Derby Hospitals NHS Foundation Trust

Quality Report

Uttoxeter New Road,
Derby
DE22 3NE
Tel: 01332 340131
Website: www.**derbyhospitals**.nhs.uk

Date of inspection visit: 8-10 December 2014
Date of publication: 31/03/2015

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Derby Hospitals NHS Foundation Trust provides both acute hospital and community-based health services. There are two inpatient hospitals, the Royal Derby Hospital and London Road Community Hospital. The trust serves a population of over 600,000 people living in Derby and the surrounding areas. In total the trust has 1,100 beds.

Derby is an urban area with a deprivation score of 63 out of 326 local authorities (with one being the most deprived). This means that Derby Unitary Authority has a significantly deprived population and is worse than the national average on a range of population health measures.

Life expectancy for men is lower than the England average and is 12.2 years lower between the most deprived and the least deprived areas of Derby. For women the difference is nine years lower. Reducing inequalities in health is one of the local priorities across the Derby health community.

We inspected Derby Hospitals NHS Foundation Trust as part of our comprehensive inspection programme.

We carried out an announced inspection of the Royal Derby Hospital, London Road Community Hospital as well as the community-based services between 8 and 11 December 2014. In addition, an unannounced inspection was carried out between 5pm and midnight on 22 December 2014. The purpose of the unannounced inspection was to look at the accident and emergency (A&E) department, critical care and a number of wards in both the Royal Derby Hospital and London Road Community Hospital.

We made judgements about all of the services the trust provided and because just three out of the eleven core services we inspected required improvement we rated this trust as “good” overall and noted some outstanding practice and innovation. However, improvements were needed to ensure that services were safe, effective and well led.

Our key findings were as follows:

Cleanliness and infection prevention and control

- There was a dedicated inspection prevention and control team and good arrangements in place to prevent the spread of infection. All of the wards at the Royal Derby and the London Road Hospitals appeared to be clean. We saw staff adhered to the policies for infection prevention and control, for example, staff washed their hands regularly and between patient contact. where infections did occur, they were subject to an investigation. We saw examples of these investigations and the learning points to come out of them.

Nutrition and hydration

- We saw patients received help to eat and drink. There were systems in place to identify patients who needed help, such as the "Red Tray," and protected mealtimes. There were nutritional assistants available at meal times. We also noted some good practice for patients where the day rooms were used to have communal meals and create a more informal atmosphere to help stimulate patients to want to eat and enjoy their meals.
- Nutritional risk assessments were completed appropriately, but most importantly we saw the outcomes of risk assessments were acted upon. Food charts were maintained and there was accurate recording and totalling of fluid balance charts.

Mortality

- We did not have concerns about mortality rates at the trust. Where there had been any identification of trends that required further investigation the trust reviewed data and submitted their responses appropriately. There had been a mortality outlier which intelligence systems had identified in February and March 2014. This concerned coronary atherosclerosis and other heart disease. An investigation had been undertaken which identified a need to ensure improvements in coding and documentation. The clinical treatment of the patients was not found to be of any concern.
- The trusts Summary Hospital-level Mortality Indictor (SHMI) and the Hospital Standardised Mortality Ratios (HSMR) mortality measures show the trust as being

Summary of findings

within expected limits between August 2013 and July 2014. SHMI and HSMR are ways in which the NHS measures healthcare quality by looking at the rates of mortality in the trust.

Staffing

- There were significant staffing problems within the community nursing teams. There were high levels of vacancies as well as staff sickness and absence which meant case loads were high. The complexity of the patients being cared for at home was also increasing. In addition, the community nursing teams were providing a service that exceeded what it was commissioned for. The district nursing activity was over target and for seven of the last 18 months, district nursing teams carried out more than twice as much work as they were scheduled for. All of these factors meant the community nursing teams were under immense pressure and the service was not sustainable. The concerns about staffing levels had been escalated and it had been an item at the trusts safer staffing board.
- At the Royal Derby Hospital, a recognised safe staffing tool had been used to calculate nurse staffing levels. During 2014, a review had taken place and changes to the establishment had taken place. Wards displayed their staffing levels on a board and it compared the daily planned numbers of staff with the actual staff on duty. Patients at the Royal Derby Hospital told us the nurses were busy. Many staff told us they felt under pressure and worried that their workloads kept on increasing as the demand for services increased. Despite this, we found all of the services we inspected apart from medicine and end of life care were adequately staffed with nurses. In medicine and end of life care, there were some occasions where the nursing staff ratios dropped to below the required level.
- Within the community services, the trust had used a recognised safe staffing tool to assess the staffing levels required on the inpatient wards at the London Road Community Hospital. This had resulted in increased funding to employ additional nurses. We were encouraged to see the trust had reduced bed numbers on the wards as an interim measure while they ensured they had adequate staff in place.
- The trust employed more consultants and junior doctors than the national average but less registrars and middle grade doctors than the national average. Doctors we spoke with were generally positive about the medical staffing arrangements and we did not identify any concerns with the numbers of medical staff employed by the trust.

Complaints

- The trust had a compliance action set by the Care Quality Commission in July 2013 to improve the handling of complaints. The trusts target for responding to complaints within the 25 or 40 day timescale had improved. In December 2014, performance was 72% which was slightly better than the trusts own target of 70%. We reviewed nine complaints during the inspection and we found not all of these had been responded to in the time set. the trust had met their quality target set by the commissioners for complaints handling. we judged the compliance action had been met, but the improvement needed to continue and be sustained.

We saw several areas of outstanding practice including:

- The trust was providing responsive care for patients who had dementia. On the Medical Assessment Unit there was a dedicated lounge known as the FEAT lounge (frail elderly assessment team). A dedicated healthcare assistant with qualifications in caring for patients living with dementia to assist patients was available in this lounge every day. We found this was providing care to patients that was very responsive to their individual needs.
- Ward 205 should be commended for helping to improvement the mental wellbeing of elderly patients and patients with dementia through the use of the reminiscence room, pictorial information and advanced service planning to further enhance care.
- The MAU had pharmacists on the ward 12 hours each day, seven days a week. They worked as part of the frail elderly team with the aim of optimising the use of medicines. The overall aim was to help patients make the most of their medicines.
- Respiratory medicine had introduced the use of patient colour-coded wristbands to identify how much oxygen each patient needed. Excessive amounts of oxygen can be dangerous for some patients and it is important that the correct amount of oxygen is administered.

Summary of findings

- Echocardiography was used as the main monitoring tool of cardiac output and fluid status for intensive care patients. Point of contact echocardiography for these patients is a highly innovative and valuable service.
- The maternity department bereavement service had been recognised by the Royal College of Midwives. The lead midwife had been nominated for the Royal College of Midwives Award 2015 National Maternity Support Foundation Award (NMSF) for Bereavement Care, improving the environment, which was known to be an important key to effective bereavement care.
- The Nightingale Macmillan Unit was dedicated to providing end of life care to patients with life-limiting illnesses and staff were able to respond appropriately to meet the individual needs of patients. The facilities and resources available for patients on the unit were excellent.
- The trust worked with the Arts Council and had an initiative in place knows as Banishers of Boredom. this was a small team of staff of staff who worked with patients to participate in different activities.

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

Importantly, the trust must:

- Ensure that patients thought to have reduced mental capacity, or those who lack mental capacity, to make decisions about their care and treatment, receive prompt and effective assessments in line with the Mental Capacity Act (2005).
- Ensure all DNA CPR order forms are completed accurately in line with trust policy and the Mental Capacity Act (2005).
- Ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced nursing staff in the district nursing, medicine and end of life services, employed for the purposes of carrying on the regulated activity.
- Ensure that all district nursing staff are able to attend mandatory training and other essential training as required by the needs of the service.

In addition the trust should:

- Ensure that there are suitable arrangements in place to ensure that sufficient and suitably qualified staff are on duty on all medical wards to meet patient's needs safely.
- Ensure that the lone working policy and arrangements for community maternity staff are reviewed to ensure they feel safe and secure when out in the community.
- Ensure that patients notes are stored securely to ensure that confidential patient information is not accessed inappropriately.
- The trust should ensure that there are sufficient numbers of suitably qualified, skilled and experienced nursing staff on the adult emergency observation ward to safeguard the health, safety and welfare of patients.
- The trust should ensure that there is sufficient storage available to enable equipment to be appropriately stored and enable safe access to bathrooms on medical wards.
- The trust should consider providing information for patients and friends and family comment cards in different formats and different languages. This would enable people with learning disabilities, those who's first language is not English or those with cognitive impairment to access information and provide their feedback.
- The trust should review arrangements for undertaking venous thromboembolism (VTE) assessments on the surgical assessment unit.
- The trust should consider reviewing the arrangements for the care of patients on high dependency units who would be categorised as requiring level two care. Current arrangements were not meeting the Core Standards for Intensive Care Units (2013).
- The trust should consider developing their electronic prescribing system to enable it to be used in intensive care as for other wards and departments in the hospital. The use of different systems across the hospital meant there was a risk of poor communication about previously administered medications.
- The trust should ensure that staff on Puffin ward are trained and supported to care for patients who require a CAHMS assessment whilst on the ward so that they can ensure their welfare and the welfare of other patients is protected.

Summary of findings

- The trust should ensure that all clinical single use equipment is stored safely and appropriately; and disposed of when it has expired it used by date.
- The trust should ensure that the design and layout of the neurology outpatient clinic at London Road Hospital is suitable for the needs of all patients, including those with limited mobility.
- The trust should consider improving the facilities for patients who need to collect prescription medicines from the pharmacy within Royal Derby Hospital. This is to reduce the long waiting times for prescriptions to be dispensed and the pharmacy and improve access for patients with limited mobility.
- The trust should consider hearing "patients stories" during their public board meetings to ensure the positive and negative experience of patients is taken account of when they make decisions.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Derby Hospitals NHS Foundation Trust

Derby Hospitals NHS Foundation Trust consisted of acute and community-based services and had two inpatient hospitals: the Royal Derby Hospital and London Road Community Hospital. Monitor authorised the trust as a foundation trust in July 2004. An NHS foundation trust was still part of the NHS, but the trust had gained a degree of independence from the Department of Health. The trust provided a full range of hospital services, including an emergency department, critical care, general medicine, elderly care, general surgery, paediatrics and maternity care. It provided community-based services for adults, but not children. In total, the trust had 1,123 hospital beds and served a population of over 600,000 people living in Derby and the surrounding areas.

The Royal Derby Hospital was a modern, purpose built hospital, which was officially opened in April 2010. The hospital also incorporated the Derby Medical School and a School of Health Sciences.

Derby is an urban area with a deprivation score of 63 out of 326 local authorities (with one being the most deprived). This means that Derby Unitary Authority has a significantly deprived population and is worse than the national average on a range of population health measures.

The local health profile shows that Derby has a number of indicators that are worse than the England average. In 2011, 24.7% of Derby's population were from Black and minority ethnic (BME) groups, the largest group being Asian/British, this is significantly higher than the England average of 14.6%. Thirteen point nine per cent of the population in 2011 were born outside of the UK.

The trust was rated as band 2 in the December 2014 update of the CQC's (Care Quality Commission) intelligent monitoring system (the scores range from bands 1-6, with band 1 being the highest risk and 6 the lowest). The highest risks within our monitoring were:

- Composite indicator: In-hospital mortality – dermatological conditions.
- Composite of hip related PROMS indicators (1 April 2013 to 31 March 2014).
- Monitor: Governance risk rating (9 September 2014 to 9 September 2014).
- Monitor: Continuity of service rating (9 September 2014 to 9 September 2014).

In 2013/2014, the trust had a total income of over £477 million and a deficit of over £15 million. It employed 8,779 staff.

The trust was placed in breach of its Monitor license in September 2014 for two areas: "Breaches and finance".

The breaches related to failure to meet nationally set targets regarding access to services and the trust's financial deficit. The trust have provided plans to Monitor of how they are addressing the breaches.

The inspection did not include the Radbourne Unit on the Royal Derby Hospital site, wards 1 and 2 and the Dovedale Day Hospital on the London Road Community Hospital site. This was because these services were provided by a different NHS Trust.

Our inspection team

Our inspection team was led by:

Chair: Jan Ditheridge, Chief Executive, Shropshire Community Health NHS Trust

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission (CQC)

The team of 46 included CQC inspectors and a variety of specialists, including: a medical consultant, a surgical consultant, a consultant obstetrician, a consultant paediatrician, a consultant anaesthetist, a junior doctor, board-level nurses, modern matrons, specialist nurses, theatre nurses, emergency nurse practitioners, a midwife, a student nurse, a paramedic, experts by experience, a physiotherapist and a safeguarding advisor.

Summary of findings

How we carried out this inspection

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group (CCG), at Southern Derbyshire, Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Derby on 9 December 2014 where 18 people shared their views and experiences of services provided by the trust. Some people also shared their experiences with us through email or telephone.

In addition to the listening event, we held two events on 25 and 26 November 2014 in conjunction with the Asian Disability Network in Derby. We met with 30 people who had a disability and 14 people who were homeless. At both of these events, people shared their experiences and gave us an insightful account of what it was like for them using healthcare services in Derby. The comments we received about GP services were used by our colleagues in the CQC who focus on the inspection of primary medical services (GP services).

What people who use the trust's services say

The NHS Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The trust's performance in all of the NHS Friends and Family Tests in November 2014 was largely positive and scores were, without exception, above the England average.

- The trust scored slightly higher than the England average of 96% for the inpatient NHS Friends and Family Test, with 96% of patients recommending the inpatient services provided by the trust.
- The trust scored slightly higher than the England average of 87% for the A&E NHS Friends and Family Test, with 88% of patients recommending the service.
- The trust scored higher than the England average of 96% for the antenatal question in the maternity NHS Friends and Family Test, with 100% of women recommending the service.
- The trust scored higher than the England average of 97% for the birth question in the maternity NHS Friends and Family Test with 99% of women recommending the service.
- The trust scored higher than the England average of 93% for the postnatal care question in the maternity NHS Friends and Family Test, with 97% of women recommending the service.
- The trust scored the same as the England average of 97% for the postnatal care in the community question in the maternity NHS Friends and Family Test, with 97% of women recommending the service.

From April 2014 the Staff NHS Friends and Family Test was introduced to allow staff feedback on NHS services based on recent experience. Staff were asked to respond to two questions. The 'care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The 'work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work.

The trust's scores in this test were positive and were above the England average. The trust's scores in the staff NHS Friends and Family Test were also positive and were all above the England average. Eighty-five percent of staff would recommend the trust in relation to the 'care' question and 68% for the work' question. The England averages for this test were 77% for the 'care' question and 61% for the 'work' question.

In the CQC Adult Inpatient Survey in 2013 the trust performed in line with other trusts. The survey asked a number of questions relating to people's views on the hospital and the care and treatment they had received.

Summary of findings

There were two areas where the trusts scores were better than other trusts; being given enough privacy when being examined and being told how they could expect to feel after the operation or procedure.

In the Survey of Women's Experience of Maternity Care (CQC 2013), the trust performed about the same as other trusts in three out of four areas. The survey asked women a number of questions relating to their labour and birth, the staff who cared for them and the care they received in hospital following the birth. The trust scored worse than other trusts for two questions, namely: "If you used the call button how long did it usually take before you got the help you needed?" and "Thinking about your care during labour and birth, were you involved enough in decisions about your care?"

The national Cancer Patient Experience Survey 2012/2013 was designed to monitor national progress on cancer care. The trust was performing within the middle 60% of trusts for 27 of the 34 areas and in the top 20% of trusts for seven areas. The top areas were: all staff asked patients what name they preferred to be called by, patients were always given enough privacy when discussing their condition/treatment options, hospital staff did everything to help control pain all of the time, patients were given clear written information about what they should or should not do post-discharge, family members were definitely given all the information they needed to help care for their relative at home, patients were definitely given enough care from health or social services and staff told patients who to contact if they were worried post-discharge.

The patient-led assessments of the care environment (PLACE) programme are self-assessments undertaken by teams of NHS and private/independent healthcare providers and include at least 50% members of the public (who are known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The outcomes of the patient-led assessments of the care environment for 2014 showed that the trust was rated higher than the England average in scores for cleanliness, privacy, dignity and wellbeing and facilities. It was rated slightly lower than the England average for scores relating to food.

The feedback we obtained from the patients, relatives and carers we spoke with during the inspection was generally positive.

Facts and data about this trust

Derby Hospitals NHS Foundation Trust provided both acute hospital and community-based health services, serving a population of over 600,000 people in and around Southern Derbyshire. Twenty per cent of the population is made up for ethnic minorities. The trust ran two hospitals, the Royal Derby Hospital and London Road Community Hospital. Acute services were from the Royal Derby Hospital, which opened in 2010 and included the Derbyshire Children's Hospital. The site had a rooftop helipad. Community and rehabilitation services were run from London Road Community Hospital.

The city of Derby has a deprivation score of 63 out of 326 (one being the worst). Deprivation measures show that Derby Unitary Authority has a significantly deprived population, and is worse than the national average on a range of population health measures. South Derbyshire and the Derbyshire Dales have less deprivation and better public health outcomes in comparison.

The trust has 1,123 beds. It employs 8,779 staff, 782 medical staff, 2,191 nursing staff and 3,680 other staff.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of the services at the trust as “requires improvement.” For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital. The inspection team made 11 separate judgements about the safety of services across the trust. Three services were judged as "requiring improvement," and eight were judged as “good”. This meant that the trust can and did provide safe services, but did not do so consistently. Staffing levels within the community health services for adults were not adequate to meet the demands of the service. Teams were delivering far more activity than they were contracted for and demand for services kept on increasing. Staffing shortfalls were impacting on morale, attendance at mandatory training and the reporting of incidents. There were also staffing shortfalls within some of the medical services at the Royal Derby Hospital, although the need to recruit additional staff had been identified and this was underway. We found inconsistencies in the completion of do not attempt cardio-pulmonary resuscitation (DNA CPR) forms across the hospital. Thirty-one out of 35 forms we looked at were not completed in line with the trust’s policy. We found the trust were focused on safety and quality and it was a priority for the leadership team. There was culture amongst staff of reporting incidents and we saw evidence of learning taking place, particularly within the Royal Derby Hospital.	**Requires improvement** 
Are services at this trust effective? Overall we rated the effectiveness of the services at the trust as “Good.” For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital. The inspection team made 10 separate judgements about the effectiveness of services across the trust. Three services in the	**Good** 

Summary of findings

community were judged as requiring improvement and nine were judged as "good." The effectiveness of the outpatients service was not rated. This meant that the trust can and does provide effective services, but did not do so in the community settings it managed.

We found the arrangements for the management of patients of level 2 patients in the high dependency units did not meet national standards. There was daily review by medical consultants but there was no routine involvement or support from intensive care consultants. Nursing staff were working to competency frameworks relevant to their specialty but few had critical care qualifications. Audits of performance, and outcomes for patients in the high dependency areas were not compared against similar care units nationally.

Mental capacity assessments were not completed for 93% of patients deemed not to have capacity to make and communicate decisions about cardiopulmonary resuscitation. End of life care followed national guidance and the trust participated in national audits. However, there were inconsistencies with the use of end of life care documentation across the trust.

Some community teams, including the specialist palliative care team, were unable to access the electronic records system. This meant that staff did not always have the complete information they needed before providing care and treatment.

We found services took account of national guidelines and there were policies and procedures in place. We found lots of evidence of teams working well together in order to provide better outcomes for patients.

Are services at this trust caring?

Good

Overall, we rated the caring of the services at the trust to be "good". For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 11 separate judgements about how caring services were across the trust. All services were judged as "good".

The inspection team observed that compassionate care was being delivered throughout the trust. Staff treated patients with respect

Summary of findings

and patients, relatives and visitors told us that they had been treated with kindness. At our focus groups with staff, staff spoke of their overwhelming desire to care for patients to the best of their ability.

Are services at this trust responsive?

Good

Overall we rated the responsiveness of the services at the trust as "Good." For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community health services for children and young people and families, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 11 separate judgements about the responsiveness of services across the trust. All services were judged as "good."

Are services at this trust well-led?

Good

Overall, we rated the leadership of the services at the trust as "good." For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 11 separate judgements about the leadership in services across the trust. All services at Royal Derby Hospital were judged as good for their leadership. Two services within the community services were judged to require improvement.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of the services at the trust as “requires improvement.” For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital. The inspection team made 11 separate judgements about the safety of services across the trust. Three services were judged as "requiring improvement," and eight were judged as “good”. This meant that the trust can and did provide safe services, but did not do so consistently. Staffing levels within the community health services for adults were not adequate to meet the demands of the service. Teams were delivering far more activity than they were contracted for and demand for services kept on increasing. Staffing shortfalls were impacting on morale, attendance at mandatory training and the reporting of incidents. There were also staffing shortfalls within some of the medical services at the Royal Derby Hospital, although the need to recruit additional staff had been identified and this was underway. We found inconsistencies in the completion of do not attempt cardio-pulmonary resuscitation (DNA CPR) forms across the hospital. Thirty-one out of 35 forms we looked at were not completed in line with the trust’s policy. We found the trust were focused on safety and quality and it was a priority for the leadership team. There was culture amongst staff of reporting incidents and we saw evidence of learning taking place, particularly within the Royal Derby Hospital. **Duty of Candour** • The inspection coincided with the introduction of the new regulation on Duty of Candour –Regulation 20 of the CQC (Registration) Regulations 2009. The executive team and those in senior management positions we spoke with were aware of the Duty of Candour and what it meant for patients. A discussion about the Duty of Candour was seen in the public board minutes from November 2014. • We saw there was a system in place to meet the requirements, but the trust recognised it was still early days and more work was to be done to ensure it was fully implemented.	**Requires improvement** 

- We spoke with the CCG about a recent serious incident that had taken place in the trust. They told us the trust had followed the Duty of Candour and the patient and their relatives had been informed.
- The trust was taking forward work on human factors and had recently held a clinical staff study day on this. Human factors encompass all those factors that can influence people and their behaviour. In a work context, they are the environmental, organisational and job factors, and individual characteristics, which influence behaviour at work. There was a growing recognition in the trust about the importance of human factors and how they influence staff in their work.

Safeguarding

- Overall, there were suitable arrangements for safeguarding adults and children.
- There was a trust wide safeguarding policy and procedure in place and staff were aware of this.
- Safeguarding referrals were regularly made to the local authority. The trust wide safeguarding team received copies of the referrals. Staff knew what constituted abuse and the types of things they should report.
- Safeguarding training was part of the trust mandatory training and 99% of staff had received level one training. Volunteers working in the trust also received the level 1 training.
- The level 1 training consisted of the completion of a work book but there was no centralised mechanism to check that the learning targets had been achieved or the books had been read. This was reliant on local managers to check through the appraisal process.
- There was access to eLearning if staff wanted to access any refresher training in between the mandatory three year period, but access to this was not monitored.
- Staff at band 6 as well as all staff working in the community and above received face to face enhanced training. All staff working in the community also received enhanced training. The team did report there had been some confusion over which level of training was required for different staff groups.
- We saw the trusts appraisal process was used to check staff were up to date with their safeguarding training and had completed the required level.
- The trust employed two safeguarding leads, a lead nurse and a liaison nurse. In addition, there was leadership at board level from the Chief Nurse.
- The inspection team saw examples of appropriate action being taken in response to potential safeguarding concerns.

Summary of findings

Incidents

- The trust had reported two never events during 2014. These had occurred at the Royal Derby Hospital. Never events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. These events had been investigated using root cause analysis (RCA) methodology. We saw minutes of governance meetings where they had been discussed, along with the learning being implemented. The trust did implement learning from incidents. All staff were informed of never events by email and senior staff were charged with cascading the information to their teams. The trust had started to develop personal computer screen savers that had the learning points from events so that messages could be cascaded quickly and were easily visible for staff. A patient safety newsletter was produced which contained learning points and a series of staff briefing on quality issues, including key themes from incidents and never events were held in November 2014. There was also a never event section on the trusts internet with information and the learning points.
- The trust had appointed a non-executive director with the lead for quality and safety.
- Within the community services, patient safety incidents were increasing and these were mainly pressure ulcers. District nurses were supported with managing and preventing pressure ulcers through a part time clinical team leader role. The team leader carried out all RCAs and attended the incident scrutiny group. Community staff received good feedback about incident investigations, but there was little sharing and learning across the service in order to improve practice.
- Community and ward staff did not always report incidents due to time pressure or failing to consider an event was reportable. Senior staff raised at business unit governance and performance meetings that district nursing teams were working with a reduced workforce to meet a high demand, which resulted in outstanding incident reports.

Staffing

- All community teams were carrying high levels of vacancies and sickness absence. District nursing teams in particular were under-staffed and taking on increasing workloads. Recruitment was not successful in filling vacancies, and teams were delivering far more activity than contracted for. This was

impacting on attendance at mandatory and other training, including on incident reporting. Ward staffing levels were under pressure but were supported through reduced bed numbers and employing temporary staff.

Are services at this trust effective?

Good

Overall we rated the effectiveness of the services at the trust as "Good." For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 10 separate judgements about the effectiveness of services across the trust. Three services in the community were judged as requiring improvement and nine were judged as "good." The effectiveness of the outpatients service was not rated. This meant that the trust can and does provide effective services, but did not do so in the community settings it managed.

We found the arrangements for the management of patients of level 2 patients in the high dependency units did not meet national standards but the care they were providing was effective. There was daily review by medical consultants but there was no routine involvement or support from intensive care consultants. Nursing staff were working to competency frameworks relevant to their specialty but few had critical care qualifications. Audits of performance, and outcomes for patients in the high dependency areas were not compared against similar care units nationally.

Mental capacity assessments were not completed for 93% of patients deemed not to have capacity to make and communicate decisions about cardiopulmonary resuscitation. End of life care followed national guidance and the trust participated in national audits. However, there were inconsistencies with the use of end of life care documentation across the trust.

Some community teams, including the specialist palliative care team, were unable to access the electronic records system. This meant that staff did not always have the complete information they needed before providing care and treatment.

We found services took account of national guidelines and there were policies and procedures in place. We found lots of evidence of teams working well together in order to provide better outcomes for patients.

Evidence based care and treatment

Summary of findings

- Care and treatment were evidence based and staff followed current national guidance and best practice recommendations. This was consistent within all of the services we inspected.

Patient outcomes

- Staff monitored the quality of the service they were providing through a range of outcome measures. The use of dashboards to monitor quality and patient outcomes was evident throughout the trust but they recognised more development was required for the community dashboards.
- The trust performed better than the national average in the heart failure audit and Sentinel Stroke National Audit Programme (SSNAP) for October 2013 to March 2014. Further improvement was also needed to improve diabetic care within the hospital.
- Surgical outcomes for patients were monitored and were mostly within the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements.
- We saw that the dementia care framework programme for the care of patients with dementia had been in place for two years. We found that the availability of reminiscence lounges and, in particular, the Frail and Elderly Assessment Team (FEAT) lounge in MAU provided positive outcomes for patients who were living with dementia.

Multidisciplinary working

- We found evidence of good multidisciplinary working across the trust. one example of this was the Nightingale Macmillan Unit (NMU) and the palliative care team demonstrated strong multidisciplinary team working, which linked with other trust services.
- Multidisciplinary team working was seen as effective and resulted in good outcomes for patients. We saw examples of rehabilitation services working together to support the safe discharge of patients and support for carers. Within the acute stroke unit there were daily multidisciplinary team meetings to share information.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The assessments made of patients' mental capacity were inconsistent when it came to making decisions about patients' care. Not all decision-making was informed by, or in line with, best practice guidance and legislation.

Summary of findings

- We found that 14 out of the 35 DNA CPR forms we sampled indicated that patients did not have capacity to make and communicate decisions about cardio-pulmonary resuscitation. However, of these patients we found one mental capacity assessment completed. This meant that 93% of patients deemed to not have capacity had no mental capacity assessment completed, which was not line with trust policy, or the Mental Capacity Act 2005.
- We discussed mental capacity with three F2 doctors. None of them felt that not assessing capacity before completing a DNA CPR was of concern. One commented: "Mental capacity assessments would be good practice, but we don't usually."
- There was a system in place to monitor Deprivation of Liberty Safeguards. All Deprivation of Liberty Safeguards referrals were led by the safeguarding team. There had been 67 applications made since March 2014. The majority of applications were approved. This showed that there was awareness in the trust about the Deprivation of Liberty Safeguards and the need to safeguard people whose liberty was deprived.

Records

- Community staff were only able to access electronically held information about their patients' care and treatment plans at their office base, and not while they were on home visits. Some teams, such as the evening district nurses and the rapid response team, had no access at all to the electronic system. This meant staff might not have the complete information they needed before providing care and treatment.

Are services at this trust caring?

Good

Overall, we rated the caring of the services at the trust to be "good". For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 11 separate judgements about how caring services were across the trust. All services were judged as "good".

The inspection team observed that compassionate care was being delivered throughout the trust. Staff treated patients with respect and patients, relatives and visitors told us that they had been treated with kindness. At our focus groups with staff, staff spoke of their overwhelming desire to care for patients to the best of their ability.

Summary of findings

Compassionate care

- The vast majority of patients we spoke with told us they had been treated with kindness and respect. There were a very small number of patients who were less complimentary about the care they had received, however the numbers were very low. Where this did happen, the concerns related to the way people were treated. We also noted that a small number of patients told us the nurses had rushed them or they had heard them be short because they were under pressure and were rushing.
- Despite the pressures community staff were under, they treated patients with dignity, compassion and respect.
- Children and their parents were very complimentary about the care they had received.

Understanding and involvement of patients and those close to them

- We observed many examples of patients being involved in their care, but some patients did tell us they didn't feel as involved as they would like.
- Community staff discussed care plans and treatment with patients and provided information to support patients' understanding. Patients felt involved in making choices and decisions about their care and treatment, although some patients on the wards within the London Road Community Hospital did not feel informed about discharge arrangements.

Emotional support

- We saw examples of staff providing emotional support for patients and their carers.
- The hospital had a faith centre, which patients or their families could use for prayer and emotional support. Members of staff from the centre visited patients and families on wards.
- There were spiritual wellbeing care plans in some Nightingale McMillan Unit (NMU) patient notes that stressed the beliefs and needs of the patient. The National Care of the Dying Audit 2013/2014 showed that the trust performed better than the England average in terms of the assessment of spiritual needs of the patient and their nominated relative or friend.

Are services at this trust responsive?

Overall we rated the responsiveness of the services at the trust as "Good." For specific information, please refer to the individual

Good

reports for the Royal Derby Hospital, community health services for adults, community health services for children and young people and families, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 11 separate judgements about the responsiveness of services across the trust. All services were judged as "good."

Service planning and delivery to meet the needs of local people

- The hospital worked with charities such as the Alzheimer's Society and Changing Faces to plan and deliver services to meet the needs of patients.
- The trust was part of Derby's urgent care board (UCB), a partnership group made up of clinicians, the local authority, and other specialists. The UCB aimed to collectively solve or prevent key issues regarding patient care and flow. Action plans had been developed to address key problems in these areas and to improve services for patients.
- Plans to meet winter pressures included allocating an extra 48 beds, providing a service to provide cover seven days per week, and to ensure additional staff were in place.
- Service planning around these areas had included multidisciplinary enhanced recovery after surgery (ERAS) pathways in a number of specialties. Examples included: hip and knee surgery, partial gastrectomy, total gastrectomy, hemi-colectomy, breast surgery, radical prostatectomy and, oesophagectomy. Senior managers told us ERAS had helped reduce length of stay with 50% of patients undergoing hip or knee surgery being discharged within three days of surgery.

Meeting people's individual needs

- The trust worked closely with a nurse who specialised in the care of patients who had a learning disability who was employed by another NHS trust. They had developed a "Getting it Right Charter and there was a traffic light system in place. The trust had a section of its website dedicated to people with learning disabilities. The section provided videos on what to do and where to go for different services that the hospital provides. The videos had subtitles so people with hearing difficulties could access the information. The learning disabilities section of the website also provided booklets for patients and staff on treating and assessing people with learning disabilities.
- There was an interpretation service available for patients and their families who did not have English as their first language.

- Patients over the age of 65 were routinely screened for signs of dementia. This enabled staff to put in place the right level of care and escalate any issues. If there were signs of dementia it would be escalated to medical staff to undertake further assessment. We saw examples of completed screening questionnaires and escalation in patient records. We saw patients living with dementia receive one-to-one support and that they were responded to quickly.
- The trust had a dementia liaison team who collected information about a patient's family, social background and history. This was to gain a better understanding of the patient and to ensure the level of care could meet the needs of the individual patient. This information was available to staff in the patient records.
- The hospital had a dementia steering group which focussed on improving care for patients living with dementia. The dementia steering group involved staff from other specialties and organisations, such as the local authority. The steering group had developed a dementia care framework based on national guidance, including the National Institute for Health and Care Excellence (NICE) clinical guidelines.
- In the medical assessment unit (MAU) between 10am and 6pm, a healthcare assistant with qualifications in caring for patients who were living with dementia was available to assist patients in the FEAT lounge. We saw this role as being effective in supporting people living with dementia.
- Patients living with dementia, learning disabilities and mental health problems were provided with one-to-one support, where needed, on wards. Senior nursing staff described how the staffing on some wards was flexible to ensure that patients had the support they needed. There was an increased supervision policy that senior nursing staff could use to increase staffing levels to meet patient needs.
- On Ward 301, we observed that patients and their families had access to a day room. In the day room patients could eat their meals, relax with family members, watch films and take part in group activities. The patient whiteboard on the ward also had just the patients' first names written to try and help patients feel relaxed and to try and create an informal atmosphere. This ward provided rehabilitation for patients with an acquired brain injury. Patients often spent long periods of time on the ward so it was important for them to feel relaxed and comfortable.
- The wards providing care for older people, (Wards 401, 405, and 406) had 'reminiscence rooms' for patients and their families to use. In the rooms there were old photographs, a television, an old radio and games. We found that the reminiscence rooms

were not used while we were visiting. One member of the nursing staff said that the room on their ward was "rarely used". A member of the nursing staff on a different ward said that their room was used once a week. This was due to some patients choosing not to go in there, patient mobility and staffing, especially when there were a number of patients requiring a higher level of care.

- Many of the medical wards provided activities for patients, carers, and their relatives. We were informed by patients and staff of films being shown, day rooms being utilised, and that patients were able to have communal lunches and meals. We observed musicians on one ward entertaining patients and encouraging them to sing along.
- The hospital had utilised arts council funding to set up the 'Banishers of Boredom' (BOB). This was a small team of staff who interacted with patients and provided suitable activities. One example was a board game that allowed patients of different abilities to have varying levels of participation, ensuring no-one felt left out.
- We saw that patients' individual needs were assessed and noted in their records. Staff demonstrated a focus on providing care and support that met patients' individual needs.
- We saw one of the wards had a reminiscence room designed to help improve the mental wellbeing of the elderly patients and patients with dementia. The patients we saw in this room were calm and relaxed and had nothing but positive comments to make about this facility.
- There was a range of community health services initiatives designed to ensure patients received the support they needed both to remain at home without hospital admission and to leave hospital swiftly with appropriate multi-disciplinary care in the community. Community support teams had been established in GP practices, linking community matrons with social care coordinators. A virtual ward in the community was in development, which would enable patients to receive integrated and intensive medically supervised care in their own homes. Staff worked to ensure end of life patients received care in the place of their choice.
- Community staff could access interpreters for patients whose first language was not English, but the service did not monitor the use of interpreters and community staff reported practical difficulties which had not been addressed. Patients' concerns, comments and complaints were not used systematically as an opportunity to learn.

Access and flow

Summary of findings

- Bed occupancy rates for general and acute medicine were 87% between April and June 2014 and 86% between July and September 2014. This was worse than the England average. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. Many of the wards we visited were full and did not have any available beds.
- Data from the trust showed that the majority of patients (92% between April and August 2014) did not have any bed moves during their inpatient stay. No patient moved more than twice upon admission to hospital. Most patients we spoke with had experienced minimal bed moves.
- There were bed management meetings held during the day and, when required, in the evening to discuss available beds, medical outliers, the movement of patients and to discuss those patients that could be discharged from hospital. We observed one bed meeting and saw that there was a comprehensive discussion regarding the management of admissions and discharges. There was effective communication between staff attending this meeting.
- Each ward had a dedicated discharge coordinator who was a member of the nursing staff. The discharge coordinator would take responsibility for ensuring everything was in place for a patient to be able to leave the hospital. This allowed for a single coordinated approach and contact for patients and their families. It also allowed nursing staff to focus on the care and treatment of patients. Some staff raised concerns that the role left numbers of nursing staff short and that there was a lack of cover if the designated discharge coordinator went off sick.
- There was a transfer and discharge team working at the Royal Derby and London Road Community Hospitals. The team worked with wards to identify patients who could be treated more appropriately in the community, rather than in hospital. The team ensured that ongoing care was in place and tracked the patient until they were ready to go home. This provided positive psychological and physical benefits to the patients, such as a reduced risk of infection while they were in hospital, allowing for recovery in a location they were familiar with. This also enabled beds to be made available earlier for patients who were being admitted.
- At the time of our visit, there were five medical outliers across the hospital. Outliers are patients under the care of medical consultants, but placed on other wards, due to a shortage of bed space. Outliers were discussed at the bed meetings each day so that the patients could be moved onto medical wards wherever possible.

- Where patients were not situated on the appropriate ward the hospital had allocated teams and consultants to monitor and care for the patient. Wards had teams and allocated consultants linking them together so that patients could still receive the care and treatment they would get on the appropriate ward.
- The emergency surgery ambulatory care service on the surgical assessment unit involved referrals directly from the GP to the surgeon on-call. We were told that this enabled GPs to discuss individual patient cases and surgeons to provide expert advice and sometimes prevent admission to the trust. The service was piloted at the trust in 2012 and data from that time showed a 40% reduction in emergency surgical admissions. Staff told us the service had continued, but was now a sporadic service that relied upon the availability of a 'spare' consultant.
- Between March 2013 and July 2014, referral to treatment time (RTT) performance was consistently worse than the England average. The trust was not meeting the 90% standard of admitted patients who should start consultant-led treatment within 18 weeks of referral in seven out of eight surgical specialties. We discussed this with senior managers, who identified RTT as a significant challenge. They told us that, through transformation work involving enhanced recovery pathways and additional beds on the elective procedure unit, good progress had been made with the reduction of the number of patients waiting longer than 18 weeks for treatment.
- We saw that RTT waiting lists had been reduced by 35% at the time of our inspection and five out of eight specialties were on target to meet both performance and sustainability by the end of December 2014.

Learning from complaints and concerns

- Nursing staff told us that they received positive feedback and learning from complaints. Feedback from patients was shared in a variety of ways, including staff noticeboards, emails, team/ward meetings and newsletters on the back of staff toilet doors. Ward managers had tried different ways to share the information to ensure that it was seen by all staff. There was a lack of consistency in how information and feedback was shared with staff.
- The medical director produced a newsletter which included learning from complaints.

Summary of findings

- Within the maternity and gynaecology service, complaint themes were shared with staff on their mandatory training days and by the Supervisors of Midwives when they met for their annual appraisal. Complaints were reviewed and discussed at the department meetings.

Are services at this trust well-led?

Good

Overall, we rated the leadership of the services at the trust as "good." For specific information, please refer to the individual reports for the Royal Derby Hospital, community health services for adults, community end of life care and community inpatient services at London Road Community Hospital.

The inspection team made 11 separate judgements about the leadership in services across the trust. All services at Royal Derby Hospital were judged as good for their leadership. Two services within the community services were judged to require improvement.

Vision and strategy

- The trust had an up-to-date strategy in place which was "Quality Through Partnership". The vision and strategy had recently been refreshed following a period of consultation with staff and patients. The trust's long-term vision was: "To be a national beacon for all that is best in the NHS, delivering 21st century healthcare." There were four strategic 'must do's' for the trust, delivering quality in everything they do, including: safety, effectiveness and patient experience, transforming services to maximise productivity and efficiency, creating networks for acute and complex care and develop integrated care for people with long-term conditions to help them stay as health as they could be. The vision and strategy was underpinned by a set of values which were referred to as CARE (compassion, a positive attitude, respect and equality).
- We found that staff could articulate the vision and values of the trust. The CARE values were very well embedded. There was a lot of information around the hospital about the values and the trust used an eye catching logo to publicise them.
- We spoke with a group of six patients who were waiting for an appointment at the Royal Derby Hospital. They visited the hospital frequently. They could also tell us about the CARE values because they had seen them advertised within the hospital corridors. We also found that volunteers at the Royal Derby Hospital knew about them. At a focus group with eight healthcare support workers who worked at the Royal Derby Hospital we heard how they understood how the objectives of the chief executive translated down to their own objectives. It

was impressive to hear this group of staff talk about the appraisal process and how their objectives were linked to the vision, values and objectives of the trust. The governors of the trust could also articulate the vision and strategy of the trust and had been involved in its recent refresh.

- Within the community services, there was a community clinical strategy, which was set out in March 2013. This strategy was to develop integrated services across acute and community hospitals, specialist therapy and community-based therapy, nursing and social care services promoting self-management. Community support teams were established and a therapy review was underway, led by the trust's newly appointed chief therapist.
- There had been considerable upheaval for community staff over the last few years. In 2011, community staff transferred from the primary care trust and were in a "holding position". These changes all contributed to staff feeling disconnected from the trust, overall, and there had not been a clear plan for the services or the community hospital. Since the divisional changes, senior managers had attempted to focus on the community services, making sure care pathways extended into the community. There had been successful sector-wide improvement events involving staff at all levels.
- The community services manager said there was now a clear vision for the hospital site but it was not clear if this had been shared with staff.

Governance, risk management and quality measurement

- Since the divisional reconfiguration in April 2014, new governance and performance structures had been established. The trust was divided into three divisions, each with a clinical lead, a nursing lead and a management lead. There was a divisional governance structure within each division and a clear reporting structure up to the trust board.
- Each business unit had monthly performance and governance meetings. These identified items for escalation which were reported to the equivalent monthly divisional meetings. From there issues were escalated to the trust's quality and risk committee, and via the quality committee to the trust board. Managers told us they received responses and feedback from the divisional director.
- In the governance meeting minutes we saw, managers discussed items on and for the risk register but there was no

record of agreeing items for escalation to divisional level. They contained brief discussion of incidents focused on requests for further information and issues concerning levels of reporting, rather than learning from them.

- In the business unit that covered the community services, we saw that the governance report for November 2014 showed the top three risks to be: district nursing staffing, ward staffing and lack of medical and advanced nurse practitioner cover on the wards. District nursing and ward staffing were placed as high risks on the divisional risk register in October 2013. In November 2014, they remained at the same level of risk, with a rating of 15. Lack of medical cover was placed as a high risk on the register in June 2014 and remained a high risk at the same rating of 12. We looked at quality review committee meetings in June, July and August 2014, at which the division was represented by the divisional nurse and medical directors. In the three sets of minutes there was only one instance of one of these risks (ward staffing levels) being highlighted, although district nursing staffing levels was also escalated to the trust wide Quality Committee from this meeting in July 2014.
- Despite the admirable efforts of the lead matron working within the community nursing service, long standing risks associated with district nursing staffing levels and demands on the service had not been reduced. The concerns about staffing numbers and the capacity to meet demand and compliance with mandatory training were escalated to the safe staffing board and the trust quality committee most recently in September 2014. Challenges to recruitment to this service were discussed with the trust board at a board time out. The management executive also received reports about the difficulties with staffing from the safe staffing board. All teams had started the productive community modules aimed at improving efficiency and the quality of patient care. Funding had been made available for additional support worker posts and these posts had recently been recruited to. These actions had made little impact on the increasing vacancy rates and work demands. There had been initiatives undertaken to try and attract new staff but this remained a challenge. the trust were setting up a programme of health and well-being to support staff. The community services manager described monitoring 'hot spots' of pressure on staff, but he was unable to tell us where these were.
- The trust had a Board Assurance Framework (BAF) in place and high level risks were reviewed by the board on a quarterly basis. The audit committee reviewed the full BAF and were the

delegated committee with responsibility for providing assurance to the board on process. All risks on the BAF had an action plan to mitigate the risks and we found these action plans and progress actions to be up to date. We did not identify any concerns with the BAF.

- We met with the trusts internal audit team who provided assurance to the audit committee. The internal auditors told us there were good controls in place. All of the internal audits had action plans with agreed timescales as well as identified leads for who was responsible for delivery of the plans. There was formal follow up of action plans in place. We saw the audits focused on lessons learnt.
- The trust board had five formal sub committees one of which was a quality committee and was chaired by a non-executive director. The nursing, medical and the chief operating officers were also members of this committee.
- Both the non-executive and the executive directors told us they believed there was a good amount of challenge between them. Without exception they all told us they felt able to challenge each other but in a supportive way. The CEO was aware of the strengths and weaknesses of her leadership team and used this knowledge to ensure there was supportive challenge and her executive directors were supported.
- Governors told us they felt supported by the trust, were able to raise areas that required improvement and could challenge. Importantly, the Governors felt listened to. Governors had an annual appraisal and a daily briefing was sent around to them to keep them updated of current issues within the trust.
- The trust used dashboards to present key performance metrics such as staffing levels. These were monitored through the different levels of governance throughout the divisions as well as by the quality committee. The trust recognised more development of the dashboard relating to community services was required.
- There was a Cost Improvement Process (CIP) in place. All cost improvements were reviewed by the nursing and medical director. We saw evidence of CIP's being challenged and rejected if it was felt they would impact on quality and safety. The trusts CIP target was 3% which was considered to be low. However, the trust had previously been through a programme of service redesign.

Summary of findings

- The trust board did not hear patient stories. The quality committee did have patient stories and themes were reported through to the trust board by the chair of this committee.
- Both CQC and the commissioners of the service received comments from patients about their dissatisfaction with the trust's complaints process. Complaints management was an area the trust had been trying to improve and they were aware of their weaknesses. The trust had told their commissioners that during 2014/15 they had focused on embedding the new complaints policy, training of lead investigators and improving response rates and quality of complaint letters. in 2015/16 they would focus on driving forward learning. The trust had previously been set a compliance action by the CQC in 2013 because it had breached the regulation in relation to the management of complaints. We found that this regulation was now met but the trust needed to ensure this improvement was sustained.
- The head of complaints role had been vacant for some months, although a new member of staff had recently been appointed and was shortly due to take up their post. The trusts target for responding to complaints within the 25 or 40 day timescale was not always met although performance had recently started to improve significantly. In December 2014, the trajectory was for 70% of complaint responses to be within accepted timescales, but the actual performance was better and was 72%. Barriers to the improvement of response times were reported as being at the investigation stage where staff might not always be available to investigate. The quality of the responses was also a barrier and the need for further training on the expectations from complaints investigations had been undertaken.
- An internal review group for complaints had been set up, which included representatives from the Patient Advice and Liaison Service (PALs), the council of governors, non executive directors and a range of trust staff. They sampled 24 complaints every year as part of the trust's Commissioning for Quality and Innovation (CQUIN) payment framework targets. CQUIN targets are created by the commissioners of the service in order to improve quality and better outcomes for patients. An audit on complaints management had been undertaken and an action plan to improve performance was in place and it was being monitored. Weekly complaints meetings were being held to monitor performance. All patients who had complained received a survey after the resolution to gain feedback of their experience. However, the response rate from the surveys was

poor. At the time of our inspection, there were 142 open complaints, 16 of these had been open over 40 days and 16 fell between the 25 and 40 day timescale. One hundred and ten complaints were still within timescales and were still under investigation. The trust trajectory for their quarter two 2014/ 2015 CQUIN target was on track.

- We saw evidence that they were learning from complaints but more development was required to ensure this was consistent across all of the services. There was no system in place to spread the findings and recommendations from the Parliamentary and Health Service Ombudsman. improving learning from complaints was a priority for the 2014/15 improvement plan.
- Best practice in offering patients who had complained a meeting with trust staff was in place.

Leadership of the trust

- The profile of the chief executive officer was high within the acute part of the trust. Many staff told us she had worked in their areas. She was very visible in the Royal Derby Hospital but less so in the community hospital and within the community teams.
- The medical director commenced in post in March 2014. Medical staff spoke positively about this new appointment. The medical director was highly visible at the Royal Derby Hospital but was less visible in the community part of the trust.
- The chief nurse/director of patient experience was visible, particularly within the acute hospital. Nurses knew who she was and many nurses told us she was approachable. Nursing staff spoke positively about the chief nurse and senior nurses felt she was a good ambassador for them. The chief nurse was less visible within the community services, although community teams knew who she was. The chief nurse was very aware that there were pressures in the community, particularly within district nursing teams
- The trust had recently appointed a chief therapist in order to provide stronger leadership for the increasing number of therapists within the trust. The majority of staff were positive about this new appointment, although some felt it wasn't needed.

- There were board to ward sessions where members of the trust board visited clinical areas, teams and departments. The chief nurse went back to the floor most weeks and she included community services within this programme.
- There was good strong leadership for quality and safety provided by a non-executive director who had a clinical background. The board member was very well respected by clinical staff and the leadership team alike.
- There appeared to be a shared vision across the executive team. Governors had been invited to join a range of different groups which focused on quality. The non-executive directors had a broad range of experience, including backgrounds in health as well as private industry.
- The trust had a talent map in place which was linked to the objectives of the trust. There were development programmes in place to support staff who had been recognised as having potential for promotion.

Culture within the trust

- We talked with staff about whether they felt able to raise concerns and speak openly within the trust. The vast majority of staff that we spoke with did feel able to report concerns and felt well supported, there were a small number of staff who contacted us to say they did not feel able to speak out and didn't feel they were listened too. There was a feeling amongst some of the more senior clinical staff that in the past there had been a culture where challenge was perceived as criticism but this was not the case anymore. The medical director had introduced weekly open sessions for doctors where they could drop in to talk with him. We found the medical director was approachable and very open with our inspection team.
- Two of the non-executive directors had commenced surgeries for staff so they could talk about areas of concern in a safe environment. There had been six sessions to date and around 20 staff had attended, two of the sessions had been held at the London Road Community Hospital. There were two planned sessions for March 2015 to be held in the community so that community staff could access these. The trust had also set up an email hotline direct to the non-executive directors whereby staff could raise concerns anonymously if they wanted to.
- We met with the staff side representatives at the trust. They told us they felt there was a positive culture within the organisation despite the pressures placed on staff. There was recognition

that the hospital was getting busier and busier and never closed its doors and this affected staff morale. They told us they had noticed an increase in the number of staff experiencing mental health problems.

- Staff side told us there were five cases of bullying being investigated at present. This was consistent with what the HR team told us. Staff side told us they felt the number of cases had increased over the past five years but they did not feel there was institutional harassment or bullying in the trust. They were positive about the leadership development programmes for managers and the introduction of more policies to empower staff. There was a partnership forum in place which was a forum that acted as a broker between staff, managers and the unions. This group met monthly and it was described by both staff and management sides as an effective group.
- Although communication with community services was improving there was still a feeling amongst staff working in the community that they were not an integral part of the trust. They felt senior managers did not have genuine insight into their roles and challenges. These ranged from persistent problems with essential car use, to accessing patient information in the community, to the impact of new initiatives on already stretched teams.
- Members of the executive team visited the community hospital to attend staff forums, but these were held during patient contact time and workload pressures meant staff were not always able to attend. We were not provided with any feedback from these events since February 2014, so it was not clear what recent outcomes were. There was no designated board lead for community services.
- Sickness absence rates reflected a similar patter to the England average, although in 2014 they were lower than the England average. Sickness absence in community staff was higher than the trust average.
- The staff survey results for 2013 showed some improvement from the 2012 survey. Positive scores for team work, work pressure and staff recommending the trust as a place to work or receive treatment had increased. The areas where the trust scored the lowest related to staff feeling pressure to attend work when feeling unwell, the percentage of staff witnessing potentially harmful errors, near misses or incidents and the percentage of staff experiencing bullying harassment or abuse from patients.

Summary of findings

- There was a trust wide staff survey action place in place which was then broken down to divisional and department level. The plans were monitored by the HR team. The trust has placed increasing importance on communicating with its staff and the efforts that were being made were recognised by the union representatives we spoke with. A number of listening events had taken place to encourage staff to provide feedback about the way services were delivered and improved.
- The union representative told us that equality and diversity (E&D) was given increasing priority. Monitoring of E&D in mandatory training was taking place and the trust was taking steps to promote opportunities for staff within minority BME groups. The trust had a diverse workforce and followed the NHS Equality Delivery Scheme with goals in place which were monitored. There was a lead Director for equality and diversity and training was included as part of the trusts suite of mandatory training. We saw the trust had taken part in various campaigns, such as Dignity at Work, Derby PRIDE, LGBT month and Black History Month.
- It was clear to us from our focus groups with all of the different staff groups that they were very committed to their roles and wanted to do their best for their patients. Staff working at the Royal Derby Hospital were proud of the facilities they had for patients and many staff commented on how lucky they and their patients were to have a new hospital. However, there was no doubt that the nursing and Allied Healthcare Professional workforce were concerned about increasing workloads and the pressure associated with this. Community nurses were very stretched and they were worried about the impact on the quality of care that they could provide.
- Staff working at the Royal Derby Hospital were concerned about the impact on some staff groups of the 12-hour shift pattern. While this suited some staff very well, there were other staff who struggled with working for 12 hours. We were told that the trust had introduced a six-hour shift, but it meant the staff member's weekly hours had to be reduced in order to facilitate the change. The trust told us staff could choose to work reduced hours. The shift patterns were a concern expressed by senior nursing staff when we carried out our focus groups.
- Despite staff telling us about the pressure they felt, the majority also told us the trust was a friendly place to work and there was good teamwork. Almost all staff felt the team spirit helped them cope with the pressures of working within a very busy acute and community trust. In most cases, staff felt they received good support from their immediate managers. Although

community staff felt supported by immediate line managers, many were not aware of the local management structures. There was a tendency for teams in the community to work in silos, without the time, or facilities to interact with other teams and professional groups.

- Many staff, as well as patients and visitors, told us they felt unhappy about the car parking arrangements. For some staff, the car parking issues really affected their experience of work. Some staff had to park some distance from the hospital, which added time to their working day although there were drop off bays for staff to use. Community therapy staff told us that there were discrepancies between those staff who paid for parking and those who didn't,. The trust confirmed that for staff who transferred into the trust from a different NHS organisation as part of the reconfiguration of services, they had their first year of car parking fees waived as part of the transition agreement. Some staff had completed this transition period and some were still in their free year. There was a parking fee waiver in place for community staff who spent less than eight hours a week parked on site. Community staff did not have reserved parking and they sometimes had to take equipment to their cars down a gritty and muddy path. This was to be addressed in 2015/16 and was on the London Road hospital improvement plan. When staff returned to base again they had no certainty of getting a space and by the time the community staff came back in the late afternoon they had to park a distance away and again carry the equipment back into the building. Community staff were very frustrated by this and they felt it dissuaded people taking jobs at the trust.
- The CEO told us car parking problems had been exacerbated by nearby major road works. Despite the concerns by staff and patients, the trust had planning obligations to meet and they were unable to create more car parking space. The trust did have a travel plan in place and had worked in partnership with Derby City Council and local transport providers to increase the use of other modes of transport. They provided an incentive scheme for staff who shared cars or used a bicycle for work and there was a detailed policy in place for staff and visitor/patient parking.

Fit and Proper Persons

- The Fit and Proper Person's regulation came into effect on 28th November, just prior to this inspection.
  The aim of this regulation is to ensure that all board level appointments of NHS trusts, carrying on a regulated activity are

responsible for the overall quality and safety of that care, and for making sure that care meets the existing regulations and effective requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The fit and proper person regulation is about ensuring that those individuals are fit and proper to carry out this important role. The new regulation has been introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust , which recommended that a statutory fit and proper persons requirement be imposed on health service bodies.

- We found the trust were at an early stage in their journey to ensure they met the requirements of the regulation and this will continue to be monitored by the Care Quality Commission.
- The trust board had undertaken a discussion about the requirements at its November 2014 public board meeting. A range of actions were confirmed and agreed. These included a self-declaration by all of the trust board and covered a range of areas including convictions, competency, health, professional registration, confirmation of qualifications, and solvency and bankruptcy checks.
- Job descriptions and terms and conditions for any relevant new posts to the trust were in the process of being verified to include reference to the requirements of the fit and proper person test.

Public and staff engagement

- The 2013 staff survey gave the trust an overall indicator for staff engagement of 3.75 out of 5 (higher score the better). This score was average when compared with other similar trusts. Engaging with staff and ensuring staff felt communicated with was a priority for the leadership team. We found this was more evident within the Royal Derby Hospital site than in the community. The leadership team was aware they had more work to do to engage with staff working within the community.
- The trust had a staff awards scheme in place. This was well very well publicised throughout and hospital and many staff told us about the scheme and spoke positively about it.
- Patient engagement was well developed. The trust website provided opportunities to leave feedback. The trust had relationships in place with Healthwatch Derby. We found examples of services engaging with patients and making changes as a result of feedback.

Summary of findings

- Following extensive consultation with over 2000 patients, staff and the general public, a list of people's top five moments that mattered most to them was produced. Feedback was gathered from a range of sources so the trust could monitor how well they were doing against the five pledges. We saw the pledges were publicised throughout the hospital.

Innovation, improvement and sustainability

- The commissioning contract for district nursing did not reflect current activity which meant teams were under-resourced. Both the CCG and trust managers were aware that nurses were carrying out roles that were outside their remit. The district nursing teams were subject to increased referrals. In September 2014, the lead matron reported to the safe staffing board that teams were carrying out medication prompts and continuing care assessment, previously carried out by social services, as well as continence care for patients not meeting their criteria. As one community team leader said, "The district nursing service never says no, we feel at saturation point."
- Community health services had a number of initiatives to support people in the community without the need for hospital admission. A virtual ward had just started. This would be able to provide more integrated, intensive support in the community so that people could receive medically supervised care and treatment in their own homes. The new chief therapist had been instrumental in driving this development. Initially this was being staffed by the existing intermediate care services team.
- The trust had an active volunteer service with over 500 volunteers. The volunteers provided a wide range of services including a Home from Hospital service which provided a volunteer to visit a patient for up to four weeks once they had been discharged home. There was also a popular programme in place through a school link scheme to provide younger people with opportunities to volunteer in the hospitals.
- SpARC was one of only two UK Centres of Excellence in Parkinson's research, care and outreach, nominated by the US National Parkinson Foundation. Senior staff and consultants were active in research in the field and the lead physiotherapist had developed a validated, objective measure of functional mobility. The palliative care team had produced a training DVD for staff, and an associated facilitators' handbook.

Summary of findings

- The trust held integrated care and community services rapid improvement events in May and December 2014. Therapists were enthusiastic about their involvement and the potential for developing new ways of working across the health and social care community in Derby.
- Sustainability was fragile in the community service, the latest board assurance framework available showed that the inability to deliver an effective integrated community services offer was identified as a very high risk at “almost certain/major”.
- The trust was forecasting a financial deficit of around £15 million and was in breach of its license with Monitor because of this. A long term recovery plan was in place and this had been agreed with Monitor. Although financial pressures were a significant challenge for the trust we did not identify areas where quality was being reduced to save money. The director of finance was fully sighted on quality and safety issues.

Outstanding practice and areas for improvement

Outstanding practice

Outstanding practice - urgent care

- Certificate of Eligibility of Specialist Registration (CESR) project work in the department, allowing recruitment of middle grade doctors at a time of national shortage and offering career progression to this group.
- There was 24 hour mental health liaison support with a one hour target response time for patients in mental health crisis.
- The VISA assessment process for patients at risk of self-harm.

Outstanding practice – surgery

- Ward 205 is to be commended for helping to improve the mental wellbeing of the elderly patients and patients with dementia through use of the reminiscence room, pictorial information and advanced service planning to further enhance care.

Outstanding practice – critical care

- Echocardiography was used as the main monitoring tool of cardiac output and fluid status for intensive care patients. Point of contact echocardiography for these patients is a highly innovative and valuable service.

Outstanding practice – maternity and gynaecology

- The maternity department bereavement service had been recognised by the Royal College of Midwives. The lead midwife had been nominated for the Royal College of Midwives Award 2015 National Maternity Support Foundation Award (NMSF) for Bereavement Care, improving the environment, which was known to be an important key to effective bereavement care.
- The birthing centre promoted a home from home environment with the security of medical support when necessary.

Outstanding practice – children and young people's services

- The KITE (kids in their environment) team provided an innovative outreach support service to children with chronic conditions in their homes. The service had proved popular and they were expanding and developing the service as a result. This included employing a youth worker for the team.

Outstanding practice – end of life

- The Nightingale Macmillan Unit was dedicated to providing end of life care to patients with life-limiting illnesses and staff were able to respond appropriately to meet the individual needs of patients. The facilities and resources available for patients on the unit were excellent. The unit operated a 24-hour advice line for patients at home, their carers and health professionals.
- The mortuary had excellent facilities to promote teaching.

Outstanding practice and areas for improvement

Outstanding practice –Community end of life care

- Staff were passionate and committed to providing a good standard of end of life care for patients. Staff were positive about their role and the work they were doing despite the resource difficulties they were experiencing.
- The holistic therapy service in the Nightingale Macmillan Unit provided an excellent service to patients from the community .

Outstanding practice – medical care

- The frail elderly assessment team (FEAT) lounge on Medical Assessment Unit (MAU) was provided for people living with dementia.
- The MAU had pharmacists on the ward 12 hours each day, seven days a week. They worked as part of the FEAT with the aims of optimising the use of medicines. The overall aim was to help patients make the most of their medicines.
- Respiratory medicine had introduced the use of patient colour-coded wristbands to identify how much oxygen each patient needed. Excessive amounts of oxygen can be dangerous for some patients and it is important that the correct amount of oxygen is administered.

Outstanding practice - community inpatient services

- There was good multidisciplinary and integrated on the wards and supporting intermediate care beds, which clearly placed the patient at the centre of care.

Outstanding practice and areas for improvement

Outstanding practice - Community health services for adults

- Staff were passionate and committed to providing a good standard of care for patients. Staff were positive about their role and the work they were doing despite the resource difficulties they were experiencing.

Areas for improvement

Action the trust MUST take to improve

- Ensure that patients thought to have reduced mental capacity or those who lack mental capacity to receive prompt and effective assessments in line with the Mental Health Act 1983.
- The trust should ensure all DNA CPR order forms are completed accurately in line with trust policy and the Mental Capacity Act (2005).

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
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person must ensure that the service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of: (a) an accurate record in respect of each service user, which shall include appropriate information and documents in relation to the care and treatment provided to each service user. DNA CPR order forms were not recorded accurately in line with trust policy. This generated the risk to the delivery of safe patient care and treatment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not take appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced district nursing staff employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have suitable arrangements in place to ensure that all district nursing staff were able to attend mandatory training and other essential training as required by the needs of the service.

This section is primarily information for the provider

Compliance actions

[Regulation 23 (1)(a)]

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 The provider did not have suitable arrangements at the London Road Community Hospital and the Royal Derby Hospital for establishing and acting in accordance with the best interests of patients without the capacity to give consent to care and treatment, in line with the requirements of the Mental Capacity Act 2005. (Regulation 18 (1)(b) & (2))

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider did not ensure that electronic patient records could be located promptly by staff visiting patients at home, before providing care and treatment . [Regulation 20 (1)(a) & (2)(a)]