware of a slip, trip or fall outside of the clinic they were working in. This prevented staff from being vigilant and focusing on keeping people safe.

Systems processes and practices

At all three sites we observed that there were sufficient staff of an appropriate skills mix to enable the effective delivery of care and treatment.

None of the staff we spoke with raised concerns about staffing levels. One member of staff told us, "We [the clinics] help each other out if someone phones in sick".

Most staff we spoke with told us they were up to date with their mandatory training and had received an appraisal within the last 12 months. All the allied health professionals we spoke with also received supervision every six weeks. This meant that staff were supported by the Trust to deliver care and treatment safely and to an appropriate standard.

We spoke with a patient at one of our listening events who described their experience at the Trust. The patient had been referred for medical tests and investigations. Throughout the patient's journey, staff referred to the wrong side of the patient's body until the patient pointed out their mistake.

The resuscitation equipment we inspected was clean, single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff in the outpatient department. This meant the equipment was safe and ready for use in an emergency.

The outpatient service across all three sites was provided in a clean, safe and accessible environment. We observed good infection control practices, including hand hygiene gels used throughout the department by staff and some patients. At the Dudley Guest Hospital, some outpatient clinics displayed information about the number of staff trained in hand hygiene.

Consent to treatment

Staff we spoke with told us the medical and nursing staff explained in depth any diagnostic tests and treatment needed, including the risks and benefits of any proposed treatment. In the urology clinic at Corbett Hospital, we saw evidence in the medical records that consent had been obtained.

Most of the patients we asked said they had given consent before they had any tests or treatment. One patient told us, "He [the doctor] explained everything thoroughly so that I understood what my options were". However, one patient told us that consent was not sought before they were examined.

Our evidence demonstrated that staff were giving patients the information they needed to make informed decisions about treatment. Also, most staff were asking for the patients' consent before any examination, procedure or treatment took place.

We saw evidence of the policy and procedure for dealing with non-attendance in the children and young people's outpatient department This helped to focus staff on safeguarding concerns.

A member of staff on one clinic at Dudley Guest Hospital told us of a safeguarding issue that they had referred to the local safeguarding team. We spoke with other staff who could describe what safeguarding was and the process for referring any concerns about at-risk patients.

Another member of staff gave an example of a safeguarding issue they had been involved with and how it was handled appropriately. This told us staff were aware of how to protect patients from abuse, as well as their responsibilities to record, report and refer any safeguarding issues they identified, to ensure patients were safe from abuse or harm.

Monitoring safety and responding to risk

When we analysed data for reported outpatient incidents between April 2013 and March 2014, we saw that there had been 12 incidents relating to health records in outpatient clinics during this period. Seven of these were related to missing records or a delay in obtaining records. A further five incidents related specifically to the secretaries obtaining medical records.

When seen in context of the number of outpatient appointments which took place at the Trust during this period, this was not a significant number, indicating this was not a systemic problem for patients.

Outpatients

During our inspection we observed that medical records were stored in a secure, accessible way that allowed them to be located quickly. This meant the Trust had systems in place to ensure patient records remained confidential.

Senior staff at Dudley Guest Hospital told us they used a specific health records system – Retrieval of Active Records (ROAR) to access medical records in a timely manner. Current Trust data was reported to show that 98% of medical records were retrieved appropriately.

During our inspection we observed an episode of patient aggression in one of the clinics at Russells Hall Hospital. This was largely due to the delay in appointment time the patient was experiencing. The nurse in the clinic responded quickly to this incident. We observed the nurse to remain calm and professional throughout and diffuse the situation promptly with minimum impact on surrounding patients and relatives.

Anticipation and planning

Staffing levels seemed to be appropriate during our inspection. Staff from the focus groups and those we spoke with in the clinics at all three sites told us they supported each other by working across clinics if staffing levels were reduced due to sickness or leave. This meant appointments and clinics were not cancelled.

The lead nurse at Russells Hall Hospital told us they walked round the clinics each morning to determine the staffing levels for the day. This meant that any concerns about staffing levels could be addressed or escalated at the earliest opportunity.

This told us there was good organisation and arrangements to deal with unforeseen staffing shortages.

Are outpatient services effective?

Not sufficient evidence to rate

Evidence-based guidelines

At Russells Hall, we spoke with an advanced glaucoma practitioner. They told us they were trained in glaucoma-related care and worked to guidelines defined by the National Institute for Health and Care Excellence (NICE). The nurse was competent to assess patients and determine diagnosis and initial treatment. The nurse worked as part of the ophthalmology multidisciplinary team. This meant patients received timely treatment and care.

Monitoring and improvement of outcomes

In the 2011 Outpatient Survey, the Trust achieved a rating of 'about the same' for the effectiveness of its treatment of problems that had led to patients' referral to hospital and overall satisfaction with outpatient treatment. This means that the Trust is average in its performance here (i.e. about the same as most other Trusts).

During the inspection, the clinical services manager discussed difficulties with the transport arrangements to and from outpatient appointments. Currently, across the three sites, 250 outpatient journeys via hospital transport take place each day.

The Trust's key performance indicator for patients arriving and leaving the outpatient department on time is 95%. We were told that the Trust currently achieves 90% for patients arriving either 45 minutes before or 15 minutes after their appointment time, and 85% for transport arriving to take patients home within 60 minutes of booking. The clinical services manager told us they are involved with monitoring this and they regularly attend performance review meetings with the Dudley Clinical Commissioning Group.

We received no comments from patients either at our listening events or during our inspection concerning delays in transport.

Multidisciplinary working and support

Our staff interviews and focus groups revealed good joint working with the medical, nursing and allied health professional teams. Staff told us of nurse-led clinics, clinics led by allied health professionals and multidisciplinary clinics. We observed several of these clinics, at all three sites, during our inspection.

We found that there had been generally good collaborative working across the children and young people's outpatient department. Within the diabetic clinic, a multidisciplinary approach facilitated the transition of children and young people to adult services.

Are outpatient services caring?

Outpatients

Good

Compassion, dignity and empathy

We observed staff treating patients respectfully and with dignity at all three hospital sites. All staff in the clinics we visited were welcoming towards patients and supported them in a professional and sensitive manner. We noted that there were good working relationships between different professional groups, and there was an apparent mutual respect between staff.

We did hear information from a patients at one of our listening events that their privacy and dignity was not maintained.

Most of the patients and relatives we spoke with were very happy with the quality of the care and treatment they were receiving and with the approach of the clinic staff. At Russells Hall patients told us, "Staff are very caring", "very friendly" and "the consultant always spends a lot of time with you".

Parents attending the outpatient clinic for children and young people told us "we are very happy with the staff" and "staff are always friendly and helpful".

Patients and relatives gave us very positive feedback about staff working at the Corbett Hospital. Patients commented:

- "The staff are very friendly."
- "Staff are very friendly and helpful."
- "You are made to feel relaxed."
- "Consultant is very friendly."
- "My treatment has been second to none."

Patients attending the Dudley Guest Hospital commented, "Good friendly staff", "staff are lovely" and "staff spend a lot of time with you, they [the nurses] listen to your problems and try to help sort them out".

Involvement in care and decision making

Most patients we spoke with felt they had the time they needed to discuss their health with the doctor and that doctors had listened to their views. One patient told us, "I received information from the very start of my treatment". Another said, "I got good information about what was wrong with me".

Our inspection found that most patients were receiving the information they needed about tests and treatments.

Trust and communication

We attended a nurse-led consultation in the ophthalmology clinic at Russells Hall. We observed the nurse positively interacting with the patient and their relative. During the consultation the patient's diagnostic tests were discussed in depth, and patient notes about diagnosis and treatment were updated to ensure they were accurate.

Following the consultation, the patient was told they would not need to attend the clinic for a further seven months. The nurse told them who to contact should they experience any problems in the meantime. When leaving, the patient told us, "This clinic is wonderful; I will miss [the nurse]".

Emotional support

At Russells Hall Hospital we met with the ECLO who works closely with medical and nursing staff to support patients. They help connect patients with the practical and emotional support needed to understand their diagnosis, deal with their sight loss and maintain their independence. The ECLO explained that their aim was to increase and improve patient confidence through education and awareness. They told us, "I walk the journey with the patient".

The outpatient clinic for children and young people adopts the CONI programme. This programme supports families before and after the birth of their new baby, and following a parent's loss of an infant through sudden infant death syndrome (SIDS).

One patient, who had completed the CQC's Survey March 2014 wrote, "We have always asked for specific appointment times in view of our son's autism. We have never needed to explain our reasons; staff have been knowledgeable and extremely willing to help".

Are outpatient services responsive?

Requires improvement

Meeting people's needs

Within outpatient services for children and young people, we observed dedicated clinical areas with a child-friendly approach. The department and the consultation rooms

were imaginatively decorated and the main waiting area displayed many information leaflets aimed at children. This meant the department was conscious of attending to patients' emotional, comfort and safety needs.

At Russells Hall Hospital we were told that the ophthalmology department had not allocated an adequate number of follow-up appointments. This meant people who had undergone ophthalmic surgery may not have been checked to make sure the surgery had been successful and that there were no complications.

People we spoke with at our listening events also raised concerns about the process for ophthalmic follow-up appointments. One person told us they sometimes have had to wait up to two hours to see their doctor from arrival at their appointment. Another person commented on delays in the referral process. We also noted that the eye clinic received a number of negative comments from patients in feedback we received before our inspection. Two patients told us that they felt they got inconsistent communication, care and advice from this clinic.

We received mixed feedback about the care people received in the ophthalmology clinic. One person told us, "Waiting times poor but great consultant". Another patient, who had been attending the ophthalmology clinic for the last 17 years at Dudley Guest Hospital and then Russells Hall Hospital, described the service as having, "efficient and good care".

We looked at the patient comments made via the CQC's Dudley Disability Rights UK Survey March 2014. The following were comments about the ophthalmology service:

- "At each appointment my father's needs were always taken into account and I have no complaints at the treatment he has received."
- "Have been a patient since 1986 and have always been treated well."

At one of our listening events, a patient told us their appointment in ophthalmology had repeatedly been cancelled over a period of two years. They had now been seen and required surgery, however, due to the length of time from referral to appointment, their treatment plan may need to be changed.

During our inspection we spoke with staff working in the ophthalmology clinic. Staff told us of the problems with lack of capacity in the clinic. The Trust was already aware of this and it was on their risk register. Staff told us plans were in place to address this risk and gave examples of extended working hours, additional training to offer more nurse-led services and 'virtual' clinics. None of the staff we spoke with could give us a time period for when these actions would be in place.

We spoke with patients attending the outpatient departments at all three sites. Most of the patients and relatives we spoke with were very happy with the quality of the care and treatment they were receiving and with the approach of the clinic staff. They told us that the service was responsive to their needs.

Before our inspection, we received a comment from the mother of a patient who had used the outpatient services at Russells Hall Hospital. She told us, "My daughter has a severe needle phobia. They [the phlebotomy service] went the extra mile for us".

Patients at Corbett Hospital told us staff were kind and treated them with respect. Patients said, "staff very friendly" and "very friendly, informative staff, they answered my questions".

In the outpatient clinic for children and young people, we spoke with the parents of a young child who had come for an appointment. They spoke positively about the staff and told us, "Staff were always very friendly and helpful". They said they had received good written information about their child's condition and that staff were really good at explaining anything they did not understand.

Access to services

Most clinics were on the ground floor, making access safe and easier for patients with mobility difficulties.

Patients' experience of access to the outpatient department varied. Several patients said they found their experience disappointing because of parking problems. Patients and relatives told us:

- They often have trouble getting in disabled parking.
- Parking charges become expensive, especially if they are delayed by a clinic running late.
- Even if they hold a blue badge they still have to pay the full 'pay and display' fees.
- Car parks are often full.

Outpatients

At a focus group run by Disability Rights UK, held prior to our inspection, one patient told us about the problems they had experienced when trying to park after 4pm. The Trust's process is that patients requiring disabled parking access use an on-site phone to contact the private finance initiative (PFI) contractor that manages car parking at the Trust. The patient commented that the phone was not easy to access for wheelchair users (it was attached too high on the wall) and, when they did manage to make contact the PFI, they were unaware of the procedure. This meant the patient had to park in a non-disabled parking area further away from the entrance to the Trust which could delay the patient getting to their appointment on time.

Sufficient capacity

Data on the number of patients who did not attend their booked appointments at Russells Hall Hospital between April 2010 and August 2013 showed that rates were comparable with the national average. Data provided by the Trust on the day of the inspection showed that non-attendance rates at Corbett and Dudley Guest Hospitals were not significant considering the number of outpatient appointments made.

Staff at all three sites (including outpatient services for children and young people) told us that some clinics used reminder calls and texts. This enabled the Trust to achieve good rates of appointment attendance. Parents in the children and young people's outpatient department described the service as, "a really good service, helps us a great deal".

We identified where some clinics at Russells Hall Hospital had used a partial booking service to achieve good rates of appointment attendance. Partial booking was used if a patient needed a follow-up appointment in more than six weeks' time. The patient received a text or telephone call reminding them to book their appointment, usually after four weeks. Staff told us this gave patients more choice and also reduced the risk of the patient cancelling.

Staff we spoke with were unsure if all clinics at Russells Hall Hospital used this process. Staff at Corbett and Dudley Guest Hospitals told us they did not use a partial booking service. The Trust had not identified this good practice or shared it with other clinics which were not achieving good rates of appointment attendance.

We looked at data about referral to treatment times and this showed that patients were seen within the agreed national timescales.

Vulnerable patients and capacity

We found that there was good access to interpreting services, and all information leaflets could be requested in other languages. One person told us they had experienced difficulties getting timely access to an interpreter. This resulted in their appointment being cancelled and re-booked.

Staff in all clinics were aware of the availability of telephone translation services (Language Line), and they also gave examples of where they would choose to use a face-to-face interpreter. This allowed more sensitive information to be passed on to the patient in a compassionate way.

Staff in the ophthalmology clinic told us their leaflets had been formatted for the visually impaired and they could also offer leaflets in braille and audio formats.

Leaving hospital

During our inspection we found that an on-site pharmacy service was offered at all three sites. We received no comments from patients, either at our listening events or during our inspection, concerning obtaining medications.

Learning from experiences, concerns and complaints

Leaflets and information about how to complain were seen throughout the outpatient department at all three sites. We also observed feedback displayed to the public in some of the clinics across the three sites.

Most patients we spoke with said they would not know how to make a complaint if they were not satisfied with their care, but that they would find out. At the listening events held prior to the Trust inspection, one patient told us she had raised concerns with the chief executive. Another told us she was unsure who to raise her issues with. A patient in the ophthalmology clinic told us, "If they want us to see the posters asking for feedback, they need to provide them in large print".

Feedback received prior to the inspection via the CQC's Dudley Disability Rights UK Survey March 2014 told us that most people knew how to make a complaint about the service if they needed to.

The Trust quarterly complaints and Patient Advice and Liaison Service report for quarter ending December 2013

identified 16 complaints relating to the outpatient department and one relating to the outpatient clinic for children and young people. This suggested the Trust had systems in place for informing patients of how to raise a complaint.

Appointment times and delays

The lead nurse at Russells Hall Hospital told us that consultants largely observed the rule about giving six weeks' notice of their absence and any impact on their clinic so that patients could be notified accordingly. The same nurse gave us an example of a consultant calling in sick the day before our inspection. In this instance the staff were able to identify a replacement so that patient appointments were not cancelled. This told us staff were committed to ensuring patients attended their appointments as planned.

Staff at the cardiac diagnostics clinic at Russells Hall Hospital told us they staggered their appointments to avoid delays to appointment times. This allowed patients to be seen in a timely manner before the next patient arrived and also allowed for fluctuations in demand for appointments.

On the day of our inspection, the outpatient clinic for children and young people was quiet and no delays were observed. Staff in this clinic told us they allocated 30-minute appointments to patients and were able to change the allotted time if necessary. This allowed more flexibility for patients and the clinic.

At most of the clinics we visited across the three sites, we saw evidence of staff informing patients of any delays to their appointment times. This information was given verbally and written on a whiteboard at the front of the clinic.

We observed the phlebotomy clinics at Russells Hall and Corbett Hospitals to be very busy and overcrowded. Many patients had to stand up because the seating in the waiting area was all taken.

Both clinics operated a ticket controlled system. This allowed the patient to take a sequentially numbered ticket that automatically organised the queue flow.

Patients at Corbett Hospital told us their average waiting time to have blood taken was between 30 and 60 minutes.

One patient said, "The length of time is so much better than Russells Hall Hospital". One patient at Russells Hall Hospital told us he had been standing for 90 minutes waiting for his turn because all chairs were taken.

Patients in the outpatient department across the three sites gave mixed feedback about whether they were kept fully informed about delays they experienced in some clinics. Some patients were aware of what would happen next and the reason for waiting times; others were not. Many patients were frustrated with the waiting times.

Some patients thought that, despite the wait, they received good care from the staff. Other patients felt less satisfied and told us:

- "Sometimes I feel a little neglected when clinics are running ridiculously late and no one communicates to explain what's going on."
- "In February 2014 I had to wait one hour and 15 minutes before seeing a doctor and in 2013 I had to wait over one hour. Apologies and reasons for delay were given but I still felt the length of time to wait was unsatisfactory."
- "The eye clinic needs to organise appointments so that you are not left waiting an hour to see the consultant."

Are outpatient services well-led?

Good

Vision, strategy and risks

At the staff focus groups at Corbett and Dudley Guest Hospitals, staff commented on positive changes in the culture at the Trust and described it as a Trust that "listened to and involved frontline staff". Staff commented on feeling supported; they told us, "we feel supported" and "it's a friendly Trust". Most staff said they felt they were encouraged to speak up and contribute their ideas.

We looked at the staff survey results and saw that the levels of staff satisfaction for the Trust were tending towards 'better than expected'. Most of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed. Staff knew about the Trust's commitment to patients and the values of the organisation they worked for.

Outpatients

Staff working in the cardiac diagnostics clinic at Russells Hall Hospital told us that, over the last year, the board had become more visible and developed an open culture for feeding back information.

Most of the staff we spoke with told us they attended monthly departmental meetings. Within medicine this included the medical director. Staff who were unable to attend received the minutes. This allowed staff to be updated on organisational changes and developments, discuss certain matters and concerns, receive feedback on incidents and participate in shared learning.

Governance arrangements

Our discussions with staff from the focus groups at all three sites and senior managers told us that the Trust was aware of the main risks and challenges for the outpatient departments and that they were identifying actions to address these areas. The NHS Staff Survey 2013 saw the percentage of staff able to contribute towards improvements at work as 'worse than expected'. However, most staff we spoke with told us they were encouraged to raise issues and work collaboratively to improve efficiency of the service, and patient outcomes.

One member of staff told us, "it's about being more imaginative with what you've got and thinking about different ways to deliver the service".

The Advanced Glaucoma Nurse at Russells Hall Hospital told us of their plans to increase the number of nurses able to offer a glaucoma screening service by offering training within the Ophthalmology clinic and the Emergency Department. This allowed for early detection of glaucoma and protection of patients vision from damage caused by glaucoma.

Leadership and culture

Most of the staff we spoke with at all three sites and at the staff focus groups talked of 'strong leadership' both locally and at board level. Staff felt there was an 'open' culture at the Trust and described feeling confident about escalating concerns. One member of staff at Russells Hall Hospital told us, "I would feel comfortable escalating things to the top".

Staff at the focus group at the Corbett Hospital told us how the Chief Executive of the Trust has held regular meetings with groups of staff. This meant staff felt listened to and valued within the organisation.

Patient experiences, staff involvement and engagement

Within some clinics at all three sites staff used a 'token system' to receive 'live' feedback from patients and the public. Coin-like tokens are posted in to one of three slot boxes depending on the answer the patient wants to give to a question about their experience within a particular outpatients clinic. During our inspection we saw evidence where clinics had displayed the results to the patients, public and staff. This meant staff were recognising the importance of patient views.

Learning, improvement, innovation and sustainability

Most staff at all three sites felt well trained through face-to-face training or e-learning (computer based training). Staff told us they felt supported in their roles.

Outstanding practice and areas for improvement

Outstanding practice

Good Practice

- The breakfast club within medical services to meet patients psychological need and void isolation. Pet Therapy was also available on wards.
- There had been positive user engagement in developing the Trust strategy for patients with learning needs. This was welcomed by this patient group and their carers.
- The Trust had developed a smart-phone app for antibiotic prescribing. All staff have access to this, it ensures those prescribing antibiotics have access to the most up-to-date Trust information.
- There was strong engagement from the executive team at all levels and staff report an open door and open communication culture.
- In response to a previous criticism of the food provided by the hospital, the Trust held an 'international' event to improve food quality. Jointly hosted by dieticians, the Trusts catering team and Interserve (PFI partners). Following this new nutrition and hydration leaflets had been produced.
- Staff were highly praised by patients for their caring approach. Numerous examples were given were staff had 'gone the extra mile' and this was appreciated.
- Hot clinics (rapid access) were in place to fast track patients who need to be seen quickly in surgical areas.
- There was a sensory room in the children's ward for young babies and children with specific needs; this was seen as highly responsive to people's needs
- We identified some excellent practice that targeted patients' specific needs in an empathetic manner. This included the Eye Clinic Liaison Officer (ECLO) and the Care of Next Infant (CONI) programme in the outpatient clinic for children and young people.
- We saw staff respond positively and professionally to anxiety and aggression in individual patients.

Areas for improvement

Action the hospital MUST take to improve

- The Trust must ensure that DNACPR orders are followed according to the Trust's policy and are reviewed regularly.
- The Trust must review its flow of patients from A&E through the hospital. There are challenges to patient flow that are preventing the service meeting needs of patients early in the pathway.
- The Trust must review its ophthalmology clinic provision to ensure patients' needs are met.
- The Trust must review its capacity in phlebotomy clinics at both Russells Hall and at Corbett Hospital.
- The Trust must review the documentation it uses for compression stockings on critical care unit; these reduce the risk of venous thrombo-embolism. The Trust must ensure that all patients who require these are given them and it is appropriately recorded.
- The Trust must review its incident recording and reporting. In many areas this is good, but this is not consistent across the organisation.
- The Trust must review its method of agreeing staffing levels in maternity so that only one figure is understood by the whole Trust.
- The Trust must ensure that staffing levels and cover for vacant shifts is satisfactory and does not place overreliance of staff who have already worked full shifts to cover these.

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
Diagnostic and screening 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 (1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010** People who use services and others were not protected against the risks relating to their health, welfare and safety as the systems designed to assess, monitor the quality of the services and identify, assess and manage risks were ineffective. • The patient flow through the hospital was not being managed effectively. There was often a shortage of beds for patients to be admitted into, which led to patients not being able to moved out of A&E. This also delayed access to care in an appropriate setting. • There are long waits in phlebotomy on two sites. The service was unable to cater for the number of patients with effective resources, nor to be able to provide adequate facilities for patients waiting. • The follow-up of patients from ophthalmology following surgery was not always undertaken. Clinical activity should be undertaken at the time interval specified. • Patients waited excessively long times in ophthalmology. The service was unable to provide adequate resources to manage this known (or anticipated) activity. • Learning from incidents was not consistently shared across the hospital. Systems to proactively share information and feedback were not universally applied.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **People who use services and others were not protected against the risks relating to their health, welfare and safety as the systems designed to obtain consent to a Do Not Resuscitate order were not properly administered.** • DNACPR forms should be correctly completed and signed. • DNACPR forms should be reviewed at appropriate intervals.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1)(a)(b)(i)(ii) HSCA 2008 (Regulated Activities) Regulations 2010** People who use services and others were not protected against the risks associated through lack of appropriate care by all staff. • The system for documenting the use of compression stockings and ensuring their correct application (these reduce the risk of venous thrombo-embolism) on the critical care unit was insufficient to identify for which patients they were appropriate.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users.

This section is primarily information for the provider

Compliance actions

- The was not a single method of agreeing staffing levels in maternity so that only one figure is understood by the whole Trust.
- Staffing levels and cover for vacant shifts is unsatisfactory and places overreliance of staff who have already worked full shifts to cover these.