This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Derby Teaching Hospitals NHS Foundation Trust acquired Burton Hospitals NHS Foundation Trust on 1 July 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations. The newly formed organisation became University Hospitals of Derby and Burton NHS Foundation Trust.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data relate to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Hospital sites at the trust

The trust operates acute and community services from five main sites shown below. Additionally, the trust has two adult community outpatient surgeries based in Uttoxeter and Swadlincote in South Derbyshire as well as a paediatric community service.
<table>
<thead>
<tr>
<th>Name of hospital site</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Road Community Hospital</td>
<td>London Road, Derby, DE1 2QY</td>
</tr>
<tr>
<td>Queens Hospital</td>
<td>Belvedere Road, Burton-on-Trent, DE13 0RB</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>Uttoxeter Road, Derby, DE22 3NE</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>Trent Valley Road, Lichfield, WS13 6EF</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>Plantation Lane, Mile Oak, Tamworth, B78 3NG</td>
</tr>
</tbody>
</table>

(Source: Trust Website)

University Hospitals of Derby and Burton NHS Foundation Trust is one of the largest NHS trusts in the country and covers the Peak District and southern Derbyshire. The Trust employs approximately 12,500 staff, serves a population of more than one million and provides clinical services in 48 specialities.

The trust has 1,708 in-patient beds over 79 wards. These include 176 children’s beds (acute, community and mental health), 21 dedicated end of life care beds and 152 day case beds. The trust operates 2,192 outpatients’ and 43 community clinics per week.

**Patient Numbers**

**Burton Hospitals NHS Foundation Trust (provided for contextual purposes)**

**Inpatient admissions**

20,765

**Outpatient attendances**

188,137

**A&E attendances**

40,831

**Number of deliveries (Babies Born)**

1,629

**University Hospitals of Derby and Burton NHS Foundation Trust**

**Inpatient admissions**

167,941

**Outpatient attendances**

1,242,920

**A&E attendances**
214,514

Number of deliveries (Babies Born)

6,275

(December 2017 to November 2018 Hospital Episode Statistics)

What people who use the trusts services say

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The trust submitted no data for July 2018. Otherwise the trust scored about the same as the England average for recommending the trust as a place to receive care in all other months from December 2017 to November 2018.

Burton Hospitals NHS Foundation Trust

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.
The trust scored about the same as the England average for recommending the trust as a place to receive care from December 2017 to June 2018.

(Source: Friends and Family Test)

Patient-led assessment of the Care Environment (PLACE) 2018
Burton Hospitals NHS Foundation Trust (provided for contextual purposes)

In the Patient-led assessment 2018 of the care environment for all indicators, privacy, dignity and well-being, cleanliness of environment, environment for dementia care and assessment of facilities and food:

- Queens Hospital scores were below the England average in all indicators.
- Samuel Johnson Community Hospital were above the England average in two out of six indicators (condition, appearance and maintenance and disability).
- Sir Robert Peel Community Hospital were above the England average in three out of six indicators (cleanliness, food/hydration and dementia).

University Hospitals of Derby and Burton NHS Foundation Trust

In the Patient-led assessment 2018 of the care environment for all indicators, privacy, dignity and well-being, cleanliness of environment, environment for dementia care and assessment of facilities and food:

- Royal Derby Hospital were above the England average in four out of six indicators (cleanliness, privacy, dignity and wellbeing, condition, appearance and maintenance and disability).
• London Road Community Hospital were above the England average in five out of six indicators (cleanliness, food/hydration, privacy, dignity and wellbeing, condition, appearance and maintenance and disability).

CQC Inpatient Survey

Burton Hospitals NHS Foundation Trust (provided for contextual purposes)

Feedback from adult inpatients (aged 16 or over) who spent at least one night in hospital during July 2017.

• Where has patient experience improved from 2016 to 2017? Five areas have improved:
  - Being offered a choice of food
  - Enough privacy when being examined in A&E
  - Staff answering questions before operation/procedure
  - Length of time on waiting list before being admitted to hospital
  - Notice given about discharge

• Where has patient experience declined from 2016 to 2017? One area has declined:
  - Treated with respect & dignity

University Hospitals of Derby and Burton NHS Foundation Trust

• Where has patient experience improved from 2016 to 2017? Two areas have improved:
  - Being told how to take medication
  - Time between arrival and getting a bed on a ward

• Where has patient experience continued to be better? Two areas performed better than expected:
  - Being offered a choice of food
  - Hospital changing admission date
Is this organisation well-led?

Leadership

To write this well-led report, and rate this organisation, we interviewed members of the board, including both executive and non-executive directors. We held focus groups with a range of senior staff across the trust, this included a wide group of clinical and non-clinical service and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

We carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. A fit and proper persons (FPPR) procedure was in place. The trust chairman explained his responsibilities in relation to the fit and proper person requirements.

Fit and Proper Person checks were in place. We reviewed the personal files of four executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. Board members completed annual self-declaration forms to confirm that they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found all files were fully compliant with FPPR.

There was clear leadership of the trust to drive and improve the delivery of high-quality person-centred care. Leaders were visible and approachable and were mindful of the importance of being visible across all five sites.

The board included full-time executives and part-time non-executive directors. Non-executive directors are not full-time employees of the trust. They help to ensure the trust is accountable to the people it serves. They are people who live or work in the area and have shown an interest in the provision of health services for the local people.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The board of directors included a chief executive, executive director of finance and performance, executive medical director and deputy chief executive, executive director of strategy and integration, executive managing director (Burton), executive chief nurse, executive chief operating officer, executive director of workforce and organisational development and nine non-executive directors. The chairman of the board was a non-executive director. The board understood the challenges of the new organisation and were able to articulate these challenges and priorities clearly.

Leaders were clear about their portfolios and recognised there was a need to keep these under review. We noted the chief nurse had a particularly large span of accountability.

The executive medical director was the executive lead for mental health, mental capacity and deprivation of liberty safeguards. The executive chief nurse was the executive lead for safeguarding, learning disability and autism.
The board of directors was accountable to the non-executive directors for the running and performance of the trust and was supported by the audit committee, quality committee, finance, investment and performance committee, nominations and remuneration committee and the people committee.

The trust had 41 governors on its council. The council of governors helped to shape the strategic direction of the trust. Their role was to hold the non-executive directors individually and collectively to account for the performance of the board on behalf of all trust members and the public. The governors oversaw the performance of the trust, appointed the chairman and non-executive directors and acted as a link between the trust and its members and the wider community. Governors spoke highly of how inclusive they felt the board were and how they felt able to contribute to discussion and influence decisions.

There was evidence of a shared understanding across the Board of the financial position and challenges facing the trust. Prior to our inspection we attended a board meeting. The board meeting was appropriately chaired with the chair promoting contributions from all members, including governors. It was clear the influence the NEDs had on the overall leadership of the trust, we saw an appropriate level of challenge from NEDs at board meetings. We observed trust and respect around the table and it was apparent the board members were open and challenged each other professionally and openly. However, the agenda did not balance time effectively, whilst we were there the agenda had overrun by an hour. Senior leaders told us it was ‘normal’ for the board meeting to overrun.

Leaders welcomed new or improved ways of organising or providing care through outcomes of regular external governance reviews. The most recent having taken place immediately prior to our inspection. In addition, reviews of individual specialties had also taken place. For example, orthopaedic and maternity services.

The trust had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership and there was a development programme, which included succession planning. Talent management and succession planning was supported through various interventions at the trust. For example:

- Two candidates were on the ASPIRE Programme. This is a national talent pool for staff ready for executive director roles.
- A detailed succession planning programme had been delivered for matron posts to both identify the skills gaps between senior sisters and matrons, the key recommendation from this work was to create rotating band 6 roles to start development for staff earlier than the senior sister role.
- There was a steady flow of staff access coaching for talent and development conversations; and coaching was promoted to staff who were new to role to support their first 100 days in post.
- A wide range of apprenticeship programmes were promoted including developing health care assistants (HCAs) into nursing associate roles and offering an MSc in leadership to senior managers.
- A job transfer pilot for HCA’s and registered nurses had been run to encourage exposure to different areas for skills development, but also to aide retention.
- Band 5 nurses were offered rotations to support their breadth of experience to enable career progression.
- Staff development in the physiotherapists and occupational therapist roles was promoted through acute, social care and community roles.
Linked with the trust’s talent management and succession planning programme was the trust’s ‘flagship’ programme; DB LEAD Programme of Exemplary Leadership. This programme was for aspiring senior leaders and facilitated by existing exemplary leaders. Consisting of eight modules the programme concluded with a presentation to the trust board and included a recommendation for the board to take forward. Examples of projects taken forward included:

- Just culture
- Training and awareness for line managers supporting staff with mental health problems
- Simple ‘culture’ questionnaire for line managers.

The Workforce Planning and Talent Management Group met monthly to coordinate workforce planning, talent management and development activity across trust.

As part of the leadership strategy of the new organisation, the trust implemented a trust-wide directorate structure to ensure services on all sites were delivered in a consistent and equitable way. The trust had an operational structure which comprised of five divisions; medicine, surgery, women and children’s, cancer diagnostics and clinical support and corporate. Triumvirate leadership was provided at divisional level by a divisional medical director, divisional director and divisional nurse director. Business unit triumvirate leadership consisted of a general manager, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by ward/department managers.

Pharmacy services were led by a chief pharmacist (CP). The CP explained the structure of the department across the two sites and the plans to appoint an additional deputy to ensure succession planning supported the delivery of the pharmacy departments priorities. The structure was in the process of being aligned to ensure that all key clinical and senior organisational groups were supported by the senior pharmacy team.

### Board Members

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 25.0% were female.

Of the non-executive board members 0% were BME and 22.2% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>22.2%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

There was a lack of diversity amongst board members. The board was not reflective of the local population; however, the board were aware of this and had started to act to help develop a more diverse senior team. For example, positive action statements were to be included on job adverts for senior leaders to encourage applications from diverse groups.

The construct of the Board was scrutinised during the NHSI assessment of the transaction to acquire Burton Hospitals NHS. The assessment considered the leadership capacity and capability
under the Transaction Execution domain, for which an Amber-Green rating was issued. This was because the trusts were found to have planned well for the acquisition, had a detailed Post Transaction Implementation Plan in place and had a fully appointed prospective Board. However, there was some concern that a new role of (Executive Managing Director, Burton) might lead to confusing accountabilities and lack of clarity over decision making. During the inspection we explored this role and did not find any evidence of this and the role appeared to be working well.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a clear vision and credible strategy to deliver high quality sustainable care. The board were especially patient focused. It was very clear during our interviews of how important it was to not lose sight of the promises the board had made when they undertook the acquisition.

The acquisition of Burton hospitals was based on the opportunity to improve NHS services for the local population, and the strategic rationale was rated Green in the NHSI transaction assessment. The trust provided regular updates on progress post the transaction. In February 2019 they provided an overview which emphasised how their approach took into account population needs and requirements as well as alignment with wider system and national ambitions. It was clear from the meeting that the trust was continuing to progress the ambitions set out in the transaction business case, although the pace of change had been slower than originally planned.

At the time of our inspection staff were working towards a vision of ‘Exceptional Care Together’, the CARE values of ‘Compassionate, Approachable, Respect and Excellence’ and the PRIDE priorities:

- Putting patients First
- Right care, first time
- Invest our resources wisely
- Develop our people
- Ensuring value through partners

Following the creation of University Hospitals of Derby and Burton in July 2018, the trust undertook a wide-ranging engagement exercise involving staff from the across the five hospitals. Using an external engagement platform, the vision, values and strategy of the trust had been developed in collaboration with staff, people who use services, and external partners. Staff shared 1,910 ideas, comments and votes to define and validate the trust’s new vision.

The vision of ‘Exceptional Care Together’ remained the same, but with a new vision statement created by staff. Staff replaced the CARE values with ‘Compassion’, ‘Openness’ and ‘Excellence’, and to each of these they attributed three behaviours they wanted to see (nine in total). Finally, staff kept the PRIDE objectives, with some of the wording amended to fit the new vision and values.

**Exceptional Care Together:** Together we make a difference; we save lives and improve health, caring for everyone who needs us. We will be the best place to work, learn and receive care in the NHS, applying the highest levels of skill, knowledge and research.
As part of a structured planning process, 2,300 ideas, comments and votes were contributed in relation to ‘How should everyone at UHDB behave’. Together, these contributions resulted in the following values and behaviours framework:

<table>
<thead>
<tr>
<th>Value</th>
<th>Behaviour and description</th>
</tr>
</thead>
<tbody>
<tr>
<td>We value compassion</td>
<td>• We show kindness&lt;br&gt; • We behave with integrity&lt;br&gt; • We are thoughtful</td>
</tr>
<tr>
<td>We value inclusivity</td>
<td>• We behave with respect and value everyone&lt;br&gt; • We collaborate&lt;br&gt; • We actively listen, give and seek feedback</td>
</tr>
<tr>
<td>We value excellence</td>
<td>• We take responsibility&lt;br&gt; • We continuously learn and grow&lt;br&gt; • We push boundaries and challenge ourselves</td>
</tr>
</tbody>
</table>

Collectively, the trust’s staff supported five key objectives (PRIDE):

- **Put our patients and communities first**
- **get things Right first time when we must and create a safe environment to innovate when we can**
- **Invest our resources wisely**
- **Develop and nurture our colleagues**
- **Ensure improvement and innovation through partnership**

The new vision, values and objectives were to be launched in May 2019.

The trust was in the process of building a long-term overarching strategy by March 2019. This would set out ambitions to improve patient care, secure important services at Queens Hospital Burton, develop tertiary services based at Royal Derby Hospital and make best use of community hospitals. This was informed through a comprehensive staff, patient and stakeholder engagement process.

The trust’s ‘5 Strategy’ described the scale of the operational and financial challenge facing the organisation (and the wider health local health economy) and how through significant system wide transformation, they sought to work collaboratively with commissioners and other health and social care providers to deliver a sustainable health and social care system.

The 5 Strategy had been aligned to the trust’s five key objectives. These plans (known as plan on a page) were broken down into the five values. Abbreviated to PRIDE, the plan on a page had annual objectives which outlined the contribution to the overall aims of the strategy.

The strategy was to articulate an approach to changing the way the trust delivered services:

- Grow some complex and tertiary services,
- Shift low complexity work into appropriate settings
- Consider disinvesting in unsustainable services
• Innovate and Improve quality and productivity
• Reduce unwarranted variation
• Reduce unscheduled admissions
• Develop new and alternative forms of health provision
• Help operationalise integrated care locally
• Support self-care leveraging knowledge and technology

The strategy was to be supported by a number of enabling strategies; quality, transformation, people (which included an inclusion framework/agenda), finance, information management and technology, and estates.

The trust was actively engaged in STP working and ensuring that its Strategy aligned with key STP priorities. The trust’s capital programme included three schemes that have been prioritised by the STP to aid transformation, and these are supported by STP capital funding.

Other areas of the strategy and plans which were fully aligned with plans in the wider health economy included, recognising the mental and physical health of the local population, and there was a commitment by all board members to system-wide collaboration and leadership. Without exception senior leaders knew and understood what the vision, values and strategy were, and their role in achieving them. During our core service inspection most staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their teams. The board, senior leaders and frontline staff across the organisation lived the vision and demonstrated the trust values.

The hospital pharmacy transformation plan formed the medicines optimisation plan for the trust. The priorities were to set up a wholly owned subsidiary pharmacy for outpatient medicines supply and the adoption of biosimilars, automation of medicines supply and new automated dispensing cabinets at ward level.

The Chief Pharmacist (CP) had established a 24/7 on site pharmacy cover at the Derby site and had recently started a seven-day service at the Burton site to include a dispensing, supply and clinical service. A new deputy pharmacist post had been created to replace an existing post to assist in a portfolio approach of managing the team.

**Culture**

The executive board were committed to promoting a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Throughout this inspection and through our observation of the trust we saw cooperative, supportive and appreciative relationships among the executive team. The executive team worked collaboratively, shared responsibility and resolved conflict quickly and constructively.

Candour, openness and honesty were the norm for the board and leaders all spoke about empowering staff to drive improvement. The work the board had done on freedom to speak up was recognised and valued by staff.

The trust had appointed a Freedom to Speak Up Guardian. Freedom to speak-up guardians (FTSUG) were introduced following Sir Robert Francis’s Freedom to Speak-up Review (2015). Their role is to work with leadership teams to create a culture where people can speak-up to protect patient safety.
Since the FTSUG post was introduced in January 2017, there had been 186 contacts in total to the Freedom to Speak up Guardian across all five sites. For the reporting period March 2018 to February 2019 there had been 91 contacts. Themes of concerns included:

- Behaviour
- Bullying/harassment
- Cultural
- Leadership
- Middle management issue
- Patient safety/quality
- Senior management issue
- Systems/process

There is a clear correlation between a trust having effective speaking up arrangements and showing evidence of being a well-led trust. As a result, NHS Improvement and the National Guardian’s Office published a guide in 2018 setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help them create a culture that was responsive to feedback and focused on learning and continual improvement. To accompany this, they produced a self-review tool for all boards to use as an assessment of their current position with regards to speaking up as well as to inform areas for development.

Key trust board members worked with the FTSUG to use this review tool, as well as information from local case reviews undertaken by the National Guardian, to assess the trust’s current position and inform next steps for the production of a meaningful and effective speak up strategy.

The tool highlighted the work undertaken so far by the trust. It also outlined actions for priority over the next 12 months which included:

- Finalise the strategy and vision for speaking up.
- Ensure the Guardian role is well known across all 5 sites.
- Continue Drop in surgeries with non-executive director (NED) presence.
- Leadership and management training to ensure increased awareness on all issues related to speaking up including their own responsibilities and specialist training to provide greater clarity on The Public Interest Disclosure Act (PIDA) and protected disclosures.
- Recruitment of ‘Speak up champions’ across a range of staff groups and backgrounds
- Roll out of anonymous electronic reporting tool previously developed at Burton.
- Development of a confidential area to share learning with leaders from other areas.
- Development of a robust peer review system with local FTSUGs.

Leaders recognised and valued the importance of a shared responsibility with staff and without exception, leaders spoke about staff as being their proudest asset. The board recognised there was more work to do to develop the culture of the new organisation but had very clear plans in place to achieve this.

The culture of the organisation encouraged openness and honesty at all levels, including with people who use services in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken as a result of concerns raised.

We met with different grades of staff during our core service inspection, through staff focus groups and during this inspection. We also received staff feedback through our National Customer
Service Centre. Most staff felt positive and proud to work in this organisation and demonstrated a patient-centred culture. However, there were ‘pockets’ of low morale especially on the previous Burton Hospitals sites. Senior leaders were sighted on this and plans were already in place to increase the visibility of executive leaders across all five sites. In addition, staff development was to form an integral part of the trust’s ‘5 Strategy’.

During our interviews with members of the executive and non-executive team, we found leaders placed a strong emphasis on the safety and wellbeing of staff at this organisation. In addition to outputs from the people and inclusion committees staff had access to a wide range of benefits, rewards and health promotion services. Including for example:

- Gym and activity classes
- Support to stop smoking
- Counselling and support
- Stress training
- Back care and physiotherapy
- Flu Fighter
- Flexible working
- Staff recognition awards
- Clinical Excellence Awards

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

The board demonstrated commitment to providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. ‘Developing Our People’ was one of the trust’s PRIDE objectives and reflected the trust’s acknowledgement that the organisation was full of talented people committed to delivering the best healthcare. The ‘Developing Our People Policy’ outlined how the organisation intended to deliver this objective and support the people strategy.

As of October 2018, the total percentage number of staff that had received an appraisal in the last 12 months was 88%. This was in line with the trust target of 90%.

The chief pharmacist (CP) explained that appraisals were completed with a portfolio approach and they had a 94% completion rate. The pharmacy team supported the educational training for doctors and non-medical prescribers within the trust and produced communication bulletins around themes arising from the medicine safety group. The CP explained they were trying to continually improve communication channels.

Throughout our interviews with members of the board we were told, having skilled, motivated, well supported and developed staff was the trust’s greatest assurance that the necessary care could be provided to patients now and in the future. Underpinning this, the people committee, chaired by a non-executive director (NED) and a sub-committee of the board, met monthly to discuss and review staff performance across the organisation. We reviewed the minutes of three meetings,
items discussed included; organisational development, workforce risks, workforce dashboard, health and wellbeing and staff engagement.

The combined workforce strategy for the new organisation was under development at the time of this inspection. It was envisaged the new strategy would be presented to the people committee in March 2019.

The strategy was to be in two parts:

Part one was to be a number of chapters around the work streams that the trust had:
- Equality and diversity and speaking out
- Recruitment and retention
- Pay, reward, flexible workforce, workforce governance and health and safety
- Leadership and organisational development (including talent management and succession planning, and engagement)
- Staff health and wellbeing
- People development
- Partnerships
- Measurement

The second part of the strategy was to focus particularly on supporting the trust wide and clinical strategy and would be finalised when the trust strategy was in final draft.

The trust had appointed a Guardian of Safe Working Hours (GSWH). The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors are not working unsafe hours. Guardians act as the champion of safe working hours for doctors in approved training programs. They record and monitor compliance with the restrictions on working hours and provider assurance to the trust board that doctors are safely rostered.

The Guardian of Safe Working Hours provided quarterly assurance to the board that the process for reporting, monitoring and resolving exception reports remained robust and complied with the terms and conditions of the 2016 contract.

For the reporting period January to March 2019, there had been no exception reports that had raised immediate patient safety concerns. Any exception reports that were identified as immediate safety concerns were escalated to the relevant division and speciality who were asked to triangulate reports with any incidents or serious incident reports.

There was a total of 72 exception reports in the period 1 October to 31 December 2018. This represented a reduction from the previous quarter.

Respiratory medicine continued to attract unusually high numbers of exception reports from trainees, despite previous work schedule reviews, and this had been escalated with a further meeting scheduled for early February 2019 to agree next steps.

Staff told us the pharmacy department was understaffed, and this was recorded on the pharmacy risk register. Staff told us that recruitment and retention was an issue and as a result they were working over their contracted hours and under intense pressure. However, the data provided around staffing levels showed an average level of vacancies. We were told that there was a hierarchy of communication and did not feel comfortable raising concerns.
We reviewed the trust incident reporting system and found the trust had a robust process in place to ensure that there was learning from incidents across the trust. Staff understood how to report incidents. However, the trust was currently using two incident reporting systems resulting in difficulties for staff accessing at different sites. This was recorded on the trust risk register. Plans were in place to align the systems and there was no evidence of incidents not being reviewed because of this, although feedback from incidents was not always given due to the different systems. An ad hoc 'work around' process was currently in place and working well but required separate lap tops to be used at individual sites. Incidents, including serious incidents, were reported as required to the NHS National Reporting and Learning System or the NHS Strategic Executive Information System in a timely way despite having two separate administrations teams.

Staff at the pharmacy staff focus group told us they knew how to report incidents and knew the process and they would encourage ward staff to report errors regularly to ensure they were logged and feedback to senior management. Incidents were reported and discussed by the medicine’s safety group.

We noted 378 incident records of which more than 200 were over five days without review. There were a few incidents open longer than one year but the incident record showed that they were updated. We were told that staff received training in incident reporting and how to use the incident reporting system.

Where there was a serious incident (SI) investigation it was a mandatory requirement for feedback and learning from the incident to be provided to the staff. We were told that the governance team liaised with commissioners when identifying an SI and worked together to confirm severity. Investigations into SI’s were led by the business units and any actions that were not completed were monitored by the patient safety team. Outstanding actions were then escalated to the divisional leads, executive chief nurse and medical director. Band 6 and 7 staff had responsibility for reviewing incidents with final approval undertaken by matron where applicable, and there was a system for alerting matrons to overdue incidents.

The patient safety team told us about examples of sharing good practice across site since the acquisition. They told us about good team working, evidence of sharing incidents however there was less evidence of learning from incidents. We were told about a series of never events relating to incorrect connection of air supply which resulted in a trust wide action plan. There was evidence of good team working to share lessons learnt widely across the trust.

Trust wide and divisional learning was facilitated in many ways:

- Introduction of incident learning group chaired by the medical director of quality and safety with clinical governance representation from each division.
- Central trust team to review all serious incidents all of which were trained in human factors.
- Trust wide electronic patient safety newsletter. Plans were currently in place to audit how many staff read this.
- Monthly patient safety team meetings held and chaired by medical consultant.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
The trust employed a band 7 duty of candour manager covering five sites. This position had been in place since September 2018. In addition, there was a team of clinical governance facilitators working within the four divisions. However, the trust did not always apply duty of candour appropriately.

For the reporting period November 2017 to October 2018, the trust had applied duty of candour on 363 occasions.

**Duty of candour compliance as of 6 March 2019:**

<table>
<thead>
<tr>
<th></th>
<th>RDH</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sep-18</td>
<td>Oct-18</td>
<td>Nov-18</td>
<td>Dec-18</td>
<td>Jan-19</td>
<td>Feb-19</td>
</tr>
<tr>
<td>Within 10 working days</td>
<td>42.30%</td>
<td>57.70%</td>
<td>57.10%</td>
<td>58.30%</td>
<td>67.30%</td>
<td>56.40%</td>
</tr>
<tr>
<td>Completed</td>
<td>57.70%</td>
<td>65.50%</td>
<td>61%</td>
<td>70.80%</td>
<td>69.40%</td>
<td>56.40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>QHB</th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sep-18</td>
<td>Oct-18</td>
<td>Nov-18</td>
<td>Dec-18</td>
<td>Jan-19</td>
<td>Feb-19</td>
</tr>
<tr>
<td>Within 10 working days</td>
<td>100%</td>
<td>33%</td>
<td>22%</td>
<td>67%</td>
<td>44%</td>
<td>40%</td>
</tr>
<tr>
<td>Completed</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>77%</td>
<td>40%</td>
</tr>
</tbody>
</table>

We discussed duty of candour with the executive chief nurse. They told us, and we saw, an action plan in place to improve compliance. This included for example, an action to improve recording when duty of candour letters had been sent.

Incidents which were reported electronically were monitored by clinical governance facilitators and advisors. Those incidents requiring investigation/moderate or above harm then triggered a duty of candour section within the reporting form.

Staff working within the incident area, offered the initial verbal apology to patients and their next of kin/ family. For incidents where there was a fall, pressure ulcer or safety incident that had caused harm, the initial written apology was given in a leaflet format with patient details, contact details of the nurse/manager in charge of the ward/department and contact details of the investigating officer. Business units and clinical governance leads would then commence an investigation that included populating the electronic reporting system with any duty of candour information. Once an investigation had been completed reports business units upload and send out a duty of candour letter to the Patient and/or next of kin.

Staff across the organisation were familiar with the requirements of the duty of candour regulation and talked about the importance of being open and transparent with patients and the public.

The trust provided training to senior staff within the organisation through their legal services department. Prior to the acquisition, Derby Hospitals and Burton Hospitals both provided this training for doctors, nurses and other senior managers involved with delivering duty of candour. The training was followed up with a resource pack and flow chart. Follow up support was provided by clinical governance facilitators in quality and risk meetings.
Currently, individual divisions had provided study days for their junior doctors and duty of candour was included. The doctors in training ‘corporate induction fair’ included a stand promoting duty of candour information and advice.

The new duty of candour manager was currently working on finalising the newly merged trust’s duty of candour process, which was to include updated training, initially for clinical governance facilitators, senior sisters, managers and matrons.

A legal podcast was available on the trust’s intranet, giving staff access to duty of candour information as required.

The chief pharmacist (CP) could describe what was meant by duty of candour and explained how staff were encouraged to report incidents. When we spoke to members of the pharmacy team, they contradicted this by saying that they felt they were encouraged to not report incidents because there was no time. One person was able to describe how staffing pressures had led to an incident last week and that the department errors were often as a result of a “swiss cheese” model.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – White – British/Irish/Any other white background</td>
<td>46.8%</td>
<td>81.7%</td>
</tr>
<tr>
<td>B – BME - British</td>
<td>38.9%</td>
<td>12.4%</td>
</tr>
<tr>
<td>C – BME - Non-British</td>
<td>11.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td>E – not stated</td>
<td>2.9%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Staff Diversity tab)*

**NHS Staff Survey 2018 results – summary scores**

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.
The trust had nine of 10 key indicators equal to or above the national average for similar trusts in the 2018 NHS Staff Survey. However, the response rate of 38% was below the national average of 44.4%.

Quality of care and safety culture were better than the national average.

Areas better than the national average included:

- “Care of patients/service users is my organisation’s top priority”. 79.2% compared to the national average of 76.7%.

Areas significantly better than the national average included:

- “I would recommend my organisation as a place to work”. 69.9% compared to the national average of 62.6%.
- “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”. 78.6% compared to the national average of 71.3%.

**Workforce race equality standard**

The Workforce Race Equality Standard (WRES) is designed to help organisations gauge their current state of race equality and track what progress is being made to identify and promote talented black, Asian and minority ethnic (BAME) staff, as well as helping to eliminate wider
aspects of discrimination in the treatment of BAME staff.

The WRES takes a small number of indicators and requires NHS organisations to close the gap between the BAME and white staff experience for those indicators:

- 26.5% of 3,714 White staff experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months (national average 28.2%).
- 25.0% of 541 BME staff experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months (national average 29.8%).
- 24.4% of 3,668 White staff experienced harassment, bullying or abuse from staff in last 12 months (national average 26.4%).
- 30.2% of 536 BME staff experienced harassment, bullying or abuse from staff in last 12 months (national average 28.6%).
- 88.3% of 2,556 White staff believe that their trust provides equal opportunities for career progression or promotion (national average 86.5%).
- 70.5% of 332 BME staff believe that their trust provides equal opportunities for career progression or promotion (national average 72.3%).
- 5.7% of 3,705 White staff experienced discrimination at work from their manager / team leader or other colleagues in the last 12 months (national average 6.6%).
- 15.9% of 536 BME staff experienced discrimination at work from their manager / team leader or other colleagues in the last 12 months (national average 14.6%).

(Source: NHS Staff Survey 2018)

**Workforce Disability Equality Standard (WDES)**

The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant organisations to develop a local action plan and enable them to demonstrate progress against the indicators of disability equality.

- 32.7% of Disabled staff experienced bullying, harassment or abuse from Patients / service users, their relatives or other members of the public compared to 24.9% of Non-disabled staff.
- 19.1% of Disabled staff experienced bullying, harassment or abuse from Managers compared to 8.9% of Non-disabled staff.
- 30.4% of Disabled staff experienced bullying, harassment or abuse from Other colleagues compared to 18.6% of Non-disabled staff.
- 44.3% of Disabled staff reported, or had a colleague report, their last experience of bullying, harassment or abuse compared to 45.0% of Non-disabled staff.
- 78.2% of Disabled staff believe their organisation provides equal opportunities for career
progression or promotion compared to 88.1% of Non-disabled staff.

- 38.8% of Disabled staff felt pressure from their manager to come to work, despite not feeling well enough to perform their duties compared to 24.4% of Non-disabled staff.
- 35.3% of Disabled staff were satisfied with the extent to which their organisation values their work compared to 49.9% of Non-disabled staff.
- 70.0% of Disabled staff said their employer has made adequate adjustment(s) to enable them to carry out their work.

Senior leaders within the trust had oversight of the results of the latest WRES and WDES and told us these were to be discussed at the April 2019 trust board meeting where actions would be decided. An inclusion group met bi-monthly, was chaired by the executive chief nurse and included representation from those staff with particular protected characteristics under the Equality Act. Any outcomes from this group fed into the board through the people committee. We reviewed three sets of minutes from these meetings and were assured the trust was wholly committed to the equality and diversity agenda.

The board was keen to promote equality and diversity within and beyond the organisation and through its commitment to delivering equal opportunities for all staff and service users had developed the following objectives:

- Using positive action in recruitment (Positive action is when an employer takes steps to help or encourage certain groups of people with different needs, or who are disadvantaged in some way, access work or training. Positive action is lawful under the Equality Act).
- Currently reviewing all policies.
- Involving a third party to sit on all interview panels for band 8a and above.
- Anyone with protected characteristics going through disciplinary action to be signed off by the workforce director.

The trust employed a team of chaplains from a variety of faith traditions to meet the spiritual, religious and pastoral needs of patients, relatives and staff. This support was not limited to those who were religious.

Policies and procedures were in place to meet the needs of staff and the local community and any ethnicities represented within it.

As part of this inspection we held two black, Asian and minority ethnic (BAME) staff focus groups, one of each on the Royal Derby and Queens Hospital sites. Feedback was largely positive especially around the inclusion committee and the commitment felt from the executive team. However, most BAME staff felt career progression remained limited.

**Sickness absence rates**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are
The trust’s sickness absence levels from October 2017 to September 2018 were similar to the England average. There was a spike in sickness in the winter period, centred on January.

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition date are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

As with Derby Teaching Hospitals NHS Foundation Trust, there was a spike in the sickness rate in the winter months, centred on January. In January the trust’s sickness absence level was more than 1% higher than the England average. Otherwise the trust’s sickness level was similar to the England average from October 2017 to May 2018. The trust submitted no data for June 2018.
In the 2018 General Medical Council Survey the trust performed the same as expected for all 13 indicators. This was true of both predecessor trusts.

(Source: General Medical Council National Training Scheme Survey)

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The Trust Board had six sub-committees:

- Nominations & Remuneration Committee
- Charitable Fund Committee
- Audit Committee
- Finance, Investment and Performance Committee
- Quality Committee
- People Committee

In addition, the Board is supported by two delivery groups:

- The Transformation and Integration Group (responsible for the delivery of the trusts transformation programme and the integration of all services following the transaction)
• The Trust Operational Group (responsible for the operational management of the trust and the delivery of the objectives set by the Board).

The committee structure was reviewed as part of the transaction process and the new arrangements ensured that all committees had two NED representatives, including one from each legacy organisation, in attendance. Each committee had approved respective terms of reference. Trust Board papers included reports from each of the sub-committees to ensure board members were aware of key issues and any action being taken.

**Board Assurance Framework**

The trust provided their Board Assurance Framework, which details a number of strategic risks. A summary of these is below. All these risks were rated between eight and 16 and given a high or above consequence risk.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
</tr>
</thead>
<tbody>
<tr>
<td>890</td>
<td>Failure to address the findings from regulatory, safeguarding, quality and compliance inspections could lead to clinical and reputational risks in specific areas of service provision.</td>
<td>12</td>
</tr>
<tr>
<td>891</td>
<td>Failure to build on the CQC rating of good and integrate and develop a new Quality Strategy to deliver its strategic objectives and ambition to move to an &quot;outstanding&quot; rating.</td>
<td>12</td>
</tr>
<tr>
<td>892</td>
<td>Failure to achieve sufficient medical engagement to deliver strategic changes in Clinical pathway redesign and transformational service reconfigurations may lead to adverse clinical, operational and financial outcomes.</td>
<td>12</td>
</tr>
<tr>
<td>893</td>
<td>Failure to achieve and maintain national performance targets - 4 Hour Emergency Standard; 18-week RTT; 62-day, 31 day and 2 week wait cancer treatment target; seven-day services</td>
<td>16</td>
</tr>
<tr>
<td>894</td>
<td>Failure to maintain the standards of care to patients during increased levels of escalation, patient crowding, increased waiting times and staff morale due to additional operational pressures over the prolonged winter period.</td>
<td>12</td>
</tr>
<tr>
<td>895</td>
<td>Failure to deliver 2018/19 financial plan in respect of: Income, Expenditure.</td>
<td>12</td>
</tr>
<tr>
<td>896</td>
<td>Failure to deliver the 2018/19 operational or financial plan in relation to Capital. Trust has no internally generated source of Capital funding; therefore, any replacement of business as usual equipment and strategic developments requires NHSI and DoH approval prior to expenditure being committed. Impact of assessment criteria being applied by the STP will fundamentally affect the ability of the Trust to obtain capital.</td>
<td>16</td>
</tr>
<tr>
<td>897</td>
<td>Failure to deliver required financial benefits described in the Full Business Case or Transformational Plan.</td>
<td>12</td>
</tr>
<tr>
<td>898</td>
<td>Failure to optimise available space and improve</td>
<td>12</td>
</tr>
</tbody>
</table>
the quality of the environment, leading to operational and financial risks of unnecessary spend to maximise operational capacity.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>899</td>
<td>Failure to implement new IT systems, hardware and software and failure to deliver requirement for robust cyber security leads to system noncompliance, downtime and potential loss of data.</td>
<td>12</td>
</tr>
<tr>
<td>900</td>
<td>Failure to recruit and retain staff in sufficient numbers across all clinical areas to deliver high quality services to patients leading to increased clinical, financial and operational risks to delivery.</td>
<td>12</td>
</tr>
<tr>
<td>901</td>
<td>Failure to ensure critical leadership posts are filled, and structured OD support is put in place, during potential management changes from the merger, may result in reduced resilience of teams that negatively impacts upon our ability to deliver the trust strategic objectives.</td>
<td>12</td>
</tr>
<tr>
<td>944</td>
<td>Failure to develop and implement a robust and effective Inclusion Strategy / Plan may lead to the trust not being representative of the community we serve and with few senior managers from diverse back grounds. This can have a negative impact upon the performance of the Trust.</td>
<td>12</td>
</tr>
<tr>
<td>945</td>
<td>Failure to develop and implement an effective workforce strategy that addresses workforce issues in immediate and long term including those impacted by external influences.</td>
<td>12</td>
</tr>
<tr>
<td>902</td>
<td>Failure of new organisation to effectively engage and influence system including partners, providers and commissioners individually and collectively as STP's to achieve ambitions and deliver services at times of increased pressure.</td>
<td>12</td>
</tr>
<tr>
<td>903</td>
<td>Failure to have a contingency plan in place to mitigate the potential significant negative impact that a no deal Brexit or other external influences would have on service delivery and procurement</td>
<td>8</td>
</tr>
</tbody>
</table>

*(Source: Trust Board Assurance Framework – November 2018)*

The board assurance framework (BAF) provided an effective structure, process and system of accountability to support the delivery of the strategy and good quality, sustainable services and was aligned to the strategic objectives of the organisation.

The board were sighted on risk within the organisation. The BAF was being used to track strategic risks and there was a clear escalation process for the higher risk areas to go onto the corporate risk register.

Our review of the BAF found it to be presented in a clear and logical format starting with a high-level summary followed by a more detailed analysis of each risk description. Each BAF risk had a named executive lead who held responsibility for the risk and identified the assurance committee responsible for providing assurance to the board. The BAF was reviewed bi-monthly by the identified assurance committee and annually by the trust board. Where risks had been rated as
15 or more, these were reviewed monthly by the risk and compliance committee.

In addition, a risk appetite statement was declared for each risk. This made clear the board of directors’ expectations in relation to the category of risks they expected management teams to identify and the level of such risk that was acceptable.

The risk appetite statement was based on the premise that the lower the risk appetite, the less the board was willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk. The higher the appetite for risk, the more the board was willing to accept in terms of risk. All risks contained within the BAF had a ‘low’ risk appetite.

Senior leaders were clear about their roles and understood what they were accountable for, and to whom. The director of governance and communications was the board lead for corporate governance across the trust.

As part of the business case for the acquisition a potential risk of "gravitational pull" of senior people to the largest hospital in the group (the Royal Derby Hospital) was identified, and it was noted that there was an expectation from the local community, staff and stakeholders, that a senior leadership presence should be retained in Burton.

As a result, as part of the organisational design for the new trust, an executive managing director role at Burton (EMD) was established to provide day-to-day leadership presence and ensure that the local interests of Burton and the community hospitals at Litchfield and Tamworth were fully considered. The EMD reported directly to the chief executive officer (CEO), with no direct reporting line to the chief operating officer (COO). At the same time a leadership team for the Queens Hospital Burton (QHB) was also established.

Six months following the evolvement of the new trust a review of these governance arrangements on the QHB site took place to ensure there was no confusing accountabilities and lack of clarity over decision making.

Within the terms of authorisation issued by the Independent Regulator, NHS Foundation Trusts are required to demonstrate the existence of comprehensive governance arrangements for the practice and procedure of the board of directors. We reviewed the trust’s ‘Scheme of Delegation’, this showed the ‘top level’ of delegation within the trust. The Scheme of Delegation set out clearly the responsibilities and extent of authority delegated to committees, working groups or individuals acting in the interests of the chief executive officer (CEO).

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. A performance management framework was in place. Key committees of the board included; finance and investment committee; quality committee; audit committee and people committee. All committees were chaired by a non-executive director (NED). Our review of a sample of minutes showed a good balanced agenda had been followed. Divisions were held to account through monthly performance management meetings with two-way discussion between executives and divisional leadership teams.

Governance structures and processes were regularly reviewed and improved. An independent review of governance had been carried out immediately prior to our inspection and previously (2017) at the sovereign trust.

Papers for board meetings and other committees were of a good standard and contained
appropriate information. We reviewed several papers as part of our inspection including for example, minutes from board meetings, the trust operational group, audit committee and the quality committee. Minutes were found to be clear and well presented with clear actions identified.

The council of governors and non-executive (NED) and executive directors were clear about their areas of responsibility. The council of governors held the NEDs individually and collectively to account for the performance of the board of directors and represented the interests of the members of the trust.

The board of directors was responsible collectively for the success of the trust and the achievement of its objectives. Accordingly, all members of the board had joint responsibility for the operational and financial management of the trust on a day-to-day basis, regardless of their individual skills or status. An appointed senior independent NED provided a conduit between the governors and the board.

Robust arrangements were in place to make sure that hospital managers discharged their specific powers and duties according to the provisions of the Mental Health Act 1983. Strong links, through a service level agreement (SLA), were in place with a local NHS mental health trust. Monthly SLA Meetings were held to ensure optimal levels of partnership working.

Due to the geographical location of the two acute sites, the trust contributed to two sustainability and transformation plans (STPs). However, up until the date of the newly formed trust the board recognised their focus had been on the acquisition and as such, they were not fully up to date with developments within the STPs. A mapping exercise was undertaken in October 2018, to ensure that the trust had full awareness of the STP workstreams and had representation at the key forums. By means of a newly formed and executively led planning group, the trust’s aim was to be fully engaged with their partners within the STPs.

Patient Group Directions (PGDs) were overseen by the medicine’s safety officer and the governance lead. There were two different systems in operation across the site and the trust held over 500 PGD’s. The chief pharmacist (CP) had identified that this was not appropriate and that there needed to be a cultural shift to reduce the number of PGDs in use at the Burton site. Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

The CP had worked to ensure the drug and therapeutic committee operated uniformly across the two sites but said that there were still challenges following the acquisition. For example, it was a challenge to support two different area prescribing committee’s with different commissioners.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
</table>

Page 26
### Finances Overview

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Surplus (deficit)</th>
<th>Full Costs</th>
<th>Budget (or budget deficit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>£736.2m</td>
<td>(£20.2m)</td>
<td>£756.4m</td>
<td>(£22.2m)</td>
</tr>
<tr>
<td>Revenue</td>
<td>£743.9m</td>
<td>(£52.2m)</td>
<td>£796.1m</td>
<td>(£51.7m)</td>
</tr>
<tr>
<td>Revenue</td>
<td>£767.7m</td>
<td>(£27.0m)</td>
<td>£794.8m</td>
<td>(£27.0m)</td>
</tr>
<tr>
<td>Revenue</td>
<td>£767.7m</td>
<td>(£15.7m)</td>
<td>£783.4m</td>
<td>(£15.7m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

NHS Improvement’s Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where ‘4’ reflects providers receiving the most support, and ‘1’ reflects providers with maximum autonomy. The trust was in segment three of the framework. This meant the trust was receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a regional support group has agreed to seek formal undertakings from the provider or the provider regulation committee has agreed to impose regulatory requirements.

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Please see the separate use of resources report for details of the assessment.

An updated ‘trust risk management: strategy and supporting policy’ (February 2019) had been approved by the board. We reviewed this policy and found it was clear in its purpose; to make clear the standards and accountabilities for the management of risk within the trust. There were seven types of risk that the trust expected to be identified and managed:

- Strategic risk – achievement of the trust strategy and strategic or corporate objectives
- Clinical risk – impact on clinical quality and safety for patients
- Operational risk – impact on the operational running of the organisation e.g. staffing, capacity, and on performance
- Environmental risk – infrastructure: property, plant and equipment
- Financial risk – impact on financial objectives and key financial loss e.g. an issue which may result in financial loss
- Information risk – collection, storage and use of data in the organisation
- Reputational risk – issues
Trust Risk Register

In February 2019 there were 520 risks identified. The numbers of risks on the trust risk register were in line with other organisations of a similar size and the majority managed at local business unit level in line with the trust risk management strategy and lines of defence.

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Number of risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>58</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>128</td>
</tr>
<tr>
<td>8</td>
<td>57</td>
</tr>
<tr>
<td>9</td>
<td>80</td>
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<td>10</td>
<td>19</td>
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<tr>
<td>12</td>
<td>82</td>
</tr>
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<td>15</td>
<td>11</td>
</tr>
<tr>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>520</td>
</tr>
</tbody>
</table>

The table below shows the total number of risks on the risk register and the level of risk assigned to each division which has scored 15 and above i.e. an Extreme Risk.

<table>
<thead>
<tr>
<th>Divisions</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Cancer, Diagnostics and Clinical Support</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td></td>
</tr>
<tr>
<td>Division of Medicine</td>
<td></td>
</tr>
<tr>
<td>Division of Surgery</td>
<td></td>
</tr>
<tr>
<td>Division of Women and Children Services</td>
<td>2</td>
</tr>
<tr>
<td>Grand Total</td>
<td>11</td>
</tr>
</tbody>
</table>
processes relating to all risks. It managed the risks recorded on the board assurance framework (BAF) and reviewed the significant risks on the trust risk register.

Risks that were extreme and those that had a consequence of catastrophic were reviewed monthly by the executive and divisional director who would report to trust operational group monthly and bi-monthly to the appropriate committee of the board.

Senior leaders repeatedly told us they were committed to realising the plans they had made prior to the acquisition. One such plan had already had a significant impact on patients’ outcomes. We saw good progress had been made, such as work undertaken with the renal services, putting in place an inpatient renal service at QHB had provided a reduction in the crude mortality of Acute Kidney Injury which had reduced from 30% to 15%. There were also plans to improve stroke services and a business case had been developed and approved in principle. The third area of focus was Cardiology.

The trust had processes in place to manage current and future performance. A robust governance framework allowed for the passage of performance from the ward/department to the board effectively. Exception reporting was presented to the board at the bi-monthly board meeting. Reporting included; referral to treatment times (RTT), cancer wait times, the emergency care standard and diagnostic performance. In addition, divisional performance dashboards were discussed at a weekly speciality governance meeting which reported to monthly clinical directorate governance meetings. These meetings upwardly reported to the quality committee which was chaired by the chief executive.

The Board to Ward programme enabled the organisation to achieve ‘ward to board assurance’ on safety and quality. An executive and non-executive board member and governors carried out each visit jointly. The focus of the programme was:

- Relationship development
- Visible leadership
- Supporting the embedding of the quality strategy
- Seeking further understanding and assurance of patient experience.

The trust used a range of tools and processes to support the assessment and review of quality. Quality compliance was managed by the quality compliance steering group, who had oversight of several work streams to support identification of themes and trends where intervention or actions may be required to improve or maintain quality compliance. The steering group was also responsible for overseeing the delivery and monitoring of the consolidated action plan. The work undertaken through this structure linked closely with delivery of the quality strategy and the trust’s approach to quality improvement.

The trust used Carter/model hospital along with a number of other sources of information in order to monitor unwarranted variation in the quality of care delivery. The opportunities highlighted by Carter helped frame the trust’s improvement plans. Whilst the trust did not maintain a separate Carter action plan the trust had developed a specialty level dashboard to benchmark progress in meeting the recommendations of the Carter report. Performance was monitored through the transformation and integration group (TIG) chaired by the CEO.

There was a programme of audit, which included national and local audits, and these were used to identify areas for improvement. Audits included both clinical and non-clinical areas. For each audit completed, actions were identified to ensure learning took place and improvements were
made.

Assurance for non-clinical audits was provided to the board through the audit committee. The audit committee met bi-monthly and was chaired by a non-executive director. We reviewed three sets of minutes from the audit committee and saw meetings were well attended with representation from both internal and external auditors. In addition, we saw where audit outcomes had been discussed including identifying where actions should be taken.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. There were robust plans in place for seasonal pressures which included a capacity flow and escalation policy.

There was a focus on continuous learning and improvement and the opportunities afforded through being part of a national pilot were being embraced by the trust. The trust was one of seven NHS trusts selected to take part in NHS Improvement’s (NHSI) new programme to deliver a “lean management system.” The three-year ‘lean programme’ builds on the success of NHSI’s partnership with the Virginia Mason Institute, which saw leaders and clinicians across selected trusts receive tools and hands-on support, including coaching, mentoring and education in lean techniques. It also builds on other independent programmes in the NHS. The programme was to focus on delivering “results that patients will see and feel.” Lean is an improved method that allows patients and staff to improve their own processes and ways of working.

Senior leaders told us that they had not progressed as rapidly as they would have liked to with their quality improvement programme but through the development of their quality strategy were confident the pace of change would improve. The Trust had a shortfall of £8.2m deficit against their plan which was driven by non-delivery of the cost improvement programme (CIP). The Trust was on target to deliver approximately £25m of the £37m required. This equated to over 5% and senior leaders told us this was a huge challenge; however, the trust had achieved 3.5% and this was better than what the two separate organisations had delivered prior to the acquisition.

The chief pharmacist (CP) described a clear system in place to manage alerts and recalls. There was a departmental risk register which fed into the trust risk register for those areas which had a significant impact on trust performance. Information was cascaded through bulletins and through the intranet.

Where the financial position has gone off track, for example in the months immediately following the acquisition, the Trust Board had been quick to implement review meetings with divisional management teams to agree financial recovery plans. There was no evidence to suggest that financial reporting procedures were not robust, and NHSI had not been approached by auditors in respect of financial governance.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However, information technology (IT) systems were not always used effectively to maintain patient records and monitor and improve the quality of care.

The trust recognised the importance of protecting personal and confidential information and was committed to ensuring that patients’ privacy was protected.

The law determines how organisations can use personal information. This is covered within the General Data Protection Regulation (GDPR), UK Data Protection Law, the Human Rights Act,
Common Law Duty of Confidentiality and other Health Service legislation. In accordance with NHS guidance, the trust had the relevant roles in place to effectively manage information. This included a director of ICT/IMT, a data protection officer, a Caldicott guardian, a senior independent risk owner (SIRO) and a chief nursing information officer, which was a new role since the acquisition. The Caldicott guardian was also the chief medical director.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation’s information governance practices. Level 2 compliance is the minimum expected level within the toolkit. NHS Digital anticipates that trusts should be striving for level 3 compliance where possible.

Based on the 2017/18 review; both sovereign trusts received an overall assessment of ‘satisfactory’. Records we reviewed confirmed this.

The trust had a Senior Information Risk Owner (SIRO) who had overall responsibility for the organisation’s information risk policy. The SIRO was accountable and responsible for information risk across the organisation.

IT systems including; electronic patient records, policies and procedures and patient administration systems were not aligned across the trust. Leaders in the trust were clear that there was much more to do for the trust to catch up with the digital agenda and had identified this as a risk on their board assurance framework. Work was in progress however, work streams appeared to us to remain separate across the hospital sites. The trust projection was that they would become a ‘paperless’ organisation by 2020.

The trust had acted to address the threat of cyber security and told us that three staff were trained in cyber security. The trust had not been affected by the recent cyber-attack and no impact had been felt.

Sub-committees of the board had both executive and non-executive representation and directly fed into the trust board. Minutes we reviewed of for example, the quality committee, showed discussions focussed on seeking defined levels of assurance, and we saw evidence of collaborative working across different assurance committees. All board members proactively received minutes of assurance committees allowing them to agree a level of assurance across the organisation.

Our observation of the trust board meeting, conversations with executive leads and review of board and assurance group meeting minutes demonstrated to us that there was a definite holistic understanding of performance, which sufficiently covered and integrated people’s views with information on quality, operations and finance. It was clear to us information was used to measure for improvement, not just assurance.

During our core service inspection, a significant information governance (IG) breach had occurred. We saw where this breach had been reported to the Information Commissioner’s Office appropriately and an investigation was underway. The Information Commissioner’s Office in the United Kingdom is a non-departmental public body which reports directly to Parliament and is sponsored by the Department for Digital, Culture, Media and Sport. During our attendance at the March 2019 board meeting we heard an update delivered to the board regarding this breach.

The trust considered IG training to be important and we were told that staff are required to complete IG training annually. Where staff had not completed this training their IT access was withdrawn until the training had been completed.
The Accessible Information Standard (AIS) aims to ensure those with impairments or communication needs receive information relating to their healthcare in appropriate formats, and that they have access to appropriate support while attending the hospital.

To meet the requirements outlined by the AIS, the trust’s patient administration system at the Royal Derby Hospital site had been developed with the functionality to record patients’ communication needs and delivered prompts to users to flag where patients had recorded needs. Queens Hospital Burton was due to ‘go live’ with AIS in April 2019.

Incidents, including serious incidents, were reported as required to the NHS National Reporting and Learning System or the NHS Strategic Executive Information System in a timely way. The trust submitted notifications to the Care Quality Commission in line with their statutory responsibilities.

Since the acquisition two electronic patient record systems were used across the trust resulting in disruption for staff. Staff told us that the use of different systems posed a risk to patients’ safety. We saw this had been identified on the trust risk register as a medium risk. Staff believed the trust had plans to solve this problem but were unaware of what they are. We were told that problems faced included, not being to log into one hospital system whilst working at another and that the two systems did not link to each other.

During our staff focus groups most staff spoke about challenges faced with the IT systems, however this was different to the executive team who told us that the systems did function together and that complaints from staff were few. Staff told us of an example whereby there had been two failed launches of the new system in the emergency department and that it “didn’t fit with how they work”.

Because of services being commissioned by a number of clinical commissioning groups (CCGs), the trust used four systems for GP records which staff told us posed a risk to patients, especially those attending the emergency department from Staffordshire.

In pharmacy services, the two sites operated different electronic prescribing systems. Staff were very positive about the system they used at the Burton site. The system helped to improve the ability to gather timely and accurate information about medicines use across the trust.

During our core service inspection, we identified some concerns and reported to the trust that staff were showing us various policies on the intranet that had not been reviewed in a number of years. It was quickly identified that since the acquisition the system still contained both Derby and Burton policies in different areas and the current up to date policies for the new joint trust. The trust immediately set about to rectify this and by the next day had produced an urgent bulletin to inform staff of the actual location for up to date information on policies and procedures.

Information received following our core service inspection assured us discussions were in place with nominated people within the directorates to ensure all policies were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms. During this inspection we saw where actions had been taken and there was now a much more robust process for staff to access policies and procedures.

The finance report to the trust board included analysis of income, pay and non-pay, balance sheet and cash flow summaries and narrative, an overview of contractual risks and details on capital expenditure.

The trust completed a Board Assurance Statement in January 2019 to support a formal change to the financial forecast outturn reported at Month 9. This confirmed that the Board had been fully briefed on the
planned adverse change to forecast and that the trust had adhered to the NHSI protocol for ‘Adverse Changes to the In-Year Forecasts’. The trust kept NHSI informed on financial performance, including key risks and issues. However, the trust does not have a solid track record of delivering financial plans, as evidenced by the revised forecast outturn for 2018/19. Through our interactions with the trust we have noted that the trust, sometimes, looks to divert the focus to external financial pressures, which are outside of their control, rather than issues that are within their gift to resolve, for example CIP delivery.

**Engagement**

**The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**

People’s views and experiences were gathered and acted upon to shape and improve the services and culture and we heard about some good examples. However, there was more work to do to engage with people from a range of equality groups. The board acknowledged it was not reflective of the population it served but was actively trying to address this.

Derby Teaching Hospitals NHS Foundation Trust acquired Burton Hospitals NHS Foundation Trust on 1 July 2018 creating University Hospitals of Derby and Burton NHS Foundation Trust. An extensive staff, patient, public and stakeholder engagement programme was undertaken from the start of the process in July 2016. These included regular team briefs with the chief executives, question and answer sessions for staff on the acquisition, public engagement events and regular newsletters. Frequently asked questions and answers were available on trusts’ websites and intranets, as well as a bespoke joint website for the life of the acquisition programme. As this was an organisational change rather than a service change the balance of the engagement work was weighted towards staff and stakeholders who were directly impacted by the change, whereas the public and patients continued to receive the current range of services from the enlarged trust.

The engagement programme provided internal and external stakeholders (including staff and governors at both trusts, commissioners, GPs, MPs, local government, health and scrutiny committees, patient representatives including three Healthwatch organisations, patients and the general public) with an opportunity to receive regular updates on the proposals, to be engaged and involved in the strategic direction of travel and development of the collaboration and to be assured on the process being followed.

There were more than 164 staff, stakeholder, patient and public meetings held over the project period, with many more informal meetings and dialogue also taking place. Nearly 700 people had their say in a public survey in late summer 2017 and careful consideration was given to all the views and comments which were largely positive. *(Source: P120)*

Patients, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. We saw there were a number of trust events the public were encouraged to attend. These included:

- Health talks; open to the public as well as all staff members and provided useful insight into clinical services and the running of the hospital.
- Council of governors meeting; open to the public and meeting papers were available on the trust website.
- Annual members meeting.
- Public board meeting; open to the public and meeting papers were available on the trust website.
- Elections.
- Members update meeting.
We reviewed the timetable of public events that had or were due to take place and saw where an event had been planned to take place within the deaf community.

A youth forum was in place at the trust chaired by a NED. With representation from previous patients of the trust it allowed young people the chance to be represented at board level. The chair of this forum told us the main focus of the group was on transition arrangements from paediatric to adult services.

Governors, along with lay representatives and staff, conducted annual Patient Led Assessments of the Care Environment (PLACE) audits to assess the quality of the hospital environment.

Patient stories were heard at the trust board meeting. This enabled the organisation to learn ‘first hand’ from patient’s experiences to continually improve the services they provided.

‘Your views matter’ leaflets were displayed on wards and departments across the trust, encouraging patients and relatives to give feedback on their experience.

The PALS team provided a confidential advice and information service dedicated to listening to patients, their carers and relatives. The team supported people to make a complaint, compliment or resolve an issue someone may be concerned about. As well as dealing with concerns and complaints, the team signposted to other services both within and outside of the trust. They collated comments and suggestions through questionnaires, face to face discussions, comment cards, the trust web site, email or telephone. In addition, they were able to find independent help and support to involve and engage people in trust work through membership, volunteering and attending specific groups.

The trust had a forum for children and parents of children with special educational needs and disabilities. Senior leaders told us members of the forum were involved in the “15 steps challenge” initiative. This is an approach to quality improvement that focuses on ward or service ‘walkarounds’ using a ‘15 steps challenge’ team that includes patients, carers, and staff. The team members consider their first impressions from the perspective of a service user, recording how it appears; looks; sounds; smells and how accessible it is.

The governors of the trust were a very active group and there was a good relationship between leaders of the trust and the governors with a shared purpose being very evident. There was transparency and openness with the governors about the trust’s performance. There was governor representation on all board sub-committees.

The trust had recently launched a new trust publication filled with the latest news around the trust. ‘UHDB News’ was produced quarterly with the “sole purpose of telling the story of everything that’s great about each of our five hospitals across Derby, Burton, Tamworth and Lichfield”. The newsletter was for staff, patients, hospital visitors and volunteers alike focussed on the latest trust news, inspiring patient and staff stories and the different services the trust offered.

Patients had access to a discharge patient helpline which was manned by the medicine’s information pharmacists at the Derby site. However, currently it was not offered to patients at Burton. There was no formal feedback sought or gathered around the pharmacy service. Pharmacy staff told us that staff on the wards were “unhappy with pharmacy” and that they were seen as the biggest hinderance in the delay of medicines supply to patients.

Medicines information is available in leaflet form in multiple languages and pharmacy staff have a visible presence at ward level.

The trust had partnered with an external organisation and had developed an online engagement platform to enable every member of staff to have a voice. Since September 2018, the trust had
been hosting both face to face events as well as the online platform to invite every member of staff to contribute to the formation of the vision, behaviours and key objectives for the trust.

The trust had a number of recognition schemes that honoured staff for the dedication, innovation and excellence they provided to staff and patients. These included for example, UHDB Hero, CEO Award and Employee and Team of the Month.

The trust used a variety of ways to engage with its staff including CEO weekly blog, emails, bulletins, newsletter and face to face briefings, staff forums and staff union groups. They also used social media using different platforms. However, some staff on the previous Burton trust sites felt disengaged. The board told us they were aware of this and recognised it as a product of the recent acquisition. As such, executive leads had increased their visibility on these sites. In addition, an ‘open staff forum’ was held on each of the five hospital sites immediately following a trust board meeting. We saw this take place during this inspection.

To coincide with Speak up month in October 2018 and to promote speaking up across all the sites, speak up surgeries were run with NED. Feedback was positive with staff finding them really useful. They used them to share a range of issues but also to tell the NED what they were proud of. All staff received feedback after attending a surgery and had indicated they were grateful to have that open access.

Following on from this the guardian also attended drop in sessions with some of the executives at all Burton sites. Many of the issues discussed there were similar themes to those raised at the speak up surgeries. These had all been passed on to relevant management and communications for further work. Themes of concerns included:

- Individual employment issues
- Community hospital staff concerned about closure and lack of information
- The merger
- Trust and departmental culture

Due to the popularity of the speak up surgeries it had been agreed to run these bi annually with the next ones taking place in March and April 2019.

A significant amount of work had been undertaken with the volunteers with regard to the trust’s vision for the volunteers. A joint volunteer’s event had taken place in February 2019 and approximately 250 volunteers from across the five sites attended. Volunteers were also supporting training for overseas nurses, and the trust had taken part in a British public service broadcaster experiment looking at clinical volunteers. Filming had taken place over a six-week period. We were told this had been a powerful experience and a presentation was being prepared for the people committee.

The trust engaged effectively with the ten Staffordshire and Derbyshire CCGs in relation to the delivery of commissioned services across the two acute and three community hospital sites. Engagement was supported by a number of regular formal forums spanning the strategic, tactical and operational levels. The directors of strategy met regularly and there were also a number of informal networks between clinical and operational leaders. An example of the high level of engagement was the collaborative working amongst partners to implement the ‘Musculoskeletal Triage Service’ (MSK), between October 2018 and March 2019.

The trust worked collaboratively with a private provider of services in regard to the Improving Lives Programme in East Staffordshire (improving outcomes for older people and those with long term
conditions). Engagement was achieved through regular formal forums, attended by senior clinical and non-clinical leaders.

There were positive and collaborative relationships with local NHS acute and community trusts for the provision and receipt of some clinical services.

The trust worked very closely with three Healthwatch branches, in order to support the continuous cycle of service improvement. Healthwatch had representation on the clinical reference group, which ensured that the ‘patient voice’ had input into the integration and transformation plans for the trust. In addition, best practice, bi-directional feedback and sharing of intelligence were discussed at the patient experience and engagement group, which Healthwatch attended.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

**Learning from deaths**

The trust had a process in place for reviewing all inpatient deaths in line with the National Quality Board's ‘Learning from Deaths’ guidance. At the time of our inspection two policies were in use across the trust. On the Royal Derby Hospital (RDH) site staff were using the ‘trust policy on learning from deaths’. On the Queens Hospital Burton (QHB) site staff were using the ‘monitoring mortality and learning from reviews policy’. Both policies afforded clinicians a consistent and effective approach to patient mortality reviews. Senior leaders told us plans were in place to develop one trust wide policy.

Any unexpected death with obvious care concerns or harm would be expected to be reported through the trust’s electronic incident reporting system. All deaths of patients with a learning disability were subject to a mortality review. Death reviews were undertaken by individual clinicians using a Structured Judgement Case Review [SJCR] process. On the QHB site reviews were completed electronically and submitted to mortality database. The trust planned to roll this out at the RDH site with effect from April 2019.

Stage two escalation deaths were discussed at the mortality assurance group meetings. Outcomes of all deaths escalated for further review were presented to the quality committee. Outcomes of reviews of deaths were reported to the board of directors on a bi-monthly basis. This included, as a minimum, the number of deaths occurring in the trust and the number reviewed.

All deaths of patients living with a learning disability received a stage 2 review. The numbers of learning disability deaths for the trust between November 2018 and February 2019 is as follows:

- November 5
- December 3
- January 0

The trust did not currently have a medical examiner in post. Medical examiners are licensed physicians who possess specialised training in forensic pathology. However, recruitment was underway with interviews to be held at the end of March and early April 2019.

**Mortality Review Data June to November 2018 – Queens Hospital Burton (QHB) Site**

Level 1 Reviews (L1); The following table shows the proportion of deaths that have had a Level 1 review completed by specialty:
The following table shows the proportion of deaths that have had a Level 2 review completed by specialty:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. of Deaths</th>
<th>No. L1 Reviews Completed</th>
<th>No. L1 Reviews Outstanding</th>
<th>% Deaths L1 Reviews Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>44</td>
<td>25</td>
<td>19</td>
<td>57%</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>43</td>
<td>30</td>
<td>13</td>
<td>70%</td>
</tr>
<tr>
<td>Medicine</td>
<td>299</td>
<td>136</td>
<td>163</td>
<td>45%</td>
</tr>
<tr>
<td>Surgery</td>
<td>29</td>
<td>24</td>
<td>5</td>
<td>83%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>17</td>
<td>12</td>
<td>5</td>
<td>71%</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>436</strong></td>
<td><strong>229</strong></td>
<td><strong>207</strong></td>
<td><strong>53%</strong></td>
</tr>
</tbody>
</table>

The above data showed, on the Burton site alone, there were delays in timely death reviews. Discussions with senior leads acknowledged this and told us QHB had previously attempted to review every death whereas the national recommendation was to review at least 40% of deaths. It was, however, still the aspiration at QHB site to review all deaths. In addition, there was a recognition that more needed to be done to strengthen this process. The trust board were assured once a medical examiner was in post and clinicians were following one policy the review process would improve.

**Complaints**

The trust board was accountable for ensuring that effective controls were in place to support complaints management. The chief executive was the ‘Responsible Person’ and the designated board member responsible for ensuring compliance with the NHS Regulations 2009. The executive chief nurse had board level responsibility for concerns and complaints management.

The director of patient experience had responsibility for the patient experience agenda, including overall management of the NHS complaints process and was the trust non-executive lead. The lead nurse for patient experience was responsible for the overall leadership and management of the Advice and Support service (PALs, Complaints and Bereavement). This role was responsible for the development and implementation of the complaints and concerns strategy and policy, including training and education of all staff involved in complaint investigations.

The complaints and PALs managers had operational responsibility for the management of the Advice and Support Services department. There were an additional 16 staff working within the PALs and complaints team covering the five hospital sites.
The divisional nurse directors/director of midwifery/director of allied health professionals had responsibility for ensuring the division appropriately and proportionately investigated and responded to complaints within trust agreed timescales. They were also responsible for monitoring the quality and effectiveness of the investigation through the quality assurance process. Lead and support investigators were identified within each business unit and had overall accountability for the timeliness, quality and content of the investigation and response.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months (November 2017 to October 2018).

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>2</td>
</tr>
<tr>
<td>What is your target for completing a complaint?</td>
<td>25</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints, please indicate what that is here</td>
<td>40</td>
</tr>
</tbody>
</table>

The numbers of complaints resolved without formal process over the last 12 months at each trust site were as follows:

- Burton campuses: 995
- Derby campuses: 2,803

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

**Number of complaints made to the trust**

The trust received 716 complaints from October 2017 to September 2018. Medical care received the most complaints with 27.1% of the overall complaints received by the trust.

Four core services accounted for 76% of complaints made to the trust: medical care, surgery, urgent and emergency care and outpatients. In addition, 4.9% of complaints could not be mapped to a core service.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>194</td>
<td>27.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>150</td>
<td>20.9%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>110</td>
<td>15.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>90</td>
<td>12.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>38</td>
<td>5.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>38</td>
<td>5.3%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>35</td>
<td>4.9%</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>4.9%</td>
</tr>
<tr>
<td>Community inpatients</td>
<td>12</td>
<td>1.7%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>7</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
We reviewed three complaints as part of this inspection including one relating to a vulnerable adult. We found although there had been some deterioration in complaints performance, the process in place appeared strong. The quality of complaints responses was good. There was good oversight of complaints and a genuine desire to learn from them and take them seriously.

Compliments

From October 2017 to September 2018, the trust received a total of 1,516 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>396</td>
<td>26.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>315</td>
<td>20.8%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>267</td>
<td>17.6%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>116</td>
<td>7.7%</td>
</tr>
<tr>
<td>Other</td>
<td>108</td>
<td>7.1%</td>
</tr>
<tr>
<td>Maternity</td>
<td>71</td>
<td>4.7%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>65</td>
<td>4.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>55</td>
<td>3.6%</td>
</tr>
<tr>
<td>Community urgent care</td>
<td>50</td>
<td>3.3%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>25</td>
<td>1.6%</td>
</tr>
<tr>
<td>Critical care</td>
<td>23</td>
<td>1.5%</td>
</tr>
<tr>
<td>Community inpatients</td>
<td>13</td>
<td>0.9%</td>
</tr>
<tr>
<td>End of life care</td>
<td>11</td>
<td>0.7%</td>
</tr>
<tr>
<td>Out of scope</td>
<td>1</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Accreditations

NHS trusts participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Fully accredited on Derby site. Fully accredited on Robert Peel Tamworth site.</td>
</tr>
</tbody>
</table>
Deferred accreditation on Burton site currently being reassessed.

**Anaesthesia Clinical Services Accreditation (ACSA)**
RDH Anaesthetics department

**Imaging Services Accreditation Scheme (ISAS)**
Imaging Service (excluding Nuclear Medicine and Services at Burton, Tamworth and Lichfield). Service has been accredited since December 2015, transitioned to standard 3.0 in September 2018.

**Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189**
Pathology, RDH. (June 2017). Preceded by CPA accreditation since 1990's. Chemical Pathology, Haematology and Blood Transfusion QHB. These services are managed via the Coventry and Warwick contract.

**CHKS Accreditation for radiotherapy and oncology services**
Accreditation Company BSI (British Standards Institution)
Standard ISO9001 2015. Accredited since 1996, covering Radiotherapy, Chemotherapy (oncology and haematology) and Brachytherapy.

**MacMillan Quality Environment Award (MQEM)**
NMU achieved this in 2017 awarded 5 out of 5

**Accreditation for Psychological Therapies Services (APPTS)**
Level 4 Clinical Psychologist’s working in Psycho-Oncology.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

The trust had received confirmation that the Department of Health and Social Care had approved the capital funding for the Outwoods Health Village. A detailed planning process was be put into place. It was an innovative proposal and a good example of integrated care. The health village concept would include a step-down facility; primary care centre; key worker accommodation; and a community hub. It was hoped that building work would commence during summer 2019.

Senior leaders regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance. For example, two programmed events were planned to take place with the clinical directors across the trust to look at service delivery across the two acute sites. In addition, an executive leads time out day had been planned for April 2019.

In October 2018, the trust FTSUG was selected to attend a reception at the House of Commons hosted by Baroness Finn to celebrate Speak up month. This was well attended by MPs and key stakeholders from national organisations. It gave opportunities for networking and to hear feedback from the national stakeholders, for example the Care Quality Commission, NHS Improvement, Department of Health and Social Care and Sir Robert Francis, on speaking up. It also gave members of parliament the opportunity to speak to local FTSUGs to hear their experiences of supporting speaking up.
Within the end of life care service, the trust had “pop up bedrooms”, an initiative to enhance the environment of the end of life care patient’s room. This consisted of a screen which was pulled across the wall with an image that can be used to transform the room from a hospital into a ‘softer’ place. For example, there could be projected onto the screen a field of poppies, or a bluebell wood or a bench in a park.

In addition, a ‘Staff Debrief ToolKit’ had been developed by the end of life care team at the trust. The toolkit was developed following a request by clinical staff who identified a need to debrief their teams following traumatic incidents or difficult patient deaths. The contents of the toolkit included:

- The Pause - A voluntary activity for staff to take a “Stop Moment” following a patient’s death to pause and “honour” the deceased patient and the life they have lived.
- Top Tips to enable a member of the team to support staff through a debrief which is an easy step by step guide to running a debrief session.
- A guide for managers to support their staff through either 1-1 or group debriefs.

A volunteer sitting service was available whereby a group of trained volunteers were available to sit with a dying patient if they were alone or to allow family member a break away from the bedside reassured that their loved one was not alone.

Scan4Safety is an initiative led by the Department of Health that is improving patient safety, increasing clinical and operational productivity and advancing supply chain efficiency in the NHS through the adoption of international standards. Derby Teaching Hospitals NHS Foundation Trust (the acquiring trust) was the first of six NHS ‘demonstrator site’ trusts to complete Scan4Safety. This project had resulted in improved product traceability for all patients in the trust operated on since 2014. It had improved the trust’s ability to undertake product recall and improved the efficiency of the infection control team by being able to trace within 35 minutes any patient affected by any presumed infected instrumentation.

The Derbyshire pathology service was formally established in July 2018 and hosted by this trust. The aim of Derbyshire pathology was to develop partnership working and further align services at Chesterfield and Derby to provide a high quality and sustainable pathology service across Derbyshire in line with the Lord Carter Review and the wider sustainability and transformation plan (STP) agenda.

The research and development department hosted the first “Engineering Better Health” event on 19 October 2017. The purpose of the event was to find solutions to clinical problems by bringing together the knowledge and expertise of NHS clinicians and leading academic engineers from universities across the East Midlands. Over 60 delegates attended the event which included engineering colleagues (including experts in tissue engineering, software development, 3D printing and specialist materials) from five local universities. They were joined by clinicians from across the trust, several of whom had identified specific clinical “problems” and wished to work with engineering colleagues to find solutions. A second event was held on 28 June 2018 with over 50 attendees.

The trust hosted the Derby Clinical Trials Support Unit (DCTSU). The DCTSU provided on-site support and expertise to clinicians who were struggling to access support from other clinical trials units (CTU). The national shortage of CTU capacity means that this is a resource that had been sought by researchers external to the trust and the unit was supporting a number of trials and studies in collaboration with investigators who were supported by National Institute for Health Research (NIHR). The DCTSU had been successful in obtaining provisional UK Clinical Research
Collaboration Clinical Trials Unit (UKCRC CTU) registration. The UKCRC CTU is a network of academic clinical trials units (CTUs) who have been assessed by an international panel of experts in clinical trials research.

The pharmacy team helped provide training for non-medical prescribers. There were various formats of learning such as team briefs and regular pharmacist meetings. Some staff felt that formalised learning was a novelty and that there needed to be more investment made in to their professional development.
Acute services Royal Derby Hospital

Urgent and emergency care

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1st July 2018 following an acquisition by Derby Teaching Hospitals NHS Foundation Trust of Burton Hospitals NHS Foundation Trust. The former acquired the latter under its existing registration with the CQC. Our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Details of emergency departments and other urgent and emergency care services

- Royal Derby Hospital Emergency department
- Queen’s Hospital Burton emergency department
- Minor injuries unit, Sir Robert Peel Community Hospital, Tamworth
- Minor injuries unit, Samuel Johnson Community Hospital, Lichfield

Royal Derby Hospital’s emergency department (ED) provides consultant led 24-hour emergency services to a population in excess of 600,000 within South Derbyshire. There is a separate paediatric (children) emergency department which is located adjacent to the adult emergency department. The adult and children’s department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

The adult emergency department comprises an initial six bedded assessment area for patients arriving by ambulance ('pit stop') at the side of the majors area, a 15 bay majors area, a six bedded resuscitation room and two triage ‘see and treat’ rooms. The minors area comprises assessment and procedure cubicles, one eye/ear nose and throat room, two dressing rooms and a plaster room. The adult area also provides two quiet rooms for relatives to utilise whilst waiting for news, a room for patients with mental health conditions and a bereavement bay.

The paediatric department comprises a two bedded resuscitation room, nine examination rooms, a plaster room and a relative’s room as well as an initial assessment area.

As part of the adult emergency department there is an ambulatory care unit receiving referrals from nursing and medical staff in ED and from GP’s. It is staffed by doctors from the medical team in the hospital.

A six bedded short stay unit (Ward 101) is available for patients from the emergency department who require a limited time of observation, generally up to 24 hours. It is staffed by ED nursing and medical staff and is open 24 hours a day.

A paediatric assessment unit which is open from 0700 until 0200 is available for children who require a short period of observation of not more than eight hours, or who are asked to return when discharged from paediatric ED to be assessed by a paediatric consultant.
Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospitals of Derby and Burton NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018

The chart above includes data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust. From August 2017 to July 2018 there were 144,613 attendances at the trust’s emergency departments as indicated in the chart above.

(Source: Hospital Episode Statistics)

Following our inspection, we requested data from the trust relating to the breakdown of ED attendances for adults and children between January 2018 and January 2019. We did not receive the correct information. (Source: DR35)

Urgent and emergency care attendances resulting in an admission at Derby Teaching Hospital
The chart above shows data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust. As the data cover periods prior to the acquisition, the data above relates to attendances at Derby Teaching Hospital only.

The percentage of A&E attendances at this hospital that resulted in an admission remained similar in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

The Data engineering team (formerly Systems and Tools) has been contacted to provide updated data for the below charts.

**Urgent and emergency care attendances by disposal method at University Hospitals of Derby and Burton NHS Foundation Trust, from August 2017 to July 2018**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted</td>
<td>40,300</td>
</tr>
<tr>
<td>Discharged*</td>
<td>85,218</td>
</tr>
<tr>
<td>Referred^</td>
<td>14,773</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>941</td>
</tr>
<tr>
<td>Died in department</td>
<td>184</td>
</tr>
<tr>
<td>Left department#</td>
<td>3,091</td>
</tr>
<tr>
<td>Other</td>
<td>96</td>
</tr>
<tr>
<td>Not known</td>
<td>10</td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Following our inspection, we asked the trust to forward us number of attendances by disposal method from August 2018 to January 2019; we did not receive the correct information. (Source: DR36)

## Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

### Mandatory training

**Mandatory training completion rates**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.

### Royal Derby Hospital

Staff at Royal Derby Hospital had mandatory training targets of either 90% or 95% for completion of most mandatory training modules. The exceptions were:

- Local induction and medicines management, where the target was 85%.
- The various resuscitation training modules, where the target was 75%.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in the emergency department at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls prevention for doctors in training</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>150</td>
<td>150</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>26</td>
<td>26</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>150</td>
<td>150</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>150</td>
<td>150</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory</td>
<td>149</td>
<td>150</td>
<td>99.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 3</td>
<td>132</td>
<td>134</td>
<td>98.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety &amp; risk awareness</td>
<td>147</td>
<td>150</td>
<td>98.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - paediatric hospital life support</td>
<td>30</td>
<td>31</td>
<td>96.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>145</td>
<td>150</td>
<td>96.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The trust had an overall training completion rate of 95.5% for qualified nursing staff in Royal Derby Hospital emergency department. The trust’s mandatory training targets were met for 15 of the 21 mandatory training modules for which qualified nursing staff were eligible. All band five nursing staff and above in paediatric ED were expected to be trained in advanced paediatric life support (APLS). At the time of our inspection this was approximately 90% although there were new staff in the department who had yet to undertake APLS training.

As of January 2019, 83% of qualified nurses were trained in automated external defibrillation (AED) and 52% in medicine management.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in the emergency department at Royal Derby Hospital is shown below:
Blood transfusion theory | 65 | 77 | 84.4% | 95% | No
Information governance | 70 | 85 | 82.4% | 95% | No
Infection control level 4 | 69 | 85 | 81.2% | 95% | No
Falls prevention for doctors in training | 4 | 5 | 80.0% | 95% | No
Local induction | 36 | 45 | 80.0% | 85% | No
Patient handling | 63 | 85 | 74.1% | 95% | No
Fire | 61 | 85 | 71.8% | 95% | No
Dementia awareness | 58 | 85 | 68.2% | 95% | No
Resuscitation - immediate life support | 37 | 80 | 46.3% | 75% | No
Resuscitation - paediatric hospital life support | - | 2 | 0.0% | 75% | No

The trust had an overall training completion rate of 80.3% for medical staff at Royal Derby Hospital emergency department. The trust’s mandatory training targets were met for five of the 19 mandatory training modules for which medical staff were eligible.

We requested up to date mandatory training compliance figures from the trust for medical staff in the emergency department at Royal Derby Hospital as of January 2019. We received compliance figures for the entire acute medicine business unit which showed figures varied from 0% (paediatric hospital life support) to 100% for induction, consent and venous thromboembolism.

Staff had access to their own training passport available electronically which they could review at any time. E-learning modules included information governance, fire, health and safety and infection control.

All staff of Band five and above were expected to have undertaken advanced paediatric life support in the paediatric emergency department. At the time of our inspection the level was 90% owing to new staff commencing their employment. Staff also receive paediatric basic life support (PBLS) and paediatric immediate life support (PILS).

Staff received training on sepsis identification and management including the use of sepsis screening tools and the use of specific care bundles. Sepsis 6 information was available as posters for staff to refer to throughout ED.

Training in mental health awareness was provided to staff as part of their induction and on a regular basis as part of their on-going training. This included elements related to dementia, learning disabilities and autism.

Safeguarding

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall safeguarding training figures for the whole trust.

Royal Derby Hospital

Staff at Royal Derby Hospital had a training target of 85% for completion of all safeguarding
training modules.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in the emergency department at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>150</td>
<td>150</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>150</td>
<td>150</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>142</td>
<td>144</td>
<td>98.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>138</td>
<td>144</td>
<td>95.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training completion rate of 98.6% for qualified nursing staff in Royal Derby Hospital emergency department. The trust’s mandatory training targets were met for all four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in the emergency department at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>79</td>
<td>85</td>
<td>92.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>76</td>
<td>85</td>
<td>89.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>67</td>
<td>79</td>
<td>84.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>40</td>
<td>75</td>
<td>53.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 80.9% for qualified nursing staff in Royal Derby Hospital emergency department. The trust’s mandatory training targets were met for two of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding training completion rates for the emergency department (ED) at Derby as of October 2018 showed nursing staff had exceeded the trust compliance target of 85%. Eighty nine percent of medical staff had completed safeguarding level 2 and 84% had completed a Workshop to Raise Awareness of Prevent (WRAP). WRAP is designed for practitioners who have little or no knowledge of the preventing extremism agenda, but who work with vulnerable young people or communities. However, only 53% of medical staff had completed level three safeguarding training. A mandatory reporting process was in place for issues relating to female genital mutilation (FGM) and staff were supported by a trust wide safeguarding policy and procedure. Contact numbers for safeguarding support for both adults and children were available in the departments.

Following our inspection, we requested data from the trust reflecting compliance rates for medical staff in the emergency department as of January 2019 for both safeguarding training level 3 and Workshop to Raise Awareness of Prevent (WRAP). We received compliance figures for the entire acute medicine business unit which showed 85% had completed WRAP training and 43% had completed safeguarding level 3.

All staff we spoke with about safeguarding understood how to recognise abuse in both adults and children and knew the processes to escalate any concerns they had.
Children were identified as being at risk of a possible safeguarding issue within the first two questions asked in triage. Any child identified at risk triggered more in-depth questions to be asked. The trust’s electronic system in children’s ED was linked to the child protection identification system (CPIS) where the nurse in charge of paediatric ED could access more information. If required appropriate people were contacted, for example social services. If a non-accidental injury was suspected and the child was not on a protection plan, all required forms were completed. A paediatric consultant always reviewed the child and the normal process of admission and investigation took place.

Training compliance for safeguarding level 3 in the paediatric ED was at 100%. The training in paediatric emergency department was a combination of e-learning and face to face by the trust’s safeguarding team.

If staff were aware of parents requiring additional support an ‘early help’ referral could be made to the children’s safeguarding team who would then alert a Health Visitor and also the school nurse where appropriate.

Adults or children who had been identified as at risk of suicide or self-harm were taken to specific rooms identified for such patients where additional risks to their safety had been minimised. The rooms were furnished appropriately and had no ligature points and no pictures on the walls, which could be used as weapons or missiles.

Mental health trained nurses formed the liaison psychiatric liaison team (PLT) and were employed by a neighbouring mental health trust. The PLT supported their colleagues in ED and were available 24 hours a day. They supported ED staff in caring for the patient, especially if they required assessment under the Mental Health Act (MHA) or required detaining under the MHA.

There were procedures on safe restraint and rapid tranquilisation. Staff we spoke with were aware of the need to closely monitor a patient’s physical health if rapid tranquilisation was required. Security staff had received training in restraint as well as mental health issues so they were prepared to assist staff and patients safely and effectively.

For patients who had been subject to, or were at risk of, domestic violence, the department used a system for alerting staff to the fact they required help. Small strips of red paper were available on the back of toilet doors, which they could hand to a member of staff discreetly. Staff would then be able to have a private conversation with the patient on how to deal with the issue going forward.

**Cleanliness, infection control and hygiene**

During our inspection all areas of the emergency department (ED), both short stay units and the ambulatory care centre (ACC) were visibly clean and tidy. Cleaning staff were outsourced to an independent provider and were in attendance or available 24 hours a day in both adults and paediatric ED which helped maintain a clean department.

A decontamination room was available in adult ED with access to the outside so patients could be admitted straight into the room without going through the department. It had a shower available although at the time of our inspection the shower curtain was not in place.

A trust policy was in place for staff to follow for controlling and preventing infection. We saw evidence of staff following best practice as well as adhering to the bare below the elbow standard when in clinical areas. This policy was included in the uniform/dress code policy.

A small device located in the resuscitation area of the adult emergency department, for detecting whether a patient had influenza within ten minutes of admission to ED, could prevent admission and reduce infection risk to other patients and staff.
Following our inspection, we requested cleaning audits for the emergency department for the previous six months prior to our visit. We did not receive these.

All areas had adequate provision of hand washing facilities for staff to use, although there were low numbers of hand gel dispensers at point of care or at the entrance to each area. One soap dispenser over a sink next to Bay 6 in the majors area had been reported as being broken on the 16 January 2019, ten days prior to our visit and was still broken during our inspection. We brought this to the attention of a senior staff member on the last day of inspection.

We observed staff adhering to the five moments for hand hygiene (World Health Organisation) during our inspection before putting on a pair of gloves to provide care and treatment. The guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.

There were side rooms within the emergency departments where patients at risk of an infectious disease were nursed which reduced the risk to other patients.

We found all equipment reviewed was visibly clean. We observed a plentiful supply of decontamination wipes in each area to support staff in maintaining the cleanliness of equipment. We also observed staff decontaminating equipment in between patient use.

**Environment and equipment**

The adult emergency department comprised an initial six bedded assessment area for patients arriving by ambulance ('pit stop') at the side of the majors area, a 15 bay majors area, a six bedded resuscitation room and two triage 'see and treat' rooms. The minors area comprised assessment and procedure cubicles, one eye/ear nose and throat room, two dressing rooms and a plaster room. The adult area also provided two quiet rooms for relatives to utilise whilst waiting for news, a room for patients with mental health conditions and a bereavement bay.

The adult ambulatory care unit had eight trolley cubicles which included two nurse triage bays. A deep vein thrombosis (DVT) clinic was run Mondays to Fridays from this area.

A six bedded short stay unit (Ward 101) was available for adult patients from the emergency department who required a limited time of observation, generally up to 24 hours. One of the beds was contained in a cubicle which was often used for patients admitted at end of life or those with mental health issues.

The paediatric department comprised a two bedded resuscitation room, nine examination rooms, a plaster room and a relative’s room as well as an initial assessment area.

A paediatric assessment unit was available from 0700 until 0200 for children who required a short period of observation of not more than eight hours, or who were asked to return for a follow-up appointment when discharged from paediatric ED to be assessed by a paediatric consultant.

All areas were within a short distance of x-ray facilities and further imaging requirements such as computerised tomography (CT). The helipad was situated on the hospital roof which meant seriously ill patients could be transferred to the emergency department by helicopter quickly.

Card operated doors were in place between the main areas of the ED which meant unauthorised access was limited.

Any new medical equipment was delivered through the medical engineering department and entered onto the trust’s asset management database. A maintenance plan had been established for all items and entered onto the database with equipment labelled with the equipment number and the ‘next service due’ date. Equipment was serviced as per the maintenance plan and the emergency
department advised medical engineering of any items not completed. Maintenance priority was centred on patient and staff safety. A risk assessment was conducted for all new equipment to categorise the maintenance risk which in turn was reflected in the management of the maintenance plan. Priority was given to ensure higher risk items were maintained as per the plan.

Repairs were prioritised to ensure equipment critical to service provision was returned to operational use as quickly as possible.

An equipment replacement plan had been established and was prioritised on the basis of risk to patients and service provision prior to allocation of available funding.

We reviewed 11 items of equipment in the department. All items had evidence of an in-date service and electrical safety test. Staff were aware of the process for reporting items of equipment which were broken or not working appropriately and knew the process of how to obtain another piece, for example a syringe driver used on Ward 101, from the equipment library.

Resuscitation equipment was checked on a weekly basis and tamper proof tags applied. We reviewed checks for the previous month and saw they were complete. Staff told us that if resuscitation equipment was used trolleys were restocked and checked immediately following their use to ensure all equipment was always available when required.

A dedicated room was available for adult patients to receive a psychiatric assessment. It was minimally furnished as per the Quality Standards for Liaison Psychiatry Services in 2017. Furniture was sturdy and of a good condition. No ligature points were available in the room. Ligature points are anything which can be used to attach cord, rope or other material for the purpose of hanging or strangulation. Ligature cutters were available in the department. There were no pictures on the walls and no windows in the room; lighting was adequate.

The room had two doors to enable a member of staff to exit through one if the other was barred.

Although a push button alarm was not available around the room, one specific chair had access to a panic alarm underneath it to enable a staff member to call for help if required. The psychiatric liaison nurses we spoke with told us they always sat in that chair during their assessment process. Anyone at risk of self-harm or harming others identified during the triage process was placed in an area near the nurse station in the majors area prior to a psychiatric assessment process to ensure they were within sight of staff.

In paediatric ED, children with mental health issues were cared for in a separate cubicle and monitored closely by staff until they could be assessed by the child and adolescent mental health service (CAMHS). Plans were in place to improve the paediatric emergency department within the next two years as part of the ‘front door’ project, which would include a CAMHS unit with bespoke rooms for those patients and a CAMHS office. Staff were very excited about this and realised they would be able to give a much better service to children and young adults.

During our inspection the paediatric waiting room was being refurbished. However, we saw items were offered to occupy younger children and a play specialist was available.

We reviewed a selection of 25 consumable items in all the areas of the department. These included blood bottles, cannulas, needles and syringes. All were found to be in date.

Clinical and domestic waste was correctly separated. Waste bins provided were compliant with health technical memorandum (HTM) 83 and foot operated which are requirements under the larger waste management guidance document HTM 07-01 ‘safe management of healthcare waste’. The management and disposal of sharps was complied with, in accordance with trust policy.

Assessing and responding to patient risk
University Hospitals of Derby and Burton NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

In the CQC Emergency Department Survey 2016, the trust scored about the same as other trusts for all five questions related to assessing and responding to patient risk.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

In the CQC Emergency Department Survey, the trust scored about the same as other trusts for all five questions in the Emergency Department Survey 2016 relevant to assessing and responding to patient risk.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
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</tr>
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<td></td>
</tr>
<tr>
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</tr>
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<td>Q34. While you were in the emergency department, did you feel</td>
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</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the median time from arrival to initial assessment was better than the England average in 10 of the 12 months.

Over these 12 months there was an overall deterioration in the trust’s performance against this metric.

In November 2017 the trust’s median time to initial assessment was four minutes compared to the England average of seven minutes.

In October 2018 the median time to initial assessment was six minutes compared to the England average of eight minutes.

Ambulance – Time to initial assessment from November 2017 to October 2018 at University Hospitals of Derby and Burton NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Following our inspection, we requested data from the trust showing times of arrival by ambulance to initial assessment between November 2018 and January 2019. We did not receive this. (Request: DR41)

Royal Derby Hospital

From December 2017 to November 2018 there was an overall downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Derby Hospital.

In December 2017, 61.2% of ambulance journeys had turnaround times over 30 minutes.

In November 2018, 50.4% of ambulance journeys had turnaround times over 30 minutes.
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

**Royal Derby Hospital**

From November 2017 to October 2018, the hospital reported 19 “black breaches”. Nearly all occurred from November 2017 to May 2018, with the largest numbers in March and May 2018 (five each).

The most common descriptions of breaches were “no clinical staff taking handover” (four breaches, all in March 2018) and “diverted to another department” (four breaches, all in May 2018).
Following our inspection, we asked the trust for the number of black breaches from May 2018 to January 2019. We did not receive this information. *(Request: DR 745)*

Systems were in place for assessing all patients arriving in the emergency department to determine how quickly they should be reviewed. This included a clear streaming/triage process for both ambulance arrivals and walk-in patients. Criteria were in place for staff to determine which patients could be signposted to the primary care centre.

Clinical handovers were held separately for medical and nursing staff morning and evening. Safety ‘huddles’ for all staff were held at 11.30am, 3.30pm and 10pm with a further operational meeting at 8.30am. Bed meetings were normally held at 9am, 12 midday and 4pm with a further two when the departments were busy. The meetings were to ensure medical and nursing staff were aware of the status of patients in their care, treatment plans and next steps to be taken to ensure continuity of safe care, thereby reducing risk.

During our inspection we attended one of the daily bed meetings. Personnel in attendance included senior matrons from all areas of the hospital, the on-call manager, operations manager and director of operations. The focus was on any additional staffing required and moving those medical patients that needed to be admitted from the emergency department. We saw senior staff working together with good evidence of problems being shared, multidisciplinary working in place and the process being a trust wide response and not solely an ED problem.

During the meeting there was a discussion about the ‘barometer’ used by the trust to determine how busy the hospital was. The barometer stated the hospital was on ‘amber’ although it was known ED was on ‘red’. The director of operations was aware of the discrepancy and told us the barometer was inaccurate and the process needed to be reviewed.

A live electronic feed from the local ambulance trust informed the emergency department on the arrival times of ambulances due into the department. If a seriously ill patient was being conveyed to the hospital, ED was advised prior to their arrival and could prepare in a timely way.

Patients brought in by ambulance were handed over to hospital staff either in the ‘pitstop’ area or in resuscitation, dependent upon how sick they were. We observed full handovers from ambulance crews undertaken in a professional and timely manner. We did not witness any patients returning to ambulances because the department could not accommodate them.

There was no written direction for regularity of physical observations to be undertaken on the reverse of the Cas/NEWS2 score card. For example, every 30 minutes, every 15 minutes or hourly. To mitigate risks multiple posters alerted staff to patients who needed to be escalated to a senior
clinician. Staff informed us there was an expectation that all patients with a NEWS2 score of more than 5 would be reviewed by the consultant on duty. We did not observe any risk to patients as a result.

We reviewed 15 sets of patient records picked at random from across ED. Observations in adult ED were recorded on the NEWS2 chart and the regularity of when they should be undertaken was recorded on the digital record. We found there was inconsistency with recording observations, which was often decided by individual staff members as there was no specific triggers for regularity of observations dependent upon the NEWS2 score. These were not printed on the reverse of the NEWS2 chart. For example, every 30 minutes, every 15 minutes or hourly. To mitigate risks multiple posters alerted staff to patients who needed to be escalated to a senior clinician. Staff informed us there was an expectation that all patients with a NEWS2 score of more than 5 would be reviewed by the consultant on duty.

During the week of our inspection (28 Jan 2019 to 3 February 2019) information received from the local NHS ambulance trust showed average daily ambulance handover times from ambulance staff to ED staff ranged from 15 minutes 51 seconds to 18 minutes 55 seconds which was only just above the standards of 15 minutes.

Data in the tables shown above shows that all patients were assessed within fifteen minutes of admission and generally better than the England average.

Experienced nurses were on duty on each shift to triage patients who self-presented in the department. Reception staff were able to quickly alert the triage nurses on duty if a patient deteriorated. The nurse responded immediately and treated the patient appropriately. Children were triaged by a children’s nurse. Pain levels were assessed during this process.

Staff knew the assessment and streaming/triage processes and the whole department, although at times very busy, appeared calm with staff in control. Staff were trained and assessed prior to being on triaging duties.

If a patient had been deteriorating during their journey or was deteriorating as they arrived at ED this was communicated by the ambulance crews to the ED pit stop co-ordinator who would respond to the information appropriately and prioritise them for urgent attention.

On admission adult patients were assessed using the NEWS2 scoring system which included a baseline assessment to determine and monitor the severity of the patient’s condition. The score determined the degree of illness of a patient and was based on a number of vital signs including respiratory rate, oxygen saturation level, blood pressure and heart rate.

In the paediatric emergency department nurses in charge were paediatric trained. Children were assessed using the paediatric observation priority score (POPS). POPS is a bespoke emergency and urgent care checklist which quickly scores (between 0 and 16) acutely ill children on a combination of physiological, behavioural and risk identifiers using easy to collect data with an assessment of pain being experienced by the child. This enables staff to assess, prioritise and treat acutely ill children and manage risk in busy clinical areas.

Paediatric early warning scores were also used to identify children whose condition was deteriorating. We observed staff who assessed children listen to the child’s version of events and not just their parents when this was appropriate. Staff told us any child or adult who scored highly would require screening for sepsis. Sepsis is a life-threatening condition that arises when the body’s response to infection injures its own tissues and organs and action is required quickly.

Clearly labelled sepsis trolleys, containing amongst other items, syringes, blood bottles, intravenous (IV) fluids and antibiotics, were available in both adult and paediatric ED’s so treatment could be instigated quickly. During one day of the inspection we observed appropriate and timely care and
treatment being given to two adult patients who had both been diagnosed with sepsis within the department.

Sepsis Six Care Bundle posters were in all areas of the departments to remind staff of their responsibilities and what they should do. The Sepsis Six Care Bundle is an initial resuscitation bundle designed to ensure basic intervention is given within the first hour including administration of IV antibiotics. There is strong evidence that the prompt delivery of basic aspects of care detailed in the Sepsis Six Care Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions.

The trust carried out quarterly sepsis audits. Information received following our inspection showed a compliance rate of 93% (July to September 2018) and 100% (October to December 2018) for sepsis screening and 52% (July to September 2018) and 64% (October to December 2018) for antibiotic administration within one hour. Results included all emergency admission areas at Royal Derby Hospital and were not broken down by area. (Source: DR55)

In ‘pit stop’ we observed the use of thin different coloured silicone wrist bands denoting what percentage of oxygen patients should be receiving if oxygen therapy was required for their treatment. The wristbands provided a visual prompt for staff as to the individual patient’s target oxygen saturation level whilst in hospital. The colour-coding helped staff titrate oxygen to the correct range, limiting oxygen toxicity but also under oxygenation, both of which can cause harm to patients.

Processes were in place for staff to follow in the event of a sudden unexpected death of a baby or child in the department. Support was available when required.

A psychiatric liaison team staffed by mental health trained nurses was available to the emergency department 24 hours a day to support patients admitted with mental health problems and the staff caring for them. We reviewed two patients requiring intervention by the teams who both received care in a timely manner. Staff informed us the teams were very responsive and approachable. Contact numbers were made easily available for staff members to use.

Two child and adolescent mental health (CAMHS) nurses were also available from 8 am until 10 pm seven days a week.

When an aggressive, violent or traumatic incident occurred in the department, staff were offered debriefing sessions to help them come to terms with the incident. Patients brought into the department by ambulance were brought into the ‘pit-stop’ area throughout the twenty-four hour period. Our observations throughout the inspection showed the handover from ambulance staff to pit-stop staff was smooth and generally quick. On one occasion the handover took place within two minutes which was well within the recommended 15 minutes. ED staff did a full set of observations on all patients once handed over; they did not rely on ambulance staff observations for on-going care.

We observed seven triage times during a period of observation on 31 January in the ‘pit-stop’ area. These varied between five and seven minutes. We requested average arrival to triage times for both adults and children during the week of inspection from the trust. The figures provided evidenced the average time for triage for adults was 25 minutes and for children 17 minutes.

Ambulance staff from a local NHS trust told us they felt supported and listened to by both medical and nursing staff on conveyancing a patient to ED especially in resus. They also said access to trolleys for patients arriving by ambulance was not always timely and this could cause delay in patient handover.
The emergency department had a very clear escalation process in place when pit stop was busy with either large volumes of patients arriving or patients in pit-stop for longer than 60 minutes.

The emergency department took responsibility for venous thromboembolism risk assessments of patients with lower limb fractures or injuries and patients admitted to the short stay unit. Venous thromboembolism or VTE is a condition in which a blood clot forms, most often in the deep veins of the leg, it can travel in the circulation, lodging in the lungs (known as pulmonary embolism or PE).

Staff who arranged for a patient’s transfer to a ward from ED were required to complete a patient transfer form which clearly identified the patient and the receiving ward. In addition, information regarding their situation, background and assessment were documented with recent observations taken. The form was completed/signed by a nurse or doctor and a nurse on the receiving ward. This ensured that risks to the safety of the patient were minimised on transfer.

Robust processes were in place when the registrar ‘bleep holder’ was preparing to handover the bleep to the next shift. This ensured, amongst others, all staff were identified and where they were working, if any staff were absent or sick and who the consultant was on call.

During our inspection, on one occasion we saw no physiological observations were taken of a patient in the ‘pit-stop’ area pre and post administration of intravenous morphine. Although National Institute for Health and Care Excellence (NICE) guidance does not state observations should be completed, it does state ‘respiratory depression is a major concern with opioid analgesic’. We advised an ED consultant of our concerns who stated there was an expectation within the department that observations were taken.

Nurse staffing

The trust reported their staffing numbers for qualified nursing staff working in urgent and emergency care as below as of March 2018 and October 2018.

There was a small increase in the number of qualified nursing staff in post at Royal Derby Hospital in October 2018 compared to the number in post in March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>139.5</td>
<td>147.2</td>
</tr>
<tr>
<td>Queen's Hospital Burton</td>
<td>89.6</td>
<td>99.4</td>
</tr>
<tr>
<td>Total staff</td>
<td>229.1</td>
<td>246.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Qualified nursing staff for January 2019

<table>
<thead>
<tr>
<th>Day hours</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,764</td>
<td>6,429</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Night hours</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,341</td>
<td>5,399</td>
</tr>
</tbody>
</table>

Care staff for January 2019

<table>
<thead>
<tr>
<th>Day hours</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4,288.50</td>
<td>4,277.50</td>
</tr>
<tr>
<td>Night hours</td>
<td>Planned</td>
<td>Actual</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>4,218.50</td>
<td>3,953.00</td>
</tr>
</tbody>
</table>

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 10.7% for qualified nursing staff working in urgent and emergency care. The trust had a target vacancy rate of 6%.

The breakdown by site was as follows:

- Royal Derby Hospital: 8.5%
- Queen’s Hospital Burton: 14.1%

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

The trust provided a nurse vacancy rate as of January 2019 for the whole medical division which was 8%. It did not provide the component for emergency care.

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 10.6% for qualified nursing staff working in urgent and emergency care. This was within the trust’s turnover target of between 8% and 12%.

The breakdown by site was as follows:

- Royal Derby Hospital: 9.9%
- Queen’s Hospital Burton: 11.8%

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

The trust provided a nurse turnover rate as of January 2019 for the whole medical division which was 7%. It did not provide the component for emergency care.

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 4.7% for qualified nursing staff working in urgent and emergency care. This was higher than the trust’s target of 3.8%.

The breakdown by site was as follows:

- Royal Derby Hospital: 4.7%
- Queen’s Hospital Burton: 4.8%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

The trust provided a nurse sickness rate as of January 2019 for the whole medical division at Royal Derby Hospital which was 9%. It did not provide the component for emergency care.

**Bank and agency staff usage – Jan 19**

The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in urgent and emergency care.
From November 2017 to October 2018, the trust reported that 9.3% of qualified nursing staff hours in its urgent and emergency care services were filled by bank staff, while 6.8% were filled by agency staff. In addition, 3.3% of qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>22,132</td>
<td>8.2%</td>
<td>375</td>
<td>0.1%</td>
<td>9,848</td>
<td>3.7%</td>
<td>268,695</td>
</tr>
<tr>
<td>Queens Hospital</td>
<td>20,716</td>
<td>10.7%</td>
<td>31,198</td>
<td>16.2%</td>
<td>5,195</td>
<td>2.7%</td>
<td>193,056</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42,847</strong></td>
<td><strong>9.3%</strong></td>
<td><strong>31,572</strong></td>
<td><strong>6.8%</strong></td>
<td><strong>15,042</strong></td>
<td><strong>3.3%</strong></td>
<td><strong>461,751</strong></td>
</tr>
</tbody>
</table>

Over the same period, the trust reported that 17.2% of unqualified nursing staff hours in its urgent and emergency care services were filled by bank staff, while 0.6% were filled by agency staff. In addition, 4.5% of qualified nursing staff hours were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>16,721</td>
<td>14.1%</td>
<td>0</td>
<td>0.0%</td>
<td>3,769</td>
<td>3.2%</td>
<td>118,669</td>
</tr>
<tr>
<td>Queens Hospital</td>
<td>13,745</td>
<td>23.4%</td>
<td>1,128</td>
<td>1.9%</td>
<td>4,271</td>
<td>7.3%</td>
<td>58,728</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30,466</strong></td>
<td><strong>17.2%</strong></td>
<td><strong>1,128</strong></td>
<td><strong>0.6%</strong></td>
<td><strong>8,041</strong></td>
<td><strong>4.5%</strong></td>
<td><strong>177,397</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

At the time of our inspection, we were informed the emergency department (ED) was fully recruited with nursing staff and had started to collate a list of nurses wishing to join the team. There were no nurse vacancies. During our visit we saw all nursing staff including advanced care practitioners (ACPs) able to manage their case load efficiently and effectively in all areas, even when busy, and meet patient’s needs.

In the major’s area of adult ED nursing staff were divided into two teams with each caring for their own patients.

Staffing for each shift was based on knowledge of when peak demand for the department occurred. There were at least 14 qualified staff and nine health care assistants on both the day and night shift with an additional three qualified staff on duty between 11am and 11.30 pm. No agency staff were used and bank staff were used to cover annual leave or sickness. Bank staff are those health care workers who do not have a permanent contract to work in a specific area but can be utilised to fill gaps in the workforce due to for example sickness or annual leave cover. The department used specific bank staff who already worked in the trust and had worked in the department on a regular basis. They therefore knew the layout of the department as well as the routine. The department had access to a ‘virtual’ group of trained healthcare support workers who would assist ED in conveying patients to wards when the patient’s condition did not give rise for concern and therefore did not require a trained nurse to accompany them. This meant trained nurses could remain in the department to care for and treat other patients.

The ‘pit stop’ area of six bays was staffed by three qualified nurses (RNs) and three health care assistants (HCAs). At times during each afternoon of our visit we saw all cubicles filled with additional patients waiting in the area to be assessed. One nurse on each shift was in charge of the
area and had oversight of the reasons for patients’ admission and the on-going movement of patients to other areas.

Ward 101 was staffed by one qualified nurse and one health care assistant (HCA) on each shift caring for up to six patients. This had increased following our last inspection in the unit when only one qualified member of staff was on duty on each shift. Staff we spoke with told us they felt it was a much safer place to work. If required, staff could request a further staff member for 1:1 supervision of a patient. When asked, a member of staff informed us they were nearly always able to obtain a further member of staff for supervision duties. This may include caring for a patient who was at end of life, had alcohol intoxication or had taken a drug overdose.

The ambulatory care centre (ACC) was staffed between 8am and 11pm involving three shifts. A registrar was always on duty between these hours with two junior doctors (senior house officer level) between 8am and 4pm. A consultant provided cover between 1pm and 7pm and two junior doctors (senior house officer level) between 3pm and 11pm. In addition, an ACP was available in this area.

In the adult and paediatric emergency departments (EDs) specific identified staff were given roles on each shift. For example, ‘nurse in charge’, who had an overview of all patients admitted. A health care assistant had the role of the ‘chaser’ in adult ED along with another qualified nurse, the ‘escalation manager’; these two staff identified patients who were waiting for, for example diagnostic tests, admission to the medical admission unit or referrals to another specialty. Both roles increased the flow in the department. The staff were identifiable by arm bands so were easily seen. The ‘escalation manager’ was a pilot role in place until the end of March 2019 when it would be evaluated to determine if it was going to continue.

Six emergency nurse practitioners (ENPs) were on duty each day of the week spread across the times from 0700 am to 0100 am. They cared for patients with minor injuries or illnesses. ENPs are health care professionals such as nurses or paramedics with enhanced skills in medical assessment and additional clinical skills.

The psychiatric liaison team nurses from a neighbouring mental health trust were available 24 hours a day, seven days a week to assess adult patients with mental health issues. Child and adolescent mental health service (CAMHS) nurses were also available from 8 am until 10 pm seven days a week.

Paediatric trained nurses were available in paediatric ED on every shift. Although adult trained nurses could sometimes be found in the department they were never left alone and always supported by paediatric trained nurses.

A qualified play specialist was on duty every day between the hours of 2pm to 6.30pm which was the busiest time for attendances in the paediatric emergency department.

**Medical staffing**

The trust reported their medical staffing numbers for urgent and emergency care for March and October 2018 as below.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
</table>

The number of medical staff in post at Royal Derby Hospital increased from 74.8 whole time equivalents (WTEs) in March 2018 to 82.6 WTEs in October 2018. As a result, the fill rate increased from 74.1% to 79.5%.
<table>
<thead>
<tr>
<th></th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>74.8</td>
<td>100.9</td>
<td>74.1%</td>
<td>82.6</td>
<td>103.9</td>
<td>79.5%</td>
</tr>
<tr>
<td>Total staff</td>
<td>74.8</td>
<td>100.9</td>
<td>74.1%</td>
<td>82.6</td>
<td>103.9</td>
<td>79.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported the following vacancy rate for medical staff in urgent and emergency care. The trust had a target vacancy rate of 6%.

- Royal Derby Hospital: 25.1%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Following our inspection, the trust sent us information relating to the vacancy rates in each grade of medical staff in the emergency department as of January 2019:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
</tr>
<tr>
<td>Career grade/ associate specialist</td>
<td>0.6</td>
</tr>
<tr>
<td>Specialty doctor</td>
<td>2.9</td>
</tr>
<tr>
<td>Clinical teaching fellow</td>
<td>2.7</td>
</tr>
<tr>
<td>Junior clinical fellow</td>
<td>2.3</td>
</tr>
</tbody>
</table>

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 25% for medical staff in urgent and emergency care at Royal Derby Hospital. This was higher than the trust’s target of having a turnover rate of between 8% and 12%.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Following our inspection, the trust informed us that in January 2019 the medical staff turnover rate in Derby emergency department was 14.9%.

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 4.2% for medical staff in urgent and emergency care at Royal Derby Hospital. This was higher than the trust's target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

From November 2017 to October 2018, the trust reported that 0.2% of medical staff hours in its urgent and emergency care services were filled by bank staff at Royal Derby Hospital. Over the same period 2.4% of medical staff hours were filled by locum staff. In addition, 2.6% of medical staff hours were not filled by bank or agency staff to cover staff absence.
As of September 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was lower than the England average.

Medical staff bank and locum usage in hours for January 2019 amounted to 5,233 of the 6,400 required, leaving a total of 1,178 hours unfilled. The unfilled hours were at registrar and senior hours officer level.

### Staffing skill mix for the 96 whole time equivalent staff working in urgent and emergency care at University Hospitals of Derby and Burton NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Locum Hours</th>
<th>Locum %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>847</td>
<td>0.2%</td>
<td>8,668</td>
<td>2.4%</td>
<td>9,152</td>
<td>2.6%</td>
<td>356,329</td>
</tr>
<tr>
<td>Total</td>
<td>847</td>
<td>0.2%</td>
<td>8,668</td>
<td>2.4%</td>
<td>9,152</td>
<td>2.6%</td>
<td>356,329</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

At the time of our inspection the adult emergency department (ED) had 15.7 whole time equivalents (WTE) consultants in post in the adult emergency department delivering care between 7.30 am and 02.00 am for most days of the week. The Royal College of Emergency Medicine recommends that to achieve a 16 hour presence each day in an ED department seeing 100,000 patients each year requires 16 whole time equivalent (WTE) consultants in post.

In addition, there were:

- Twentyeight specialty doctors equating to 24 WTE. A specialty doctor post is not a training grade; it is a grade where a doctor has at least 4 years of postgraduate training, two of those being in a relevant specialty, in this case emergency medicine.

- Ten junior clinical fellows. A junior clinical fellow is a very senior house officer (SHO) or a very
junior specialist registrar but is expected to produce papers for their unit on a research topic directed by the consultant.

Seven core training (CT) doctors from years one to three.

Ten GP VTS (General Practitioner Vocational Training Scheme) or Foundation Year Two doctors.

Three Foundation Year One doctors (FY1).

Eighteen ACPs (six trained and 12 trainees at varying stages) worked in the adult emergency department and five (two trained and three trainees) in the children’s emergency department. ACPs are clinical professionals who have developed their skills and theoretical knowledge to a very high standard and are able to carry out tasks similar to that of a junior doctor.

An FY1 was on duty in the short stay unit for adults between the hours of 8.30am to 5.30 pm from Monday to Friday and Saturday from 8.30am to 2.30 pm. On Sundays the unit was covered by an adult emergency department consultant when required.

Consultants with additional training in paediatrics were available to support paediatric ED. All organisations employing 10 or more trainee doctors are required to appoint a guardian who represents them and helps resolve issues related to working hours for junior doctors employed by it.

The junior medical staff in ED were able to report any issues they had in relation to their working hours through ‘exception’ reporting’. Prior to our inspection an FY1 doctor had reported issues through this system which had prompted a work schedule review. This had led to a change in the rota times which had resolved the issue. At the time of our inspection there were no exceptions being reported.

A consultant physician was available in adult ED three or four times week from 11 am until 7 pm to review medical patients quickly and help increase the flow of patients though the process of admission or discharge where appropriate. Staff reported there was an excellent working relationship between ED and acute medicine.

Records

Staff used a combination of paper and digital records for patients admitted to the adult emergency department (ED). The trust had trialled a digital only system previously but this had not been successful. A new digital system was going to be re-commenced gradually in March 2019 and would include electronic recording of observations.

Paediatric ED used a digital only system which staff informed us they found easy to use and records for patients admitted to the minors’ area were all computerised.

The digital system being used in adult ED at the time of our inspection had not been upgraded to meet the reporting requirements for the 2018 emergency care data set (ECDS). ECDS is a national data set for urgent and emergency care, which is used to collect information from emergency departments across England. By implementing ECDS across all emergency departments, data will be able to be used to provide a more accurate, detailed and comprehensive picture of all emergency attendances. The introduction of the ECDS introduced a requirement for providers to increase submission of their emergency department data from monthly/weekly to daily in line with a national move to have access data in a timelier manner.

The initial ‘cas card’ for patients admitted to adult ED majors was an A3 sheet of paper which had the NEWS2 chart and scoring system in the middle. Information such as diagnostic tests required, pain score, allergies and venous cannulation were documented along with drug
prescription/administration and intravenous fluids. All paper records were scanned when a patient was given a designated ward for admission. Times of booking in and triage were placed on the digital system.

Paper notes were kept in plastic folders. Although secure when in the folder, single sheets could be lost. Electronic records could only be accessed by a system that was password protected.

The ambulatory care centre (ACC) used two digital systems for record keeping and recording observations and was a paper free unit.

The psychiatric liaison (PL) team had access to the ED and were responsible for recording their own assessment of patients in the emergency department’s digital system. However, ED staff could not access the local mental health trust notes on patients who had been or were currently patients of the acute mental health trust. Unless they were informed by the PL team they did not know if patients had received previous contact or treatment by the acute mental health trust. The trust was aware of this and had undertaken discussions with the acute mental health trust although the situation remained the same. Paediatric nurses told us they could usually see any previous or current Child and Adolescent Mental Health Services (CAMHS) involvement through the electronic GP system.

Paper records for patients admitted to a ward were sent with the patient but scanned as soon as they had a bed available for them. Records for patients discharged were kept securely, scanned, stored and then subsequently destroyed.

Records on Ward 101 were in both electronic and paper format. A full assessment of care was undertaken as soon after admission as possible and placed in the booklet produced for this purpose. A plan of care for each assessment was then completed. It included, but was not limited to assessments for falls, personal handling, pain, oral hygiene and pressure ulcers.

**Medicines**

Medicines were prescribed, administered, recorded and stored appropriately. Intravenous fluids were stored on shelving. We did not see any additional high visibility shelf labelling for intravenous fluids for particular use, for example those containing potassium. This meant in an emergency the fluid could be picked up by mistake.

Drug fridge temperatures were recorded on a daily basis and were in the correct temperature range. Staff were aware of the actions to take if fridges were not within the correct range.

Recording of medicine administration was undertaken using a digital system on Ward 101, which prevented any overdosing of drugs.

Staff from the pharmacy department visited every day to check stock levels and restock when required. Drug cupboards we reviewed were tidy and stocked appropriately. On Ward 101, a pharmacist assessed patient’s medication prior to discharge and if using blister packs at home would order them to be obtained as soon as possible. Their role also included a reassessment of the patient’s medication and liaising with the GP if changes were required.

Any medicines delivered to the ED department were checked and stored appropriately.

Controlled drugs checked across all the areas of the emergency department were found to be correct including nasal diamorphine for children. Patient records reflected any known drug allergies. A cold spray was available for children prior to an injection which reduced any pain they might feel.

Resuscitation trollies we checked had appropriate emergency medicines available.
If patients were discharged with any medicines, labels gave clear instructions on how and when to take them.

We reviewed patient’s Cas charts/digital records and saw they were completed appropriately. They included oxygen administration, with the recommended flow rate completed and whether a silicone wristband stating the flow rate had been applied when this was appropriate.

An in-date Patient Group Directive (PGD) policy was in place. PGD’s are legal mechanisms that allow certain health care professionals (for example, nurses, advanced care practitioners (ACPs) and emergency nurse practitioners (ENPs)) to supply and/or administer medicines to certain patients without a prescription and only after approval by a pharmacist and training/sign-off for the individual practitioners. Only three drugs were under a PGD for children, for example liquid paracetamol. For adults there were a number of different groups of PGD’s that staff could supply or administer dependent upon their role. Thirteen medications were approved for adult registered nurses and registered healthcare professionals, 20 for ENPs and 34 for ACPs. The PGD’s were in date and were due to be reviewed between August 2019 and October 2021.

**Incidents**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Here we have included data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust in this analysis. Because it related to the same legal entity as the acquired trust we have used this to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, the trust reported three incidents classified as never events for urgent and emergency care.

All three were of never event type “Unintentional connection of a patient requiring oxygen to an air flowmeter”. Information received following our inspection demonstrated where learning had been shared across the service and appropriate actions taken as a result of the never events. *(Source DR750)*

The never events occurred in February, April and June 2018. Following our inspection, the trust informed us there had been no further ‘never events’ up to the end of January 2019.

Information received from the trust evidenced six incidents had occurred during the month of January. Three related to 12-hour trolley breaches from the decision to admit to being admitted. One incident was as a result of head injury advice not being documented in the patient’s records. Two were for patients with mental health issues waiting over twelve hours to be admitted to an appropriate mental health unit

**Breakdown of serious incidents reported to STEIS Jan 19**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Here we have included data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust in this analysis. Because it related to the same legal entity as the acquired trust we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 24 serious incidents
(SIs) in urgent and emergency care which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Treatment delay: seven
- Medication incident: five
- Diagnostic incident including delay (including failure to act on test results): four
- Surgical/invasive procedure incident: three
- Slips/trips/falls: two
- Maternity/obstetric incident: mother and baby (this include foetus, neonate and infant): one
- Sub-optimal care of the deteriorating patient: one
- Pressure ulcer: one

The time taken by the trust to report these 24 SI’s to STEIS was variable:

- 16 were reported within 14 days
- One took between 15 and 30 days to report
- Two took between 31 and 60 days to report
- Five took more than 90 days to report

Discussions we had with staff demonstrated they had a good knowledge and understanding of what an incident was and felt confident reporting them on the trust's electronic system. All Band 7 nurses had received appropriate training to undertake root cause analysis (RCA) into incidents. The Matron of the department signed these off when satisfied with the investigation had been completed to their satisfaction.

Lessons learned from any incident were shared in the department across all staff groups and embedded into their practice. Any changes required following incidents were made quickly in order to keep patients safe. For example, concerns about patients going home with intravenous cannula in place on discharge from the department had been addressed. A checklist had been devised for use by staff in the department to ensure this did not happen again. During the inspection we were informed the pro-forma was at the printers although checks were being undertaken until the documents were delivered. This process was to be rolled out to Queens Hospital Burton emergency department. This showed lessons were being learned across the two emergency departments in the trust.

We spoke with a member of staff who had been unsure of a procedure in the paediatric emergency department (ED). They informed us of two incidents where staff had learned lessons. Following one incident, panic alarms had been issued to all members of staff.

Duty of Candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients or other relevant people of certain notifiable safety incidents and provide reasonable support to that person. The regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.

The trust informed us they had applied duty of candour to 196 incidents over the twelve month period from November 2017 to October 2018 for medical care which includes the adult emergency department. A further 43 had been applied to incidents involving children and young people. We did not have the numbers broken down into different departments.

Staff knew what duty of candour was and told us they would not hesitate in reporting such incidents to a senior manager; they understood they were obliged to do this under the regulation. Senior staff in the emergency departments had received training regarding duty of candour.
through the trust’s legal services team. In addition, staff were supplied with a resource pack and flow chart. A podcast was available on the trust’s intranet, which gave staff access to information on the duty of candour when required.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported no new pressure ulcers, falls with harm or urinary tract infections in patients with a catheter in its urgent and emergency care services.

*(Source: NHS Digital)*

Data from the Patient Safety Thermometer showed that from July 2018 to January 2019 the trust reported no new pressure ulcers, falls with harm or urinary tract infections in patients with a catheter in its urgent and emergency care services. *(Source: DR54)*

**Is the service effective?**

**Evidence-based care and treatment**

**Emergency Department Survey 2016**

**Royal Derby Hospital**

As part of the admission process to ED patients were assessed for both their physical and mental health needs. Patients were referred onwards for further professional assessment/admission when this was required.

Clinical pathways based on current national guidance (National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards were in place for specific illness presentation for example chest pain, asthma, diabetic ketoacidosis and gastrointestinal bleeding. Staff used a digital system when referring to the new hospital guidance, which could be accessed quickly through the intranet desktop. This section provided up to date guidance with review dates and ratification. The guidance was for use at both trust sites but was very clear as to which trust site they related to and considered variation in service provision on the Burton and Derby sites. However, we were not assured that staff would always follow the new guidance, as old guidance was also available on the trust intranet. When we spoke to staff they informed us they would access both sections which may pose a risk.

We raised this with senior managers during our inspection who assured us actions had been taken
which included, ensuring intranet access to old guidance was unavailable and a communication ‘comms’ message had been sent to all staff by email. Furthermore, work is being undertaken to look at clinical guidelines to ensure they are safe and they are continuing as separate documents at both Royal Derby Hospital and Queens Hospital Burton. If they were being combined a decision was being made as to whether the document should be a guideline, policy or standard operating procedure (SOP).

We found there was no specific early pregnancy pathway in place. Patients were required to be assessed in ED and then referred to the gynaecology team for assessment. If the ward was busy, the team came to ED before the patient was transferred. Staff informed us this was so that patients could be stabilised in ED to keep them safe. Staff spoke with acknowledged that ED was not necessarily the right place to be for women in this situation.

The paediatric emergency department used standards applicable to the caring of children and young people in an emergency care setting which are published by the Royal College of Paediatric and Child Health (RCPCH). The guidance provides healthcare professionals, providers and service planners with measurable and auditable standards of care for children, which are applicable to all urgent and emergency care settings in the UK.

In June 2018 a new set of standards was published ‘Facing the Future: Standards for children in emergency care settings’ developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency care settings. The Derby Paediatric Observation Unit was mentioned in the publication as being one of only 50% of paediatric EDs that have such units and resulted in a 4% reduction of admissions to the paediatric in-patient wards in the hospital.

If a specific protocol based on the National Institute for Health and Care Excellence (NICE) guidance was being used to treat a patient, this was not referenced in the notes, for example gastro-intestinal bleed.

**Nutrition and hydration**

In the CQC Emergency Department Survey, the trust scored 7.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

As part of the overall care of the patients in ED, a system called ‘TRIPP’ was in place. TRIPP stood for toilet, refreshment, information, pressure area and pain. Staff covered each of the areas every two hours and this was placed on the digital record system for each patient in the department. The nurse in charge followed this up to ensure they were completed. The system showed red when this was required and green when completed, so were easily visible.

Hot and cold drinks were available in the emergency department (ED) and patients could order hot meals during day hours. Out of hours snack boxes were provided for patients if required. A drinks machine was available in the reception area. Food was only available to patients if they were permitted to eat.

A water station was available in paediatric ED. Staff informed us that parents accompanying children suffering with diarrhoea and vomiting were encouraged to start oral hydration, for example water or squash for the young person as soon as possible after arrival.

**Pain relief**

Emergency Department Survey 2016

Royal Derby Hospital
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was better than other trusts.

The trust scored 8.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

Staff responded quickly by administering pain relief medication when both adult and paediatric patients required it. During our inspection we saw levels of pain were reviewed and documented for both adults and children as part of their assessment process and reviewed on a regular basis. For adults this was part of the TRIPP assessment; Toilet, Refreshment, Information, Pressure area care and Pain.

For adults, a new system for patients to alert staff when they were in pain had been introduced in the department as a result of their own auditing processes. Following the administration of pain relief medication, patients were given a small ‘red card’ which stated they had received medication and when. It also asked them to alert either nursing or clinical staff after a specific time scale to reassess their pain. This meant patients were empowered to have their pain reassessed in order that they could be given more pain relief if it was necessary. The red cards were available in languages other than English, for example Polish, Russian, Urdu and Punjabi. During our inspection we saw one adult patient in pain who had not been given pain relief or a red card. We alerted staff and the patient received immediate attention.

We saw no children in pain and staff were vigilant in ensuring children were assessed on a regular basis.

Staff were able to use a special spray to help take the sting out of injections for patients with a learning disability or for children. Nasal diamorphine was used on a regular basis for children with high levels of pain and was seen to be very effective.

Paper work that accompanied patients who were referred to the ambulatory care unit from the adult emergency department stated clearly if and what pain relief had been given.

**Patient outcomes**

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Royal Derby Hospital**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Royal Derby Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for six of the seven standards:

- **Standard 1a** (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 55.8%; UK: 19%.

- **Standard 2a** (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 59.0%; UK: 26%.

- **Standard 3** (fundamental): High dose nebulised β2 agonist bronchodilator should be given...
within 10 minutes of arrival at the emergency department. This department: 53.7%; UK: 25%.

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 92.1%; UK: 77%.

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  
  o Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 50.0%; UK: 19%.
  o Standard 5b (fundamental): within 4 hours (moderate). This department: 60.0%; UK: 28%.

The department’s result for the one remaining standard was within the middle 50% of results.

RCEM Audit: Consultant sign-off 2016/17

Royal Derby Hospital

In the 2016/17 Consultant sign-off audit, Royal Derby Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 25.0%; UK: 12%.

The department’s results for the remaining three standards were all within the middle 50% of results.

RCEM Audit: Severe sepsis and septic shock 2016/17

Royal Derby Hospital

In the 2016/17 Severe sepsis and septic shock audit, Royal Derby Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for six standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 95.2%; UK: 69.1%.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 98.4%; UK: 64.6%.

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 81.4%; UK: 30.4%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 80.7%; UK: 60.0%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 77.8%; UK: 43.2%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 60.7%; UK: 18.4%.

The department’s results for the remaining two standards were both within the middle 50% of results.

**Unplanned re-attendance rate within seven days**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

From November 2017 to October 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. However, the trust’s performance for this metric was better than the England average.

Over these 12 months there was overall a modest improvement in the trust’s performance against this metric.

In November 2017, the trust’s performance was 6.9% compared to the England average of 7.6%.

In October 2018, the trust’s performance was 6.0% compared to the England average of 8.0%.

**Unplanned re-attendance rate within seven days - University Hospitals of Derby and Burton NHS Foundation Trust**

![Graph showing the unplanned re-attendance rate](image)

We were informed the department participated in RCEM audits and used their involvement to improve outcomes for patients.

**Competent staff**

**Appraisal rates**

From November 2017 to October 2018, 88.9% of staff within urgent and emergency care at the
trust received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were not met for medical staff or additional clinical services staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>36</td>
<td>36</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>201</td>
<td>221</td>
<td>91.0%</td>
<td>90%</td>
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</tr>
<tr>
<td>Additional clinical services</td>
<td>62</td>
<td>75</td>
<td>82.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>13</td>
<td>22</td>
<td>59.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>338</strong></td>
<td><strong>380</strong></td>
<td><strong>88.9%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Over the same period, 89.8% of staff within urgent and emergency care services at Royal Derby Hospital received an appraisal. The trust’s training targets were not met for medical staff or additional clinical services staff.

Following our inspection was asked for updated compliance rates for medical staff appraisals. We did not receive this information. (Request DR56)

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
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<tr>
<td>Administrative and clerical</td>
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<td>18</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
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<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>126</td>
<td>136</td>
<td>92.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>51</td>
<td>58</td>
<td>87.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>11</td>
<td>20</td>
<td>55.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>230</strong></td>
<td><strong>256</strong></td>
<td><strong>89.8%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Security staff were available 24/7 for emergency department staff. Most of the time this was because nursing/medical staff required support for patients with mental health needs. Although always available, at times emergency staff had to wait for security because they were busy elsewhere in the hospital. Security staff had received training in conflict resolution and restraint to enable them to support staff and patients in the emergency department and the short stay unit.

The induction process for both medical and nursing staff was comprehensive and included an introduction to the department as well as corporate items. New nursing staff in the emergency department were treated as supernumerary for the first four weeks of their employment in ED and was strictly adhered to. This meant staff had time to familiarise themselves with the department, other members of the team and the department’s policies and procedures. An extension of their
supernumerary role was negotiable if necessary.

During the induction process new nursing staff had exposure to all areas of the department and were allocated a specific person to work with. An emergency department clinical educator took on the role of ‘preceptor’ during this period. Following induction, staff were allocated a band six or seven nurse and their progress reviewed every three months for a year, with a clinical educator supporting them during this time.

Ensuring staff were competent to undertake their role in the department was seen as a priority for senior managers. The clinical education team for the emergency department was led by a Band 7 nurse and consisted of staff at all levels including a consultant and a registrar, emergency nurse practitioners and health care support workers. Clinical educators were responsible for delivering training three times a day for a half hour period, delivering the same content each week. These took place at 8.00am, 8.30 am and 9.00 am. This meant all staff could receive the same training. Registers of those attending were kept and feedback on delivery and content was taken. Monthly themes were in place, for example elderly care in January 2019. Anaphylaxis was due to be undertaken in February 2019. The training followed the Royal College of Nursing competency framework for emergency care levels one and two for registered nurses. We were informed the trust was developing their own competency framework for health care support workers in the emergency department. The consultant and registrar involved in the clinical educating team wished to bring the training of all staff together, for example multidisciplinary simulation scenarios.

Clinical skills workshops had been introduced, for example the application of a Thomas splint, sling, collar and cuff and using an automatic cardiopulmonary machine.

For staff working in streaming and ‘pit-stop’ a bespoke theory and practical session was in place to ensure individual practitioners had the knowledge and skills to undertake this work effectively.

Advanced clinical practitioners were capable of undertaking lumbar punctures in paediatric ED following a period of consultant led training. All paediatric practitioners were trained in Ionising Radiation (Medical Exposure) Regulations.

Junior doctors had access to a weekly teaching programme, which, staff told us, was never cancelled. Every month one whole day of teaching was protected for advanced care practitioners (ACPs), junior clinical fellows and specialist registration doctors. Impromptu teaching for medical staff occurred daily.

Every team in the emergency department had three whole ‘days out’ for training each year. Last year these had been mental health, end of life care and dealing with a major accident.

Consultants who were working on administration duties, scheduled work place based assessments (WPBA) clinics to support trainees in evidencing competencies for their portfolios and training purposes. They were pre-bookable and reported to be very popular. Simulation training was also offered with occasional unannounced in-situ simulations, for example an organised simulation in the department and sounding the alarm to test staff response to medical emergencies.

The ‘Derby tilt’ was a regular feature. This consisted of staff bringing together 11 items for discussion at 11am of ‘things I learned today’, They were related to any topic of a clinical or non-clinical nature. It was open to all staff who told us it was good for learning, team building and morale.

Staff we spoke with told us they were able to attend training sessions, had regular meetings with their managers and an annual appraisal. They felt well supported. However, emergency nurse practitioners (ENPs) told us they would welcome the opportunity to progress and would benefit from tuition by advanced care practitioners (ACPs) to increase their clinical knowledge. They also felt it would benefit retention of staff.
**Multidisciplinary working**

During our inspection we observed examples of effective multidisciplinary team working and very positive feedback about relationships with different departments and staff groups especially nursing and medical staff within the emergency departments (EDs). Nurses felt empowered to challenge medical staff if they felt it was necessary to do so and medical staff respected that.

We were informed of occasional challenges experienced getting specialist teams to attend ED. A protocol had been developed and shared with specialties across the trust that outlined the professional standards expected by staff in ED and elsewhere. For example, patients seen or referred by a GP were to be directed to an appropriate assessment area and not ED. In addition, no patient was to be admitted to a specialty ward without formal handover by ED staff to the specialty involved.

Staff from the department would pre-alert the stroke team if a patient with a suspected stroke was being brought into the department. During our inspection we observed this process in place and saw the stroke team was in the department before the patient arrived, in order to work with the ED team and complete an initial assessment of the patient. This is especially important where thrombolysis is required. Thrombolysis is the breakdown of blood clots formed in blood vessels, using medication, where the stroke is as a result of blood clotting. To be effective this is required within one to two hours of the presentation of symptoms of a stroke.

Staff in paediatric ED told us there was a good relationship between the department and the paediatric wards with support given to the department when this was necessary.

A frail elderly assessment team (FEAT) worked in adult ED between the hours of 8am and 8pm to, where possible, prevent the admission of older people. The team included physiotherapists and occupational therapists who ensured there was a safe and effective process in place when patients were discharged home by completing home assessments and arranging additional equipment for those who required it.

There was a good working relationship between staff from the department and the mental health services from the local NHS mental health trust which supported them. Staff told us the psychiatric liaison (PL) team were quick to respond to requests for reviewing patients and had built up a good rapport with them as they were frequently in the department. The PL team were available 24 hours a day. There was access to an external drug and alcohol service for patients requiring this specialist support.

**Seven-day services**

The emergency department at this location was available for all patients 24 hours a day, 365 days a year. Within the department, there were areas which had times where they were unavailable to patients. The minors department was open between 8am to midnight and the ambulatory care centre (ACC) between 8am to 11pm; both areas opened seven days a week. A deep vein thrombosis (DVT) clinic operated during weekdays within the ACC.

Patients had timely access to diagnostics such as X-rays and computerised tomography (CT) scans and support services such as pathology and theatres were available 24 hours a day. There was an X-ray department at the rear of the emergency department.

There was 24 hour access to consultant directed interventions including critical care, interventional radiology, interventional endoscopy and emergency general surgery. For patients presenting with a gastrointestinal (GI) bleed there were services available at this location to effectively manage these patients 24 hours a day, seven days a week.
Maxillofacial specialists were unavailable between midnight and 8am each night. We were informed this patient group were cross-covered by ear nose and throat specialists until the next day.

**Health promotion**

National priorities to improve the population’s health in regard to smoking cessation, obesity, drug and alcohol dependency, dementia and cancer were supported and leaflets were available. Staff involved patients where appropriate in decisions about their own health and well-being.

Patient leaflets had been made available for all follow up information on care after injury or illness in collaboration with both the minor injuries units in the trust and Queen’s Hospital, Burton emergency department. Leaflets were available by using a matrix barcode (or two-dimensional barcode) which could be scanned on the trust’s website with a mobile phone and downloaded, for example issues to be aware of after a head injury. However, we did see a small amount of paper leaflets available if necessary.

Staff treating children in the paediatric emergency department ensured that any health promotion or accident prevention advice given to parents was recorded in the child’s discharge summary record.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion rates**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.

**Royal Derby Hospital**

Staff at Royal Derby Hospital were eligible for a single combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training module, with a completion target of 75%. This requirement was inherited from the predecessor trust.

All 150 eligible qualified nursing staff in the emergency department at Royal Derby Hospital had completed the trust’s Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards from November 2017 to October 2018.

The 95% target was therefore met for qualified nursing staff in the emergency department at Royal Derby Hospital.

Compliance for the trust’s Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards from November 2017 to October 2018 for medical staff in the emergency department at Royal Derby Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>80</td>
<td>85</td>
<td>94.1%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for medical staff in urgent and emergency care.

*(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)*
The Mental Capacity Act (MCA) (2005) is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make a specific and important decision for themselves. We found staff had awareness of mental capacity and the MCA. An initial mental capacity assessment was available to use on the back of each Cas card. Staff told us there were policies and assessment documentation located on the intranet for them to refer to and use if they had a patient who did not have capacity to make an important decision for themselves.

During our inspection, we observed staff gaining verbal consent before proceeding with any intervention, for example taking of temperature or administering intravenous medication. Implied consent was also used, in that a patient would offer their arm if they could see a nurse needed to take their blood pressure.

Staff demonstrated a knowledge of the Gillick competency and were able to discuss when they would use the Gillick competency. The Gillick competency is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge and understand the implications relating to the decisions made.

During an out of hours visit we saw a patient with complex needs undergoing the process of detention under the Mental Health Act. The psychiatric liaison team (PLT) were in attendance supporting department staff. An approved mental health professional was present undertaking a comprehensive assessment before admission to an appropriate facility. Staff were aware of their responsibilities in relation to patients who may be detained and would always seek specialist input from the PLT if required.

Is the service caring?

Compassionate care

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average in 11 out of 12 months from November 2017 to October 2018.

Over these 12 months there was an improvement in the trust’s performance against this metric.

In November 2017 the trust’s performance was 79.9% compared to the England average of 86.9%.

In October 2018 the trust’s performance was 86.4% compared to the England average of 87.1%.

A&E Friends and Family Test performance - University Hospitals of Derby and Burton NHS Foundation Trust
We requested data from the trust following our inspection and received the Friends and Family test results for December 2018. This showed 82% of patients would recommend ED to friends and family if they needed similar care or treatment. 9% would not recommend the department and 9% were unsure. This was based on 483 responses. Results from across 2018 ranged from 78% in January to 85% in August.

We spoke with 20 patients (15 adult and five paediatric patients) and seven relatives. The majority of feedback we received from patients was positive, with comments about how caring and attentive the staff were and what a good experience they had had in the department.

Despite the positive feedback, many patients commented on how long they had waited in the department. During our inspection, we observed the department experiencing an increase in activity at lunchtimes and on into the afternoon and evenings. However, our observations of interactions between staff and patients showed staff remained calm and polite at all times. If patients were in the main thoroughfare of the majors department in adult ED on trollies and not in cubicles anymore because they were awaiting medical beds, they appeared at times to be passed by as staff were busy caring for and treating other patients in cubicles.

Throughout our inspection we observed positive interactions between staff and patients. Patients were treated with compassion, dignity and empathy. We observed staff speaking with patients and providing care and support in a kind, friendly and patient manner. We observed staff respecting the privacy and confidentiality of patients at all times, especially when undertaking any interventions. We observed staff closing curtains prior to completing procedures.

We saw staff always introducing themselves to patients and relatives when taking over their care. During our inspection, we observed staff providing care and treatment to patients admitted with mental health concerns. Staff displayed compassionate and non-judgemental attitudes towards these patients and gave the same level of concern and respect as any other patient admitted into the department.
Medical and nursing staff displayed a very calming and caring approach to children in the paediatric ED and attempted to provide comfort to children whilst being treated and to their parents.

**Emotional support**

We observed staff providing emotional support to both patients and relatives in an appropriate and timely manner. Staff considered patients' emotional well-being as part of their caring duties. Despite the busy environment of the department, staff were aware of the benefit of having family or friends with a patient and the emotional support they could provide and encouraged them to remain with patients where appropriate.

The trust had clinical nurse specialists available to provide patients with additional support and advice if required. The department regularly requested the support of stroke and palliative nurse specialists. We saw stroke specialists providing emotional support to patients during our inspection.

A single room on Ward 101 was used frequently for patients arriving in the emergency department who were near the end of their lives. Staff on the unit evidenced how they would provide support to both patients and relatives during those times with one of the staff having received an award for the care and emotional support they had provided.

The hospital had a chaplaincy service that staff from the department could access at any time if additional support to relatives was required.

**Understanding and involvement of patients and those close to them**

**Emergency Department Survey 2016**

**Royal Derby Hospital**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG trusts</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

We spoke with 20 patients during our inspection as well as seven relatives. The majority of patients felt they had received enough information about their care and treatment and any further care required. They had also been involved in decision making (where appropriate) about their treatment choices. Parents in the paediatric ED were consulted and involved in their child’s care.

Patients told us they felt comfortable in asking staff to explain things again if they had not understood what they had been told originally.

We observed staff communicating with patients in a way which they understood and using language they understood. For example, we observed staff talking with paediatric patients in a way which made sure they could understand what was happening and what investigations and treatments they would need.

Is the service responsive?

Service delivery to meet the needs of local people

When not under undue pressure, the emergency departments for both adults and children functioned well. However, we saw how the departments could become very crowded each day at lunchtime and beyond, leaving patients waiting a long time for treatment and onward admission if this was required.

Staff in both departments believed the size of the department was too small to meet the demand for the services. The new design for the department; the ‘front door’ project, was due to be completed.
in 2020/2022 and would increase capacity and provide better facilities for the frail elderly and those with mental health issues. Further increase in medical bed capacity in the hospital was due to increase prior to winter 2019/2020. This would improve the outward flow from the adult emergency department. Senior staff in the department were very aware of this issue.

There were concerns about access to mental health beds, especially for younger people as this could take many days. However, it is acknowledged this was a national issue. A cubicle environmentally designed to care for people with dementia or a learning disability and who needed a quieter environment was not available, although a side room could be used for this purpose if not in use by other patients.

Patients arriving by ambulance were handed over to hospital staff by the local ambulance crews as soon as possible.

Patient waiting areas were spacious enough and had sufficient seating to accommodate the flow of patients as observed during our inspection.

Quiet rooms were situated in the department where relatives could wait for news of loved ones and an assessment room was available for patients admitted with a mental health illness.

The paediatric emergency department was a separate space open 24 hours a day. This meant children were not required to go into adult ED. The reception and waiting area could be monitored by a nurse at all times.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

**Royal Derby Hospital**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The department had access to a range of translation and interpreting services. Staff were aware of a telephone service which could be provided and had information directing them on how to access this. Staff could also request face-to-face translation for patients if this was required by using a ‘live’ electronic tablet.

Staff had access to British Sign Language (BSL) and some staff had learned basic BSL to communicate with patients who had a hearing impairment.
There was a referral system in place for patients with a learning disability and/or autism who required additional support. However, there was only one learning disability nurse for the trust. During our inspection we saw a patient with very complex needs being supported by the learning disability nurse in partnership with the psychiatric liaison team and department staff.

Chaplaincy services were available at this location between 9am and 5pm, Monday to Friday. Outside of these hours, the chaplaincy service provided an on-call service. All faith needs could be met if requested.

Staff told us there were limited resources available to meet the individual needs of patients living with dementia although they did have access to ‘twiddlemuffs’. A Twiddlemuff is a knitted double thickness hand muff with different items attached inside and out. It is designed to provide a stimulation activity for patients suffering from dementia and who may be anxious. There were no other resources or adaptations in the environment to meet the individual needs of a patient living with dementia.

All patients in the majors area were in line of sight of the nurses/doctors station. This meant for vulnerable patients, or patients deemed at risk of falls, staff could see them easily. If, however patients were at high risk of falls or absconding, additional staff could be requested to sit with them; this was dependent upon availability of staff.

Briefing sessions had recently been introduced for staff following a child death; these were carried out within 48 hours of the incident. Clear processes and procedures were in pace for staff to follow after a sudden unexpected death of an infant.

On Ward 101, staff informed us that if any transgender patients were admitted to the ward they were given the choice of being in the male or female bay. In most cases they tended to want to stay in the side room.

**Access and flow**

**Median time from arrival to treatment (all patients)**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard and outperformed the England average in 11 months over the 12-month period from November 2017 to October 2018.

From March to October 2018 performance against this standard showed a trend of improvement.

In March 2018 the trust’s median time to treatment was 64 minutes compared to the England average of 64 minutes.

In October 2018 the trust’s median time to treatment was 46 minutes compared to the England average of 58 minutes.

**Median time from arrival to treatment from November 2017 to October 2018 at University Hospitals of Derby and Burton NHS Foundation Trust**
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From December 2017 to November 2018 the trust consistently failed to meet the standard. The trust performed worse than the England average in eight out of 12 months.

From December 2017 to November 2018 performance against this metric showed a modest trend of improvement.

<table>
<thead>
<tr>
<th>Month and year</th>
<th>Trust rate</th>
<th>England rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>January 2018</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>February 2018</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>March 2018</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>April 2018</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>May 2018</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>June 2018</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>July 2018</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>August 2018</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>September 2018</td>
<td>86%</td>
<td>89%</td>
</tr>
<tr>
<td>October 2018</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>November 2018</td>
<td>86%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Four hour target performance - University Hospitals of Derby and Burton NHS Foundation Trust
University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

From December 2017 to November 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average.

From December 2017 to June 2018 the trust’s performance against this metric showed a trend of improvement. Then from June to November 2018 the trust performance showed a deteriorating trend.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospitals of Derby and Burton NHS Foundation Trust

The table below shows the number of patients waiting more than four hours from the decision to
admit to being admitted:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>269</td>
</tr>
<tr>
<td>January 2018</td>
<td>214</td>
</tr>
<tr>
<td>February 2018</td>
<td>105</td>
</tr>
<tr>
<td>March 2018</td>
<td>138</td>
</tr>
<tr>
<td>April 2018</td>
<td>87</td>
</tr>
<tr>
<td>May 2018</td>
<td>45</td>
</tr>
<tr>
<td>June 2018</td>
<td>37</td>
</tr>
<tr>
<td>July 2018</td>
<td>139</td>
</tr>
<tr>
<td>August 2018</td>
<td>171</td>
</tr>
<tr>
<td>September 2018</td>
<td>293</td>
</tr>
<tr>
<td>October 2018</td>
<td>166</td>
</tr>
<tr>
<td>November 2018</td>
<td>349</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps).

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

Over the 12 months from December 2017 to November 2018, 25 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in May and October 2018 (five each).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>0</td>
</tr>
<tr>
<td>January 2018</td>
<td>0</td>
</tr>
<tr>
<td>February 2018</td>
<td>0</td>
</tr>
<tr>
<td>March 2018</td>
<td>2</td>
</tr>
<tr>
<td>April 2018</td>
<td>3</td>
</tr>
<tr>
<td>May 2018</td>
<td>5</td>
</tr>
<tr>
<td>June 2018</td>
<td>3</td>
</tr>
<tr>
<td>July 2018</td>
<td>1</td>
</tr>
<tr>
<td>August 2018</td>
<td>2</td>
</tr>
<tr>
<td>September 2018</td>
<td>2</td>
</tr>
<tr>
<td>October 2018</td>
<td>5</td>
</tr>
<tr>
<td>November 2018</td>
<td>2</td>
</tr>
</tbody>
</table>

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

University Hospitals of Derby and Burton NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. Because these data related to the same legal entity as the merged
trust they are used to form part of our judgement.

From November 2017 to October 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently better than the England average.

Over these 12 months the trust reported consistent performance against this standard.

In October 2018 the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 1.0%, compared to the England average which was 1.7%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospitals of Derby and Burton NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

From December 2017 to November 2018 the trust’s monthly median total time in A&E for all patients was higher than the England average in eight out of 12 months.

Over these 12 months the trust’s performance against this metric showed a trend of improvement.

In November 2017 the trust’s monthly median total time in A&E for all patients was 177 minutes compared to the England average of 152 minutes.

In October 2018 the trust’s monthly median total time in A&E for all patients was 150 minutes compared to the England average of 151 minutes.
Following our inspection, we asked the trust for data for the reporting period December 2018 to January 2019 for the following:

- Median time to treatment
- Percentage of patients admitted, transferred or discharged within 4 hours
- Four-hour target performance
- Percentage of patients waiting more than 4 hours from decision to admit until being admitted
- Median total time in ED

This information was not provided. *(Request: DR57-DR61 and DR264-DR268)*

All staff in the emergency departments worked hard to ensure patient flow was optimal at all times. During our inspection, flow through the adult emergency department (ED) slowed towards lunchtime and beyond each day due to lack of flow throughout the hospital. There were however processes in place to try and identify additional capacity in the hospital and increase flow in ED. The ‘chaser’ in adult ED was focussed on increasing flow in the department. This included constantly following up requests for computerised tomography (CT) scans, x-rays and anything else that was required in order to improve the throughput of patients. The ED ‘live dashboard’ was available to be viewed in ED and showed the current level of escalation in ‘pit stop’, resus, majors and minors, number of patients in ED and department breaches. Just after lunchtime on 30 January we saw the department was in ‘red’ escalation, there had been 81 breaches of the four hour target since midnight and performance was at 47%. The average performance over the month had been 57%. Information from NHS England showed attendances at all EDs had risen to record levels with a rise of 7.2% over January 2018.

Bed meetings were held at regular times during each day. We attended one such meeting at 4pm on 29 January when there was a focus on clearing ED of medical patients. It was very evident that patient flow was seen as a whole hospital issue and not just a problem in ED. Senior managers worked together sharing problems and trying to improve patient flow throughout.

The emergency department had a very clear escalation process in place when ‘pit stop’ was busy with either large volumes of patients arriving or patients being in ‘pit-stop’ for longer than 60 minutes.
A standard operating procedure (Red Team SOP) was in place if ten patients were in the adult emergency department (ED) overnight with a bed not being declared more than 15 minutes after referral and ten patients were waiting on trolleys in majors and not in cubicles. The decision to start Red Team was made by the doctor in charge of ED in discussion with the nurse in charge of ED and the escalation manager and was only made when the risk posed by overcrowding in ED outweighed the risk of outlying patients. Patients were transferred to orthopaedic fracture clinic with a minimum number of two staff on duty one of which was a qualified nurse. Patients for transfer to this area were identified as not requiring monitoring or additional oxygen, completed their ED management and a NEWS2 score of six or more.

If patients were not admitted to a ward overnight from the Red Team area they were transferred back into ED in the morning and the clinic completely cleaned and made ready for use. The executive on call was informed if patients in the Red Team were unable to be transferred back into ED in the morning in order to make plans for the day’s activities.

Discussion with the assistant clinical director evidenced that an additional ward for medical patients had been opened the week before our inspection to relieve some of the pressures on the adult ED. This had provided an additional 28 beds. Although this had improved the flow of patients the hospital was still struggling to provide sufficient beds. Plans were in place to improve bed capacity even further although this would not be in place before winter 2019/2020.

**Learning from complaints and concerns**

**Trust level**

From November 2017 to October 2018 the trust received 107 complaints about urgent and emergency care. For the 95 complaints that had been closed at the time of data submission, the trust took an average of 44.0 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The 12 complaints that had not yet been closed had been open for an average of 65 days (mean) at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>68</td>
</tr>
<tr>
<td>Communication</td>
<td>11</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>10</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>6</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>

**Royal Derby Hospital**

From November 2017 to October 2018 the hospital received 85 complaints about urgent and emergency care. For the 80 complaints that had been closed at the time of data submission, the
trust took an average of 43.4 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The five complaints that had not yet been closed had been open for an average of 56.2 days at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>52</td>
</tr>
<tr>
<td>Communication</td>
<td>10</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>8</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>4</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
</tr>
</tbody>
</table>

Following our inspection, we requested data from the trust relating to compliments received by the emergency department (ED) in the twelve months Jan 2018 to Jan 2019. We were informed ED had received 93 compliments about patient care and one for communication in that time.

**Royal Derby Hospital**

From October 2017 to September 2018 the hospital received 156 compliments about its urgent and emergency care services. The trust did not provide a breakdown by subject for compliments received.

We saw eleven compliments on Ward 101. Patients were complimentary of the care and compassion showed during their stay.

The emergency departments listened to people’s concerns and complaints, responded to them and used them to improve services.

Posters and leaflets were available in the emergency departments (ED) outlining the process for patients, relatives or friends to make a complaint.

All complaints, concerns and compliments were logged on the trust’s electronic incident system to enable them to be tracked. Complaints about nursing made to the Patient Advisory Liaison Service (PALS) were all dealt with by the Matron of the department who rang the complainant and investigated the complaint. The outcome of the investigation was fed back to the complainant by the PALS team.

PALS timelines for responding to complaints was between 25 and 40 days dependent upon the complexity of the complaint. We saw that in the last twelve months there had been no breaches of any complaints raised about nursing. Matron informed us communication was the key to responding to complaints and always offered a meeting with the complainant especially if it involved a bereavement. We reviewed two letters to complainants who had written to the trust about their
experience. Both acknowledged the upset this had caused with outcomes of the investigations undertaken and actions taken as a result. Sincere apologies had been offered with the opportunity to meet if they wished.

Complaints concerning doctors or medical treatment were investigated and coordinated by the emergency department’s service manager who was not present during our inspection. Because of some complaints’ complexities and the time involved in investigating them there were sometimes breaches of the timescales regarding medical care.

Matron informed us that one complainant’s story had been taken to the trust board to enable them to understand how the complainant had felt.

Complaints were discussed at the department’s governance meetings with any resulting actions taken to improve. Information about complaints with any learning was conveyed to staff during safety huddles.

**Is the service well-led?**

**Leadership**

The adult emergency department was part of the medicine division and the children’s emergency department part of the women and children’s division at this location. Triumvirate leadership was provided at divisional level by a divisional medical director, divisional director and divisional nurse director. Business unit triumvirate leadership consisted of a general manager, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by ward/department managers.

Leaders in the emergency department (ED) demonstrated they had the experience, knowledge and skills to provide a well-led service. The focus of senior staff in ED was to deliver an excellent service to their patients. Senior team leaders in the department met once a month, which included pharmacy and diagnostic imaging personnel. They felt well supported by the chief executive (CEO) of the trust. The consultant team met fortnightly to discuss issues and challenges.

A closed social media page was available for staff in the department. If staffing was an issue this was used to offer staff the opportunity to obtain additional shifts.

Every member of staff we spoke with felt senior managers, including doctors, were approachable and they felt well supported in their role.

The matron of the department worked clinically in the department once a fortnight but was also in the department every day. This ensured they kept their clinical skills up to date and allowed them time to work with other members of all grades of staff to monitor they were working safely and in line with current clinical practice. If the department was busy they were able to help ease pressure in the department and support more junior staff.

One of the adult ED consultants led on mental health issues for the department. Staff were aware of who they were and would approach them if they had any concerns. The relationship between the department and the local NHS mental health trust was reported as being very good.

Senior staff were aware of the Royal College for Emergency Medicine (RCEM) guidelines and associated audits. RCEM guidelines are considered as fundamental guidelines for professionals working in emergency medicine. Participation in RCEM audits enables national monitoring of standards of care and adherence to evidence based guidance.
Staff told us the local leadership team were visible and supportive. There was high praise for the matron of the department, and assistant clinical director. Staff valued their knowledge.

Staff were aware of the executive members of the trust and told us they visited the department.

**Vision and strategy**

The trust’s overall vision was the provision of ‘Exceptional Care Together’. A member of senior staff told us they wanted to deliver ‘really high-quality care in an environment that was good for both patients and staff’. The trust had five values relating to CARE, Compassionate, Approachable, demonstrating Respect and Equality. Staff we spoke with knew what the trust’s vision was and its values. During our inspection we saw many times when staff were demonstrating the values in their work.

The new ‘front door’ project for the department was to be completed in 2020/2022. It involved redesigning the whole of the emergency departments and working closer with GP’s and the ambulatory care centre (ACC). Better facilities for frail elderly and those with mental health issues was part of the redesign, which would see increased streaming and a ‘see and treat’ area. The majors area was to increase capacity by 50%. Paediatric ED was to have a specifically designed area of 87 square metres for young people requiring input from the child and adolescent mental health service (CAMHS).

Senior staff in the department were aware that outward flow from the department needed to improve. There were concerns about access to mental health beds, especially for younger people as this could take many days. However, this issue was acknowledged as being a national concern and not exclusive to University Hospitals of Derby and Burton NHS Foundation Trust.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From December 2017 to November 2018 the trust had consistently failed to meet the standard and the trust had performed worse than the England average in eight out of the 12 months although this had shown a modest trend of improvement. It was acknowledged by senior staff they needed to improve but their focus was on ensuring patients were given safe and timely care even if it took a little longer than four hours.

Staff rotated between Ward 101 and adult ED. This meant staff were able to extend their knowledge base and become competent in both areas.

To ensure staff remained hydrated during their shift in paediatric ED, they were encouraged to bring drinks to work. These were kept out of the way of the patient areas but staff could access them at any time.

**Culture**

There was a strong and palpable culture of team work within the emergency department (ED) and providing good quality care for patients. Members of staff we spoke with told us they were happy working in the department and enjoyed coming to work.

We observed staff working well together and helping each other in an open, friendly but professional manner. Different disciplines worked alongside each other and showed respect for each other’s opinions.

Staff felt valued for their contribution to the department and because of the training they received.

Because senior leaders and managers were visible in ED and available, staff felt able to raise any concerns they had quickly before they had time to escalate further.
Senior staff informed us there wasn’t a ‘blame’ culture in ED but a culture of understanding and improving if things went wrong. This meant staff could report when an incident occurred and would be supported to put things right with further learning if this was required. Staff we spoke with supported this.

If a member of staff had concerns either about their own competencies or another colleague’s, they could refer to the lead clinical educator who would ensure further training was given. This was not seen as a negative action but a positive one in which patient safety was improved.

If staff failed to perform in their job role, processes were in place to support them. Development opportunities were open to all staff with more senior staff supported to undertake a leadership course.

The trust had a ‘Freedom to Speak Up Guardian’ in post for staff to approach if they felt unable to take issues through their line manager. Members of staff we spoke with had not had reason to use them.

Monthly well-being events were held by the occupational health department in the trust which staff could access. This included such items as yoga sessions.

**Governance**

There were effective structures, processes and systems of accountability in place to support the delivery of the trust’s strategy and good quality sustainable services. Governance and quality meetings were held monthly. Items from these meetings were fed into the senior team meeting.

During the quality meetings a consultant would bring a case for discussion which might include issues where care or treatment has not been ideal and where actions have needed to be taken. Emails were sent out to all staff with the learning taken from these meetings.

Although open to all staff, we were informed that junior staff in the department did not have the opportunity to attend the quality meetings to improve their growth and development but had access to the minutes.

Individual staff we spoke with were aware of their role and responsibility, what they were accountable for and to whom.

Relationships with third party providers were reported as being good, for example with the local mental health trust. Meetings were held regularly and any issues resolved promptly.

A commissioning for quality and innovation (CQUIN) was in place in ED and was nearing the end of its second year. CQUINs were introduced in 2009 to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The CQUIN was focused on reducing the number of re-attenders in the department.

An ED nurse had been employed to hold regular meetings with the local police and NHS ambulance trust in order to work together to build care-plans for those frequent attenders when arriving in ED. This meant there would be no delay when regular attenders were admitted as care plans for patient’s on-going care would already be in place.

**Management of risk, issues and performance**

The emergency department (ED) had systems in place for identifying risks with controls in place to manage them. Daily risks were identified and conveyed to staff during handover and safety huddles. Staff informed us they were aware of any on-going issues, incidents and concerns within the department.
We reviewed the live risk register dated 14 Nov 2018 where 10 risks had been identified in the emergency department between levels two and 16. This included overcrowding, lack of attaining the 95% performance figure and safeguarding referral processes not being adhered to. Actions had been put in place to mitigate the risks but five out of the 10 risks had review dates in the past and not after 14 Nov 2018. We were therefore not assured risks were being monitored and reviewed regularly.

There was a high daily attendance of adults with mental health issues only, which accounted for 4-5% of all patients attending and equated to 15-20 patients each day. The team did not admit these patients but where appropriate sent them to the overnight stay unit for comfort until they were fit to be discharged. These patients were then signposted back to their own community mental health team to support them.

Arrangements were in place to respond to emergencies and major incidents. Comprehensive major incident and business continuity plans had been made, detailing actions to be taken by different grades of staff.

**Information management**

Staff had access to information they needed to carry out their roles effectively with policies and procedures available on the trust’s intranet.

Patient identifiable information was managed appropriately. During our inspection we did not see any occasion when patient records with confidential information were left unattended, despite them not being stored in a lockable trolley.

The trust collected and managed information appropriately. Staff had access to information on patients’ care and treatment when they needed it, and there were no occasions when they failed to access important information about a patient.

Systems and processes were in place to ensure data and notifications were submitted to external bodies as required, for example serious incidents to both the Care Quality Commission and the commissioners of the service.

**Engagement**

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

We saw examples of winners of PRIDE awards in our visit to all areas of the emergency department. We spoke to one award winner who felt both humbled and proud to receive the award. ‘I was just doing my job’ they told us.

The department had engaged with the public regarding their views on the department and a team of staff held bi monthly meetings to discuss ideas. This included a lead, deputy matron, unpaid volunteers and research nurses. Because of issues concerning lack of confidentiality in the main entrance to adult ED, a partition had been erected to provide patients with more privacy when discussing issues with the reception staff. This evidenced the department was listening to feedback from patients.

The department was devising a ‘You said, we did” board to show what patients had said about the service and how the department had responded.
The hospital staff survey was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff, amongst other questions, whether they would recommend their service as a place to work and as a place to receive care. The results from the 2018 survey are not published until the end of February 2019. The results for the hospital for 2017 showed that 83% of staff would recommend the organisation as a place to work or receive treatment. This result was better than the average of 76% for all acute trusts.

At the time of our inspection, we did not see any specific engagement arrangements in place to receive feedback from patients who had mental health and emotional well-being concerns. There was also no specific engagement with staff about experiences of delivering or coordinating care for patients with physical and mental health needs.

During September and October 2018, the trust held five face to face engagement events for leaders from each of the four clinical divisions including medicine and women and children. Leaders were able to attend and share their ideas and experiences on developing the trust’s vision and purpose. Following this all staff were asked about their views on what was strong, wrong or missing. All feedback contributed to the trust’s vision and values. The Trust’s long-term strategic plan was to be completed by the end of March 2019.

**Learning, continuous improvement and innovation**

Staff from the department told us they were always striving to improve the quality of care and treatment they provided.

SAFECARE, a system focussing on the quality of care of patients receive, had been developed as a result of consultation with the whole emergency department (ED) and over 50 suggestions being put forward. It had been acknowledged that while the 95% four target was important to the reputation of the department it relied on a range of factors to attain it, some of which were outside the control of the emergency department. SAFECARE stood for Sepsis, Analgesia, First seen, Entrust/handover, Consultant review, Admission time, Responsiveness and Experience (patient). Each element had a team lead and one or two members with a departmental ambition. The system had been nominated for the National Patient Safety Awards. SAFECARE represented the ED quality standards with staff being engaged with the process as they were developed by the department for the department. Leads for this work were given four hours protected time a month to work on the project and prizes allocated each six months to the team who had made the most progress.

Learning from previous serious incidents was important to all staff members for this journey of continuous improvement. One example where improvements had been made was the introduction of the ‘red card’ system for empowering patients who were experiencing pain to ask for a member of staff to reassess their pain levels at regular intervals. In addition, services for people with hearing loss were in place in adult ED.

Working across sites with Queens Hospital Burton had already commenced with a consultant from Derby ED working in Burton ED the week before our inspection. Good practice elements had been gathered from Burton ED for example safety huddles and were well embedded in Derby ED at the time of our inspection.

There were planned improvements due to take place in the department with the ‘front door’ plan due to be completed in 2020/2021. This would increase the capacity in some areas of the ED for example ‘majors’ in adult ED and improve mental health facilities in paediatric ED.

Research projects were undertaken in both adult and paediatric EDs on a regular basis with specific staff being involved. Isolated rib injuries, nose bleeds, the use of Amoxicillin and the treatment of fractured wrists in children were all topics at the time of our inspection.
Medical care (including older people’s care)

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1\textsuperscript{st} July 2018 following Derby Teaching Hospitals NHS Foundation Trust’s acquisition of Burton Hospitals NHS Foundation Trust. The former acquired the latter under its existing registration with the CQC. Our legal position is that the acquired trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data relate to the same legal entity as the acquired trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust has 788 medical beds located across two acute hospitals; Royal Derby Hospital and Queen’s Hospital Burton.

Royal Derby Hospital has 576 medical inpatient beds located across 37 wards and units:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac catheter suite</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Cardiology daycase</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Combined day unit</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Coronary care unit</td>
<td>Coronary care unit</td>
<td>13</td>
</tr>
<tr>
<td>Discharge Lounge</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Elderly assessment triage</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Endoscopy daycase</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical assessment unit (MAU)</td>
<td>-</td>
<td>51</td>
</tr>
<tr>
<td>MAU triage</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical day case unit</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Renal unit</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Unwell bay / cancer services</td>
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<td>N/A</td>
</tr>
<tr>
<td>Ward 216</td>
<td>General medicine</td>
<td>27</td>
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<td>Ward 303</td>
<td>Oncology</td>
<td>28</td>
</tr>
<tr>
<td>Ward 304</td>
<td>Gastroenterology</td>
<td>28</td>
</tr>
<tr>
<td>Ward 305</td>
<td>Gastroenterology</td>
<td>28</td>
</tr>
<tr>
<td>Ward 306</td>
<td>General medicine</td>
<td>28</td>
</tr>
<tr>
<td>Ward 311</td>
<td>Care of the Elderly</td>
<td>28</td>
</tr>
<tr>
<td>Ward 312</td>
<td>Stroke rehab</td>
<td>21</td>
</tr>
<tr>
<td>Ward 315</td>
<td>General medicine</td>
<td>14</td>
</tr>
</tbody>
</table>
Medical specialties provided at this hospital include acute medicine for older people, cardiology, dermatology, diabetes, endocrinology, gastroenterology, renal, respiratory, rheumatology and stroke medicine. Each has a multi-disciplinary team including clinical nurse specialists.

The hospital has a consultant-led frailty service consisting of physiotherapists and occupational therapists, predominantly working at the front door and using the Edmonton frailty stratification tool. The frailty team could expedite discharge from the emergency pathway and follow the patient within the community.

The acute medicine for older people wards focus on the care of patients with complex needs secondary to cognitive impairment. This specialty works collaboratively with external partners to resolve issues and facilitate safe discharge.

(Source: Routine Provider Information Request AC1 - Acute context)

Admissions figures - University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018.

The trust had 76,679 medical admissions from August 2017 to July 2018. Emergency admissions accounted for 33,736 (44.0%), 1,616 (2.1%) were elective, and the remaining 41,327 (53.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 29,731
- Gastroenterology: 12,716
- Medical oncology: 10,436

Admissions figures - Queen’s Hospital Burton

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis.

The trust had 26,681 medical admissions from August 2017 to June 2018. Emergency admissions accounted for 12,046 (45.1%), 264 (1.0%) were elective, and the remaining 14,371 (53.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 9,439
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training was outlined in the trusts developing our people policy. Staff attended annual mandatory training updates on key topics.

Infection control was included in the mandatory training programme and this included updates on sepsis management, sepsis six and the sepsis care management bundle. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. The six steps identify the need for rapid escalation and treatment when sepsis is suspected. Staff working on the oncology ward and combined day-care unit had additional training on the recognition of neutropenic sepsis and this was supported by neutropenic sepsis clinical guideline document. Neutropenic sepsis occurs in patients undergoing specific cancer treatments.

As of October 2018, staff from the two predecessor trusts continued to complete different sets of legacy mandatory training modules. Because of this, it is not possible to produce trust level data.

Royal Derby Hospital

Staff at Royal Derby Hospital had mandatory training targets of either 90% or 95% for completion of most mandatory training modules. The exceptions were:

- Local induction and medicines management, where the target was 85%.
- The various resuscitation training modules, where the target was 75%.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in medical care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control level 2</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - hospital life support</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>412</td>
<td>412</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>407</td>
<td>412</td>
<td>98.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>767</td>
<td>781</td>
<td>98.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training module</td>
<td>Number trained</td>
<td>Number eligible</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met Yes / No</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>Load handling</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>249</td>
<td>258</td>
<td>96.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>56</td>
<td>61</td>
<td>91.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>56</td>
<td>61</td>
<td>91.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust induction</td>
<td>50</td>
<td>57</td>
<td>87.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>225</td>
<td>258</td>
<td>87.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>225</td>
<td>258</td>
<td>87.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion theory</td>
<td>104</td>
<td>120</td>
<td>86.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, inclusion &amp; human rights</td>
<td>220</td>
<td>258</td>
<td>85.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health, safety &amp; risk awareness</td>
<td>220</td>
<td>258</td>
<td>85.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dignity at work - harassment &amp; bullying</td>
<td>219</td>
<td>258</td>
<td>84.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>211</td>
<td>258</td>
<td>81.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 93.9% for qualified nursing staff in medical care at Royal Derby Hospital. The trust’s mandatory training targets were met for 12 of the 22 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in medical care at Royal Derby Hospital is shown below:
The trust had an overall training compliance rate of 80.1% for medical staff in medical care at Royal Derby Hospital. The trust’s mandatory training targets were met for two of the 19 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The executive nurse director had overall responsibility for safeguarding vulnerable persons across the trust supported by a safeguarding lead and team of named nurses. The trust had policies in place for safeguarding children and adults with clear guidance to support staff with safeguarding concerns. The safeguarding children policy also included female genital mutilation, child sexual exploitation and modern slavery.

Staff we spoke with were familiar with the safeguarding policies and described to us the procedure they would follow if they had a safeguarding concern. One member of staff described how she had contacted the hospital safeguarding team for further advice.

The service worked well with agencies and other health and social care organisations. We saw examples of safeguarding referrals involving collaborative working with other agencies such as the police, mental health and GP’s.

On admission all patients were assessed for indicators of risk of self-harm or harm to others. Staff were guided to follow the increased supervision bundle or to complete a full assessment in the maintaining a safe environment section in the care record incorporating management of threatening behaviours in the workplace. We asked staff how they would care for patients who were at risk of self-harm and they told us they would receive 121 supervision, 15-minute visual inpatient screening assessment (VISA) and urgent referral to the mental health team.

Staff attended Mental Health Act training at induction, all staff we spoke with demonstrated a good understanding of the Act and knew where to go for further advice if needed.

An ‘Enhanced care Team’ policy (ECT) was available to provide a framework for all staff to follow a consistent approach for the planning and implementation of increased nursing observation to maintain patient’s safety and reduce the risk of harm through enhanced nursing. However, the policy, provided to us after our inspection, was for the acquired trust and had a review date of July 2016. Whilst this had been fully implemented at the acquired trust, at the time of our inspection, a pilot of ECT was underway on two of the wards on the Royal Derby Hospital site.

As of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it is not possible to produce trust level data.

<table>
<thead>
<tr>
<th>Patient handling</th>
<th>201</th>
<th>256</th>
<th>78.5%</th>
<th>95%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control level 4</td>
<td>202</td>
<td>258</td>
<td>78.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Falls prevention for doctors in training</td>
<td>21</td>
<td>28</td>
<td>75.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - automatic external defibrillation</td>
<td>114</td>
<td>165</td>
<td>69.1%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - immediate life support</td>
<td>57</td>
<td>87</td>
<td>65.5%</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>176</td>
<td>289</td>
<td>60.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local induction</td>
<td>41</td>
<td>117</td>
<td>35.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Royal Derby Hospital

Staff at Royal Derby Hospital had a training target of 85% for completion of all safeguarding training modules.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in medical care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>402</td>
<td>412</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>380</td>
<td>390</td>
<td>97.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>216</td>
<td>237</td>
<td>91.1%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>61</td>
<td>75</td>
<td>81.3%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 95.1% for qualified nursing staff in medical care at Royal Derby Hospital. The trust’s mandatory training targets were met for three of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in medical care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>221</td>
<td>258</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>196</td>
<td>232</td>
<td>84.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>45</td>
<td>58</td>
<td>77.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>12</td>
<td>20</td>
<td>60.0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 83.5% for medical staff in medical care at Royal Derby Hospital. The trust’s mandatory training targets were met for one of the four safeguarding training modules for which medical staff were eligible.

At our last inspection we found that the service did not meet the requirement for level three safeguarding training as outlined in the Royal College of Paediatric and Child Health intercollegiate document; Safeguarding Children and Young People: roles and competencies for health care staff. Although the service was not meeting the target of 85% compliance there was an improvement since the last inspection.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All the wards and departments we inspected appeared visibly clean. Cleaning staff showed us the cleaning schedules they followed. Cleaning audits were carried out by cleaning supervisors and staff told us they received feedback on the results. Cleaning services were very well organised. Staff were divided into teams, red, blue and yellow to match the National Patient Safety Agency (NPSA's) national colour coding system of four core colours. Red for washrooms and toilet floors, blue for lower risk areas and yellow for clinical and isolation areas. Green was for food preparation and catering areas which were cleaned by the catering staff.
Staff in clinical areas were bare below the elbows as recommended in the National Institute of Care Excellence clinical guideline 139. We observed staff following the World Health Organisation ‘My five moments for hand hygiene’. The five moments for hand hygiene focuses on five moments when hand hygiene should take place, these are, before patient contact, before undertaking a clean or aseptic procedure, following an exposure risk, after patient contact and after contact with a patient’s surroundings.

Antiseptic hand gel was strategically placed in all wards and departments as was personal protective equipment such as gloves, aprons and masks. We observed staff, patients and visitors using the antiseptic hand gel and personal protective equipment when necessary.

We saw the January 2019 hand hygiene audit results for the medical division which showed 100% compliance in all areas. Hand hygiene audits were completed monthly.

On admission all patients were assessed for their hygiene needs and whether they needed any assistance with washing, patients we spoke with told us that they had their personal hygiene needs met daily.

We observed staff performing aseptic procedures for a variety of treatments. Aseptic technique is a standard healthcare practice that helps prevent the transfer of germs to or from an open wound and other susceptible areas on a patient's body.

On several of the wards we inspected we found equipment such as commodes did not have stickers on them to indicate they had been cleaned and were ready for use even though on one of the wards there was a poster in the dirty utility room reminding staff to ‘clean it, green it’ referring to the green ‘I am clean’ stickers. This meant that staff could not be assured that the equipment had been cleaned following use.

Clinical guidelines were in place for infusion therapy, this is when fluids or medications are given intravenously (IV) or subcutaneously (under the skin). The guidelines gave clear instructions on infection control during infusion therapy procedures to mitigate the risk of infection. We saw visual infusion phlebitis (VIP) scores completed for patients with an infusion. Phlebitis is caused by inflammation to the vein at a cannula access site.

A policy for urethral and suprapubic catheter management was available to staff. The purpose of the policy was to ensure the provision of evidence based practice, which would ensure that all patients who were catheterised had the best quality of care, minimised infection risk and other side effects and maximised quality of life. However, the policy, provided to us after our inspection, was for the acquired trust. It was not clear therefore, if staff at Royal Derby Hospital were following this policy. There was an adequate number of single rooms which could be used to nurse infected patients requiring isolation. We saw yellow notices displayed on some single rooms describing the infection control measures staff and visitors should follow.

Policies and guidelines were in place describing the management of methicillin resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA) and clostridium difficile infections. Most patients were routinely screened for MRSA except those in the exempt patient groups of maternity, paediatrics and end of life care. In the patient records we reviewed we saw that MRSA screening had been documented according to the hospital policy.

Staff in the endoscopy unit described how reusable equipment was decontaminated in line with the Health Technical Memorandum 01 – 06 Management and Decontamination of Flexible Endoscopes.

Some arrangements were in place to screen patients who had visited areas with a high risk of infections. On admission all patients were asked if they had been an inpatient in either a hospital abroad, in Manchester, Liverpool or London in line with Public Health England guidance for the early detection, management and control of carbapenemase producing Enterobacteriaceae. Carbapenemase-producing Enterobacteriaceae are gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections.
The trust also had a tuberculosis (TB) nursing team providing TB screening for all those coming to live in Southern Derbyshire from High Incidence TB Countries.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The hospital was well planned, wards were spacious with ample storage rooms, staff rooms, quiet rooms, day rooms, treatment rooms and dirty utility rooms. The discharge lounge had comfortable seating, television, magazines and access to hot and cold drinks. Stroke wards had access to therapy rooms, a gym and mock living rooms for assessing patients prior to discharge.

Nursing staff told us they had enough equipment to safely care for and treat patients. There was 24-hour access to pressure relieving equipment and staff told us the process for obtaining it was simple and the equipment arrived promptly.

Specialist equipment was available in some areas, for example blood analyser machines were located on the oncology and respiratory wards, this meant some essential and urgent blood tests could be done on the ward, so treatment could be commenced quicker.

Staff in the bed bureau office told us they had to share telephony headsets, this is not following call centre best practice guidance which recommends staff should have their own personal headsets. We raised this during our feedback to senior executives in the trust who assured us this would be addressed. Following our inspection the trust told us staff now have their own headsets.

We checked 30 pieces of electrical equipment and found that 28 conformed with Health and Safety Executive guidance HSG107, Maintaining Portable Electrical Equipment. Two items were out of their service date and we reported these to the nurse in charge who took them out of use and arranged for them to be serviced.

We checked eight resuscitation trollies, they were all equipped in line with Resuscitation Council guidelines. All equipment was in date and daily checks had been completed and recorded by staff.

Clinical waste was managed according to the hospital policy and in line with Department of Health safe management of healthcare waste. Clinical waste was colour coded. In all the dirty utility rooms we inspected waste was appropriately stored and labelled and there were posters to remind staff how to handle clinical waste. Full sharps bins were signed and sealed and stored safely ready for collection. Suitable products were available to clean and disinfect areas where body fluids had been spilled.

Special spill kits were available from the onsite cytotoxic pharmacy for the management of spills of cytotoxic drugs. Cytotoxic drugs are a hazardous substance.

Personal protective equipment was worn when taking and handling clinical specimens such as blood and urine. Specimens were labelled and packaged in sealed bags. A capsular chute system was used to transport clinical specimens to the laboratory.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Admission and care records included a comprehensive range of risk assessments and in the records we reviewed we saw these had been completed and updated in each case. On admission the patients past medical history was recorded and a full range of vital signs including level of consciousness, blood glucose and blood oxygen levels.

The medical assessment unit (MAU) triaged patients when they first arrived to assess the immediate presenting symptoms and initiate any urgent treatment to prevent further deterioration of the patient.
Patients were triaged by a medical consultant which meant acutely ill patients were seen by a consultant within one hour. Once stabilised the patient would be transferred to the appropriate ward for example, cardiology, respiratory or stroke.

Frail elderly patients were referred to the frailty team. The frailty team used the Edmonton Frail Scale to assess the frailty and vulnerability of the patient.

Not all patients were admitted through the MAU. Some patients were initially seen by the emergency department, were direct referrals from GP or internal hospital transfers.

Specialised care plans were used for certain conditions. For example, the stroke wards used a stroke assessment tool based on the National Institute of Health Stroke Scale, a validated tool for assessing the density of a stroke and safe initiation of thrombolysis. Thrombolysis is a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs.

The respiratory ward also used a specialised respiratory care plan for patients with chest drains, non-invasive ventilation and patients with a tracheostomy.

Patients vital signs were monitored regularly depending on how acutely ill they were, monitoring commenced within 15 minutes of arriving in a clinical area. An electronic recording system was used which automatically calculated the national early warning score (NEWS) of the patient and flagged it on the system as red, amber or green. Early warning scores enable early recognition of a patient’s worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.

We observed staff monitoring the electronic NEWS system and escalating patients to medical staff as per the hospital NEWS protocol, this had improved since our last inspection.

Patients with a NEWS score of three in any one area, for example temperature, or five in total also triggered for sepsis screening. However, on the NEWS2 escalation chart the hospital submitted there was no mention of sepsis. The sepsis screening tool gave staff clear guidance on escalation, following the sepsis care bundle and completing the sepsis 6 checklist. We saw completed sepsis screening tools and evidence that patients were given antibiotics within the hour which was an improvement since our last inspection.

The sepsis screening tool also referred staff to the febrile neutropenia guidelines for oncology or haematology patients on chemotherapy drugs. Chemotherapy drugs lower a person’s immune system making them susceptible to infection. Chemotherapy patients were given both verbal and written information about neutropenic sepsis and a rapid response alert card.

Patients with complex acute medical problems had access to level two and three critical care. The respiratory ward had four high dependency beds for patients who were acutely ill requiring a higher level of care and treatment. Staff could refer to the critical care outreach team for additional advice and support.

In the care records we reviewed we saw that risk assessments were completed and updated for the following, falls, visual infusion phlebitis, infection prevention and control, deep vein thrombosis, NEWS, sepsis, communication, oral care, malnutrition universal screening tool, pain, pressure ulcers and more.

A mental health liaison team made up of doctors and nurses was based at the hospital but employed by a neighbouring mental health trust. Senior managers told us they were happy with the service although response to referrals was challenging in the out of hours period. The trust did not monitor response times.

The trust had implemented national safety standards for invasive procedures (NatSSIPs) and as recommended by NHS England had developed local safety standards for invasive procedures (LocSSIPs). The standards set out the key steps necessary to deliver safe care for patients.
undergoing invasive procedures. Information received following our inspection showed LocSSIPs had been developed in Endoscopy.

The endoscopy unit had a range of clinical guidelines for specific procedures and an endoscopy inpatient pathway which identified a series of safety checks including the ‘stop moment’. All invasive procedures should have a stop moment to verbally confirm the intended site, procedure, and identity of the patient checking this information against the patient’s identification band, the procedure list and the consent form.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust followed national guidance on staffing ratios as recommended by the National Quality Board. Staffing levels and skill mix were reviewed at an annual workforce planning meeting for medical and nursing staff. Senior managers expressed concern over local and national pressures on nursing and medical staff and were introducing new career pathways for existing staff such as the Advanced Care Practitioner. We observed trainee ACP’s working with medical staff on the wards we inspected.

In addition, nurse staffing was reviewed weekly at the senior nurse meeting to identify any gaps requiring cover by moving existing staff or arranging bank staff. Patient acuity was also considered when reviewing staffing levels, acuity is the measurement of the level of care required by a patient.

Staffing levels had improved since the last inspection particularly with recruitment of overseas nurses.

During our inspection we found the high dependency unit on the respiratory ward was staffed with the correct level of staff with the right skills.

Red flag events were monitored daily by the matrons. Senior managers told us that red flag events rarely occurred. ‘Red flag events’ occur when there is a shortage of nursing staff and warn ward managers to act immediately. For example, patients not being provided with basic care such as pain relief or help to visit the bathroom.

All the areas we visited had systems in place and dedicated time to handover information about patients at shift changes. We observed several meetings between medical and nursing staff where the ongoing care and treatment of patients was discussed these included board rounds and consultant led ward rounds. Board rounds are short meetings of no longer than 30 minutes during which every patient is briefly discussed.

The service used bank staff to fill gaps in the rota. Staff told us it was unusual to have a bank nurse who had not worked on the ward before and that they were mostly familiar with policies and procedures. New bank staff had to complete an induction programme and a supervised period of practice. One bank nurse told us that they could easily get support from other staff on the ward if they were unsure of anything. Staff told us they rarely had agency staff on the wards but when they did they were given the same support and induction that bank staff received.

Planned vs actual

The trust reported their staffing numbers for qualified nursing staff working in medical care as below as of March 2018 and October 2018.

Nursing staff in post in medical care increased in October 2018 in comparison to March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td></td>
<td><img src="Table.png" alt="Table" /></td>
<td></td>
</tr>
</tbody>
</table>
Vacancy rates
From November 2017 to October 2018, the trust reported a vacancy rate of 15.6% for qualified nursing staff working in medical care. The trust had a target vacancy rate of 6%. The vacancy rate for Royal Derby Hospital was 14.3%.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Turnover rates
From November 2017 to October 2018, the trust reported a turnover rate of 9.1% for qualified nursing staff working in medical care. This was within the trust’s turnover target of between 8% and 12%.
The turnover rate for the Royal Derby Hospital was 8.9%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From November 2017 to October 2018, the trust reported a sickness rate of 4.3% for qualified nursing staff working in medical care. This was higher than the trust’s target of 3.8%.
The sickness rate for the Royal Hospital Derby was 4.3%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in medical care.

From November 2017 to October 2018, the trust reported that 12.6% of qualified nursing staff hours in its medical care services were filled by bank staff, while 1.4% were filled by agency staff. In addition, 1.8% of qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th></th>
<th>Agency</th>
<th></th>
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</tr>
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<tbody>
<tr>
<td></td>
<td>Hours</td>
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<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
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<tr>
<td>Royal Derby Hospital</td>
<td>148,162</td>
<td>11.7%</td>
<td>2,937</td>
<td>0.2%</td>
<td>22,683</td>
<td>1.8%</td>
<td>1,268,823</td>
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</tbody>
</table>

Over the same period, the trust reported that 21.2% of unqualified nursing staff hours in its medical care services were filled by bank staff, while 0.6% were filled by agency staff. In addition, 4.0% of qualified nursing staff hours were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
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<th></th>
<th>Unfilled</th>
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<tr>
<td></td>
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<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
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<tr>
<td>Royal Derby Hospital</td>
<td>196,793</td>
<td>22.8%</td>
<td>0</td>
<td>0.0%</td>
<td>38,371</td>
<td>4.4%</td>
<td>862,889</td>
</tr>
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</table>
Medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Overall there were enough medical staff of the right grades to care and treat patients safely. Medical staff in some areas described to us how vacancies had presented some challenges, but recruitment processes were taking place and there were no examples of patient harm.

Medical staff levels were reviewed at the annual workforce planning meeting and were guided by the society for acute medicine and the West Midlands quality review service publication, Quality Standards in the AMU.

Locum and agency medical staff were used to cover staff absence and sickness. Managers told us locum and agency staff had a comprehensive induction before they worked independently at the hospital and were supported by more senior colleagues. The service had recently appointed one long term locum and several short-term locums to fill the gaps in the registrar rota.

We observed several shift handovers between medical staff. Handovers were comprehensive, unrushed with time to discuss patient management plans and for more junior staff to ask questions. Printed handover sheets were used as prompts and to enable doctors to see the progress and results of any treatments or investigations.

Consultants and senior doctors were either on call or available immediately to respond to medical emergencies, doctors on call could reach the hospital within 30 minutes of receiving a request to attend a patient.

Planned vs actual

The trust reported their medical staffing numbers for medical care for March and October 2018 as below.

The number of medical staff in post in medical care at Royal Derby Hospital increased from 265.7 whole time equivalents (WTEs) in March 2018 to 291.9 WTEs in October 2018. As a result, the fill rate increased from 87.6% to 91.2%.

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>265.7</td>
<td>303.5</td>
<td>87.6%</td>
<td>291.9</td>
<td>320.1</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

Vacancy rates

From November 2017 to October 2018, the trust reported a vacancy rate of 13.4% for medical staff in medical care. The trust had a target vacancy rate of 6%.

Vacancy rate for the Royal Hospital Derby was 14.1%

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 30.5% for medical staff in medical care. This was higher than the trust’s target of having a turnover rate of between
8% and 12%.
The turnover rate for the Royal Hospital Derby was 27.5%.
(Source: Routine Provider Information Request (RPIR) - Turnover tab)

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 1.0% for medical staff in medical care. This was lower than the trust’s target of 3.8%.

Sickness rate for the Royal Hospital Derby was 1.0%
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

From November 2017 to October 2018, the trust reported that 0.9% of medical staff hours in its medical care services were filled by bank staff. Over the same period 5.4% of medical staff hours were filled by locum staff. In addition, 0.1% of medical staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>5,573</td>
<td>1.3%</td>
<td>16,890</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

**Staffing skill mix**

As of September 2018, the proportion of consultant staff reported to be working at the trust was the same as to the England average. The proportion of junior (foundation year 1-2) staff was similar to the England average.

**Staffing skill mix for the 371 Whole Time Equivalent staff working in medicine at University Hospitals of Derby and Burton NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The five sets of paper records we reviewed were written legibly and in keeping with record keeping guidelines.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. Information for individual patients was stored in several different electronic systems and in paper records. Whilst there was no evidence that this caused any problems senior managers acknowledged that it was a risk and had been added to the risk register. An Information Technology (IT) strategy was in place to simplify and integrate IT systems. All staff had access to the electronic systems including bank staff who acquired a temporary password for the duration of their shift.

On the wards and departments we inspected, we observed that patient records were stored securely in locked trolleys or in electronic systems which were password protected. We did not see any records not stored securely which was an improvement on our last inspection.

Admission and assessment documentation contained information about a person’s mental capacity and risk of self-harm we saw these completed in the records we reviewed. All patients were asked about disability, vision and hearing as part of the initial nursing assessment conducted on ward admission. We saw the section on communication completed in the care records we reviewed.

Patients living with dementia or learning disability could be identified on the electronic patient record by means of a special icon.

Discharge summaries were complete and comprehensive and included all the recommended information to ensure the patients’ medical history, treatment, plans for rehabilitation and follow up were communicated to the relevant health care professionals for continuity of care. Important information that would aid community care was also included and emotional and psychological needs where identified. A copy of the discharge summary was sent to the patients GP and a copy given to the patient. This was in line with the trusts standard operating procedures for the discharge of adult patients.

In the electronic medication records we reviewed we saw that antibiotics had been prescribed correctly and indication for use, dose and duration was clearly documented.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Policies and handbooks were available to support staff with safe medicines practice. The Derby medicines code covered all aspects of medicines management and staff handbooks were in place describing the ‘shoulds’, ‘musts’ and ‘nevers’ of medicine administration. These documents incorporated best practice guidance such as the Royal Pharmaceutical Society, safe and secure storage of medicines, National Institute for Health and Care Excellence (NICE) guidance and were in line with relevant legislation. Medicine management was included in the annual mandatory training programme and we observed staff managing medicines safely according to the trusts policies and procedures.

Overall, we found that medicines and medicines related stationary were stored, ordered, transported and disposed of safely including medical gases. However, we did find one out of date medicine (Ibuprofen January 2019), one medicine cupboard with a broken lock and several oxygen cylinders that were not being stored in the recommended way. We reported these issues to the staff in charge who rectified them straight away. We also found two drug fridges with no
record of temperature monitoring being carried out. When we raised this, staff told us the
temperature checks had been made but just not recorded. Monitoring sheets were obtained and a
staff reminder to record the checks was included in the daily briefing.

The hospital used electronic prescribing and the completion of dates, signatures, and allergy fields
was mandatory. We reviewed the electronic medicine administration sheets of five patients.
Generally, all medicines were administered as intended, allergies were recorded and there was
evidence of regular review and medicines reconciliation. Medication reconciliation is the process of
creating the most accurate list possible of all medications a patient is taking and comparing that
list against medicines prescribed in hospital, with the goal of providing correct medications to the
patient.

Patients we spoke with told us they got their medicines on time and staff explained what the
medicines were for. If medicines were changed or new medicines prescribed medical staff
explained the reasons for the change.

We observed nursing staff administering controlled drugs as per the Nursing and Midwifery
Council (NMC) guidelines for medicines management. Staff we spoke with were aware of the
guidance and the special measures to take when administering controlled drugs.

Microbiology protocols were in place to support staff when prescribing antimicrobials. These were
reviewed by an antibiotic pharmacist to ensure they were in line with current recommendations in
Public Health England, Start Smart then focus: Antimicrobial Stewardship Toolkit and NICE
Antimicrobial stewardship: Systems and processes for effective antimicrobial medicine use,
published August 2015.

Staff told us that patients’ dependant on alcohol were offered withdrawal therapy and could
prescribe medicines to assist their withdrawal and associated side-effects.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported
them appropriately. Managers investigated incidents and shared lessons learned with the
whole team and the wider service. When things went wrong, staff apologised and gave
patients honest information and suitable support.

Policies and procedures were in place to support staff in the management of incidents. An
electronic incident reporting system was used for the management of incidents. Staff we spoke
with were familiar with the process and confident in the use of the electronic system.

Incidents were reviewed initially by the ward manager who then requested further information
necessary to enable a thorough investigation. Final reports were reviewed and signed off by
matrons.

We reviewed the incident management reports of two recent incidents. The incidents had been
investigated as per the incident management policy, apologies were made to patients and
relatives and learning was identified and conveyed to relevant staff.

Incidents were discussed at the quality committee meeting and we saw evidence of this in the
minutes we reviewed. Learning from incidents was shared from the matrons to the ward managers
and with staff at ward briefing meetings. Learning was also shared externally. For example, a
recent incident involving a chest drain had resulted in learning being shared with the British
Thoracic Society to be incorporated in national guidance.

Duty of candour was evident in the incident management policies we reviewed, and although
some staff we spoke with were not entirely clear about duty of candour they all demonstrated an
understanding of being open and honest with patients and their families about incidents. The trust
gave relatives the opportunity to be involved in mortality reviews if this was appropriate.
The trust was currently reviewing the way mortality and morbidity (M&M) reviews fed into service improvement. M&M’s were discussed at various meetings such as the multidisciplinary medical admissions unit and the medicine business unit, quality and risk meeting. All specialities in medicine had a nominated mortality lead who reviewed all deaths monthly and took any learning identified to the medical admissions unit senior team meeting.

Safety alerts were received centrally and disseminated throughout the trust to the wards and departments. We saw safety alerts displayed on staff notice boards.

**Never events**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust we have used this to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, the trust reported three incidents classified as never events for medical care.

The first occurred in July 2018 at Royal Derby Hospital and was of never event type “Unintentional connection of a patient requiring oxygen to an air flowmeter”.

The other two never events both occurred in November 2018. One was an incidence of wrong site surgery (the hospital location was not specified); the other was an incidence of administration of medication by the wrong route at Royal Derby Hospital.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 50 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Slips/trips/falls: 21
- Pressure ulcer: 16
- Medication incident: three
- Diagnostic incident including delay (including failure to act on test results): two
- Venous thrombo-embolism: two
- Sub-optimal care of the deteriorating patient: two
• Confidential information leak/information governance breach: one
• Surgical/invasive procedure incident: one
• Treatment delay: one
• Abuse/alleged abuse of adult patient by staff: one

The time taken by the trust to report these 50 SI’s to STEIS varied:

• 33 were reported within 14 days
• Four took between 15 and 30 days to report
• Two took between 31 and 60 days to report
• Five took between 61 and 90 days to report
• Six took more than 90 days to report

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Some wards displayed safety thermometer information on notice boards. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data relate to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported 41 new pressure ulcers, nine falls with harm and 15 urinary tract infections in patients with a catheter in its medical care services.

Prevalence rate (number of patients per 100 surveyed) of patient harms at University Hospitals of Derby and Burton NHS Foundation Trust
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Patients were holistically assessed and care and treatment was delivered in line with legislation, standards and guidance of the National Institute of Care Excellence (NICE) and other expert professional bodies. All the documents we reviewed referred to relevant guidance.

We saw the medicine division current audit plan which identified 182 different audit topics including national audits, local audits and audit against NICE guidelines.

The Trust had not submitted anything to the NICE Shared Learning database, however the clinical audit manager had registered to attend the next NICE annual conference to understand how best to engage and start to share best practice.

We saw evidence of local audit, for example, the monthly infection prevention and control audit which also identified actions for matrons to feed back to their relevant areas.

The hospital used an electronic prescribing system which had automated links to medicine and prescribing information and antimicrobial protocols.

Clinical guidelines for the treatment of suspected sepsis were available to staff to ensure that standardised treatment was delivered in cases of sepsis across the Trust and thus improve care delivery. However, the policy, provided to us after our inspection, was for the acquired trust. It was not clear therefore, if staff at Royal Derby Hospital were following this policy.

Information provided by the trust prior to our inspection showed work was underway to identify a screening tool to be used across the whole of trust, currently the Royal Derby site used a bespoke tool which included the sepsis six care bundle.

Effective procedures were in place to identify mental health and vulnerable patients who were assessed using nationally recognised tools. We saw evidence of referrals to the frailty team and the mental health team.
On discharge patients were given clear advice on what to do if their condition deteriorated sometimes supported by written information and contact telephone numbers. Patients we spoke with in the discharge lounge told us they knew who to contact if they were concerned about their condition.

Consultants were present in the medical admission unit from 8am to 11pm this meant that acutely ill patients were reviewed twice a day and senior doctors were to hand in the event a patient’s condition deteriorated.

Ward managers told us that consultants delivered ward rounds at least once a day, seven days a week. All patients would be seen unless it was determined by the medical and nursing staff that it was not necessary and would not be detrimental to the patient.

Door to needle times for the thrombolysis of stroke patients in December 2018 was 100% for within four and a half hours. This was in line with NICE guidelines.

Patients at risk of venous thromboembolism were prescribed prophylactic medicine to reduce the risk of blood clotting and we saw evidence of this in the records we reviewed.

Endoscopic procedures were carried out in line with British Society of Gastroenterology guidance and the trust endoscopy policy.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

On admission to a ward all patients had their nutritional status assessed using the malnutrition universal screening tool (MUST). The care record included clear guidance on actions to take depending on the MUST score. For example, patients at high risk and requiring nutritional treatment were referred to the dietitian.

Staff told us there was good access to support from dietitians and we observed dietitians assessing patients and completing nutrition and hydration care plans.

A range of different meals were available including Halal and Kosher, patients told us they found the food tasty and filling.

Ward host/hostesses served the meals. We observed meals being distributed on one ward, food temperatures were checked before the food was distributed and the hostess had a diet sheet detailing the requirements of each patient.

Meal times were protected and we saw a consultant ward round suspended whilst patients were eating their lunch.

Patients had easy access to drinking water and this was refreshed throughout the day and hot drinks were served regularly.

The speech and language therapy service provided assessment and treatment for patients with communication and swallowing problems.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The service had implemented the Faculty of Pain Medicine’s Core Standards for Pain Management (2015).

Pain assessment was included in the patient care record. Pain was scored using an appropriate tool ranging from ‘no pain at rest or movement’ to ‘continuous pain at rest, severe pain on
movement'. The Abbey pain scale was used for patients living with dementia or who could not verbalise.

We saw that pain relief was prescribed when needed and patients told us that staff responded swiftly to requests for pain relieving medicines. Patients were also asked if they used any alternative methods for pain relief and staff told us they encouraged patients to continue with alternative methods providing they were safe, for example hot or cold packs.

The hospital had an acute pain team consisting of three specialist acute pain nurses with a lead consultant anaesthetist. The team dealt primarily with acute in-patient pain issues, the majority being perioperative surgical management, but also included pain management in non-surgical patients. The acute pain nurses dealt with daily pain referrals from all ward areas.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. However, some outcomes for patients were worse than the England average.

Local clinical audit facilitators worked with staff to draft the audit annual forward plan. The audit annual forward plan for medicine was signed off by the audit committee and presented to the Board. The plan included local and national audit topics, routine and re audits. Each business unit within the medicine division submitted a clinical audit report to the medicine governance meeting once a quarter. The report contained information about the progress of audit topics, results of audit and any learning identified from audit.

There was no standard approach to disseminating learning from audit. Senior managers told us each business unit had a different way of sharing information, some used posters in staff room, ward meetings or signing sheets to confirm when information had been read and understood.

Best practice learning from audit was shared at the East Midlands Clinical Audit Support Network which met 3 – 5 times per year. The network included people with a clinical audit, effectiveness or quality improvement role in organisations that provided NHS services in Nottinghamshire, Derbyshire, Leicestershire Northamptonshire or Lincolnshire, along with Health Education East Midlands, East Midlands Academic Health Science Network and the Clinical Audit Support Centre. The service participated in national audits for example, The National British Thoracic Society bronchoscopy audit, lung cancer audit, chronic obstructive airway disease audit and the national audit of inpatient falls.

National audits were benchmarked against the England average. Audit results varied, senior staff told us that if they were not meeting the expected level of compliance in some aspect of a national audit they would target this as an area for improvement.

Data submitted to the national diabetes foot care audit 2016 – 2017 published March 2018 was better than the England average in most areas. Senior managers told us this audit had led to more integrated ways of working with other health care providers in the area which had resulted in year on year improvements in major and minor amputations. We saw evidence of this in the Diabetes Foot Care Profile, May 2018, Public Health England.

Royal Derby hospital took part in the national CQUIN for Sepsis, undertaking monthly audits and quarterly reports to the commissioners of the service. Results were fed back to the division to share, with cases of non-compliance with antibiotic prescription/administration highlighted as requiring further investigation.

The endoscopy unit had achieved JAG accreditation for the year 2018 and was awaiting the results of the recently submitted assessment data for 2019. There were no outstanding actions from the 2018 JAG accreditation action plan.

**Relative risk of readmission**

*Trust level – elective admissions*
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From June 2017 to May 2018, patients at the trust had a similar to expected risk of readmission for elective medical admissions compared to the England average.

- Risk of readmission for medical oncology was higher than expected.
- Risk of readmission for clinical haematology was similar to expected.
- Risk of readmission for gastroenterology was lower than expected.

**Elective Admissions – Trust level**

![Graph showing elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*

**Trust level – non-elective admissions**

From June 2017 to May 2018, patients at the trust had a similar to expected risk of readmission for non-elective medical admissions compared to the England average.

- Risk of readmission for general medicine was similar to expected.
- Risk of readmission for medical oncology was lower than expected.
- Risk of readmission for nephrology was higher than expected.

**Non-Elective Admissions - Trust level**

![Graph showing non-elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.*

**Royal Derby Hospital – elective admissions**
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From June 2017 to May 2018, patients at Royal Derby Hospital trust had a similar to expected risk of readmission for elective medical admissions compared to the England average.

- Risk of readmission for medical oncology was higher than expected.
- Risk of readmission for clinical haematology was similar to expected.
- Risk of readmission for gastroenterology was lower than expected.

**Elective Admissions – Royal Derby Hospital**

![Elective Admissions Graph]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*

**Royal Derby Hospital – non-elective admissions**

From June 2017 to May 2018, patients at Royal Derby Hospital trust had a similar to expected risk of readmission for non-elective medical admissions compared to the England average.

- Risk of readmission for general medicine was similar to expected.
- Risk of readmission for medical oncology was lower than expected.
- Risk of readmission for nephrology was higher than expected.

**Non-Elective Admissions - Royal Derby Hospital**

![Non-Elective Admissions Graph]

*(Source: Hospital Episode Statistics)*

**Sentinel Stroke National Audit Programme (SSNAP)**
Derby Teaching Hospitals NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen's Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Royal Derby Hospital takes part in the Sentinel Stroke National Audit programme. The hospital’s performance is shown in the tables below.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>D↓↓</td>
<td>B↑↑</td>
<td>C↓</td>
<td>C</td>
</tr>
</tbody>
</table>

On a scale of A-E, where A is best, the hospital’s overall SSNAP level improved from grade D for the audit period from December 2016 to March 2017 to grade C for the subsequent two audit periods from April to November 2017. The hospital's performance for this indicator then deteriorated to grade D for the most recent audit period, from December 2017 to March 2018.

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>D↓</td>
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<td>C</td>
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<tr>
<td>Domain 3: Thrombolysis</td>
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<td>B</td>
<td>C↓</td>
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<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
<td>A↑↑</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>D↓</td>
<td>D</td>
<td>E↓</td>
<td>E</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C↓</td>
<td>B↑</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>D↓↓</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Patient-centred total key indicator level</td>
<td>D↓↓</td>
<td>B↑↑</td>
<td>C↓</td>
<td>C</td>
</tr>
</tbody>
</table>

The hospital's patient-centred stroke unit indicator improved from grade D for the audit period from December 2016 to March 2017 to grade C for the subsequent two audit periods from April to November 2017. The hospital’s performance for this indicator then deteriorated to grade D for the most recent audit period, from December 2017 to March 2018.

The hospital’s patient-centred total key indicator level improved from grade D for the audit period from December 2016 to March 2017 to grade B for the next audit period from April to July 2017. The hospital’s performance for this indicator then deteriorated to grade C for the two most recent audit periods, from August 2017 to March 2018.
The hospital’s performance for the team-centred indicators for stroke unit and total key indicator level were both identical to its performance for the equivalent patient-centred indicators.

The hospital’s team-centred stroke unit indicator improved from grade D for the audit period from December 2016 to March 2017 to grade C for the subsequent two audit periods from April to November 2017. The hospital’s performance for this indicator then deteriorated to grade D for the most recent audit period, from December 2017 to March 2018.

The hospital’s team-centred total key indicator level improved from grade D for the audit period from December 2016 to March 2017 to grade B for the next audit period from April to July 2017. The hospital’s performance for this indicator then deteriorated to grade C for the two most recent audit periods, from August 2017 to March 2018.

### Lung Cancer Audit

**Derby Teaching Hospitals NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The trust participated in the 2017 Lung Cancer Audit.

The crude proportion of patients seen by a cancer nurse specialist was 73.0%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 69.9%.

The case-mix adjusted proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.8%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 71.0%. This was good practice compared to other trusts. The trust’s performance in the equivalent measure from the 2016 audit was not significantly different from the national level.
The proportion of patients with Small Cell Lung Cancer receiving chemotherapy was 72.3%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The case-mix adjusted one year relative survival rate for the trust in 2017 was 34.8%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Derby Teaching Hospitals NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

At Royal Derby Hospital the crude proportion of patients who had a vision assessment (if applicable) was 76.7%. This did not meet the national aspirational standard of 100%. Results of between 50% and 79% for this metric are rated as fair.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 25.0%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 24.1%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients with a call bell in reach (if applicable) was 100.0%. This met the national aspirational standard of 100%. Results of more than 80% for this metric are rated as good.

(Source: Royal College of Physicians)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

In all the areas we inspected we met staff with different levels of expertise and knowledge from health care assistants to advanced care practitioners. Ward staff also had access to specialist nurses and health professionals. This meant that at all times staff with the right skills and knowledge were available to contribute to the care and treatment of patients.

The induction programme for registered nurses included dementia awareness and the Mental Capacity Act, the induction programme for non-registered nurse included dementia awareness. Dementia awareness and consent were included in the trust mandatory training programme. The trust did not provide any evidence of staff training in Learning Disability, Autism or challenging behaviour.

Infection control was included in the mandatory training programme and this included updates on sepsis management, sepsis six and the sepsis care management bundle. Sepsis training was also
included in the trust induction programme. The trust was currently reviewing training with a view to introducing sepsis six refresher training every three years for clinical patient facing staff.

Staff we spoke with told us they had annual appraisals with their line manager although information from the trust indicated they were not meeting the target of 90%. Staff told us appraisal discussions were meaningful and staff could identify training and development needs. Regular 121 meetings weren’t planned but staff told us they could arrange a meeting with their line manager if needed.

Regular appraisals were in place for medical staff and all doctors were revalidated every five years based on their engagement with medical appraisal processes. Annual appraisals were undertaken with fully trained, accredited medical appraisers. The responsible officer was responsible for making a recommendation to the GMC for a doctor to be revalidated. Revalidation is the process by which the General Medical Council (GMC) confirms the continuation of a doctor’s licence to practise in the UK.

Staff told us they could access a variety of training material and were given protected time to do this. Domestic staff received regular updates by a monthly toolbox talk, we reviewed the toolbox talk for January 2019 which was about reporting incidents and near misses. Staff signed to say they had read, had an opportunity to discuss and understood the talk.

The trust managed poor performance in staff through a capability policy. Ward managers told us that if they became aware of poor performance in a member of staff either through complaints or errors they would first have a discussion with the member of staff first to identify if there were any contributory factors. Managers could put in place a competency package or a professional development support package to address the performance issues.

Individuals and teams responsible for antimicrobial stewardship monitored data and provided feedback on prescribing practice. For example, through education forums and from the ‘board to the ward’ through senior managers of the service.

### Appraisal rates – trust level

From November 2017 to October 2018, 87.4% of staff in medical care at the trust received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were met for estates and ancillary staff and allied health professionals but were not met for any other staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>33</td>
<td>34</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>205</td>
<td>223</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>54</td>
<td>61</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>38</td>
<td>43</td>
<td>88.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>838</td>
<td>950</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>381</td>
<td>432</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>529</td>
<td>628</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>88</td>
<td>108</td>
<td>81.5%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,166</strong></td>
<td><strong>2,479</strong></td>
<td><strong>87.4%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Appraisal rates - Royal Derby Hospital
From November 2017 to October 2018, 86.3% of staff in medical care at Royal Derby Hospital received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were met for estates and ancillary staff and allied health professionals but was not met for any other staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>27</td>
<td>27</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>147</td>
<td>159</td>
<td>92.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>37</td>
<td>42</td>
<td>88.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>629</td>
<td>718</td>
<td>87.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>283</td>
<td>327</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>39</td>
<td>46</td>
<td>84.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>392</td>
<td>472</td>
<td>83.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>71</td>
<td>91</td>
<td>78.0%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,625</strong></td>
<td><strong>1,882</strong></td>
<td><strong>86.3%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Each patient had a named consultant and a named nurse who was the primary point of contact for that patient during that nurse’s shift.

We observed good multi-disciplinary team (MDT) working in all the areas we inspected. Physiotherapists, occupational therapists, speech and language therapists and specialist nurses took part in board rounds and ward rounds and contributed to care planning and discharge planning. Integrated care teams and community specialists such as the community respiratory team were visible on wards, communicating with patients and ward staff to ensure that effective plans were in place for the ongoing care.

Patient records we looked at demonstrated evidence of continual MDT input and contribution to treatment plans. This included evidence of meetings and action plans as well as therapy assessments.

Ward staff were responsible for coordinating patient care, discharge support officers liaised with the discharge team to ensure referrals were made to other services including community health and social services. There was close working with integrated discharge teams who took part in MDT meetings.

Policies and procedures were in place to support staff when transferring patients between wards and other services. These were clear and based on best practice to ensure continuity of care. A discharge standard operating procedure was also in place to ensure that all relevant teams and services were informed when patient were discharged. An MDT decision was required to support the decision to discharge a patient.

**Seven-day services**
All in-patient medical ward areas were open 24 hours a day, seven days a week. Staff and patients had access to most services seven days a week. Diagnostic services such as x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI) and support services such as pathology and theatres were available 24 hours a day. The endoscopy unit opened at the weekends and staff were available on call in the out of hours period.

The service monitored its performance against the four ‘priority’ seven-day services standards. The seven-day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

Trust wide results for April 2017 to March 2018 were mostly positive with the time to first consultant review at 82% and access to diagnostic tests, access to consultant directed interventions and ongoing consultant review all at 100%.

The medical assessment unit (MAU) triaged patients when they first arrived to assess the immediate presenting symptoms and initiate any urgent treatment to prevent further deterioration of the patient. Patients were triaged by a medical consultant which meant acutely ill patients were seen by a consultant within one hour.

Some wards had blood analyser equipment for key blood tests, such as blood gases, which meant that results were available almost immediately after the blood was taken.

Patients on general wards were reviewed by a consultant at least once every 24 hours unless it had been determined less would not be detrimental to the patient. Acutely ill patients in the medical assessment unit were under constant review by consultants working on the unit until they had stabilised and were either admitted or discharged.

Health promotion

The hospital website had links to national health promotion initiatives such as smoking cessation services. Patient records we reviewed included alcohol screening and smoking history. Patients who smoked cigarettes were informed about the hospitals no smoking policy and offered nicotine replacement therapy. Patients who were dependant on alcohol were referred to the hospital alcohol team for assessment and help with withdrawal.

We saw several examples of where patients were supported to manage their own health, care and wellbeing and patients told us they were encouraged to be independent:

- All patients were assessed for capability to self-administer their own medicines. This was documented in the patient records we reviewed.
- Diabetic patients were encouraged to choose freely from the hospital menu rather than being given a ‘diabetic diet’, this encouraged them to take responsibility for eating healthy appropriate foods.
- Patients requiring long term urinary catheterisation were taught how to self-catheterise if they were physically able.
- Patients told us that staff encouraged them to be independent
- The service supported 34 patients to have renal dialysis in their own homes
- Health and wellbeing events took place for patients with cancer, these included topics such as healthy lifestyles, physical activity and financial advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The trust had a policy in place covering consent and the Mental Capacity Act and a lawful authority for providing examination, care or treatment policy.

Admission and care records included mental capacity assessments and in the records we reviewed we saw these completed when appropriate. The care record also prompted staff to record best interest decisions and involve all relevant parties such as relatives and carers.

At the time of our inspection we were not aware of any patients subject to deprivation of liberty standards or any evidence of patients being sedated inappropriately.

Consent was included in the mandatory training programme. All the staff we spoke with could articulate a good understanding of the Mental Health act, and the importance of capacity and consent. They knew how to access further advice if they had any concerns or queries. Staff talked about decisions made in the best interest of the patient.

Patients were supported to make informed decisions about their care and treatment, patients told us they were given enough information to make decisions and could discuss options with nursing and medical staff.

Junior doctors expressed concern at obtaining patient consent for complex interventional radiological procedures. They felt they did not know enough about the complex procedures to give patients enough information to make an informed consent.

**Mental Capacity Act and Deprivation of Liberty training completion**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it is not possible to produce trust level data.

Staff at Royal Derby Hospital were eligible for a single combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training module, with a completion target of 75%. This requirement was inherited from the predecessor trust. Compliance for this module for the period from November 2017 to October 2018 level for qualified nursing staff in medical care at Royal Derby Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>693</td>
<td>705</td>
<td>98.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for qualified nursing staff in medical care at Royal Derby Hospital.

Compliance for this module for the same period for medical staff in medical care at Royal Derby Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>256</td>
<td>301</td>
<td>85.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for medical staff in medical care at Royal Derby Hospital.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff understood and respected patients cultural, social and religious needs. Cultural and religious requirements were assessed as part of the personal hygiene assessment. One lady told us she had been able to request female nursing staff for help with her personal hygiene needs.

Staff treated patients and those close to them in a respectful and dignified way, doctors and nurses introduced themselves to patients. Information boards described the different staff uniforms and photos of the ward staff helped patients and carers recognise who was who. There were prompts and reminders for staff in the care records to ‘ensure privacy and dignity throughout’.

We saw posters displayed explaining to patients and their carers how their wishes would be respected during the planning of care and treatment. ReSPECT had been introduced at Derby Teaching Hospitals NHS Foundation Trust in June 2018 and trustwide, for the new organisation, in April 2019 to replace the do not attempt cardio pulmonary resuscitation policy and paperwork. ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

Staff respected patients’ privacy and dignity by drawing curtains around the bed when delivering personal care and treatments, single rooms had signs on the door reminding staff to knock before they entered.

Patients we spoke with told us that staff were very supportive and gave positive encouragement in a sensitive way to help them with their recovery and be self-caring.

We observed staff checking patients were comfortable as part of the intentional rounding. Pain relief was offered and given in a compassionate and timely way. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

Ward staff had access to a ‘pop up bedroom’ scheme for patients at the end of life. This included a temporary screen with an image such as a bluebell wood which could be pulled across a wall, a recliner chair for relatives to stay overnight, a volunteer sitting service, visits by patients own pets, and a musician to play background music.

Patients on the ward for acute medicine for older people generally stayed on the ward an average of nine days, staff told us they tried to arrange an activity every day for the patients such as therapy dogs and musical events.

Royal Derby Hospital

Friends and Family test performance

Please note that Royal Derby Hospital submitted no data to the inpatient Friends and Family Test (FFT) for November 2017 or July 2018.

From October 2017 to September 2018 (excluding November 2017 and July 2018) the FFT response rate for medical care at Royal Derby Hospital was 24.4%. This was based on 5,781 responses. This was similar to the England average of 25%.
A breakdown of FFT performance by ward for medical wards at this hospital over the same period is shown below.

All medical wards scored over 90% for these 10 months overall.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Total Responses Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oct-17</td>
<td>Nov-17</td>
<td>Dec-17</td>
<td>Jan-18</td>
</tr>
<tr>
<td>MAU</td>
<td>893</td>
<td>9%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 216</td>
<td>612</td>
<td>30%</td>
<td>97%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward 404</td>
<td>684</td>
<td>51%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 306</td>
<td>501</td>
<td>21%</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 410</td>
<td>434</td>
<td>27%</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>COU</td>
<td>415</td>
<td>57%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 403</td>
<td>397</td>
<td>42%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 101</td>
<td>362</td>
<td>36%</td>
<td>88%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward 408</td>
<td>354</td>
<td>28%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 304</td>
<td>340</td>
<td>30%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 402</td>
<td>307</td>
<td>31%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 407</td>
<td>305</td>
<td>33%</td>
<td>97%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 311</td>
<td>295</td>
<td>40%</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 305</td>
<td>280</td>
<td>51%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 409</td>
<td>265</td>
<td>37%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 401</td>
<td>240</td>
<td>44%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward 406</td>
<td>234</td>
<td>34%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 302</td>
<td>193</td>
<td>23%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward 301</td>
<td>150</td>
<td>32%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward 405</td>
<td>150</td>
<td>34%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward 303</td>
<td>134</td>
<td>15%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward 312</td>
<td>118</td>
<td>56%</td>
<td>95%</td>
<td>99%</td>
</tr>
</tbody>
</table>

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. When patients were worried or anxious staff spent time with them to talk and understand their worries.

Patients told us that even though staff were busy they would always take time to sit and explain things if needed. Staff told us that when they had been inpatients or close friends and relatives had been inpatients they knew how worrying the hospital environment could be.

From our observations of staff interacting with patients and from what patients told us we were assured that patients were given enough information for them to be able to understand their illness and allay their fears. Relatives and carers were also kept up to date and could make appointments to talk with medical staff if they wanted.

The hospital had a faith centre where patients and relatives of faith or no particular faith could find a quiet place to sit and reflect or pray. The faith centre was also home to the hospital chaplaincy and patients could request holy communion on Sundays.

During our inspection we observed a member of staff escorting a distressed relative to the ward quiet room. Staff told us that dealing with distressed and anxious carers was a regular occurrence
and they often checked with relatives how they were feeling. Staff on the oncology ward had attended an enhanced training on communication skills to help them talk with distressed relatives in an empathetic way. Medical staff were available to speak with relatives if necessary.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.** They saw this as an integral part of patient care and essential in discharge planning.

We observed doctors and nurses talking to patients, they took time to explain care and treatment plans to patients in a way they could understand. Patients told us that if they were concerned about anything staff were always happy to give further explanations and information.

The service used a ‘Getting to Know me’ form for patients living with dementia. The form is a simple tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. It enables health and social care professionals to see the person as an individual and deliver person-centered care that is tailored specifically to the person's needs. It can therefore help to reduce distress for the person with dementia and their carer. It can also help to prevent issues with communication, or more serious conditions such as malnutrition and dehydration.

Staff made sure patients and their families knew how to access further information, we saw racks of information leaflets displayed on the wards and departments we visited, and the hospital website contained information on a wide range of illnesses and conditions. Patients were encouraged to ask questions if they had any queries or concerns. All the wards and departments we visited had information boards on a variety of topics in language that patients and the public could understand for example, sepsis, diet and nutrition, privacy and dignity.

Carers and relatives were welcomed as important partners in the delivery of care. They were consulted and kept informed at key points in the patient’s hospital experience such as the reason for admission and discharge planning.

One patient living with a learning disability was cared for by his parents. A side room had been equipped with a fold out bed and access to the kitchen for preparing food and drinks. Ward staff followed the principles of John's campaign. John's Campaign is a campaign for extended visiting rights for family carers of patients with dementia in hospitals in the United Kingdom.

The hospital had ‘sharing care’ agreements for carers, the patient and ward staff to complete. The agreement detailed the care elements to be carried out by the carer such as help with washing and dressing and required carers to inform ward staff when they were leaving so it was clear to staff when they needed to takeover care.

We observed staff advising on parking for a relative who was collecting a discharged patient. Staff told the relative to park in the free (for 30 minutes) parking area and that they would escort the patient to the car which meant the relative would avoid car parking fees.

‘Your information and what you need to know’ leaflets were displayed in the wards and departments we visited and information about the management of patient information was also available on the hospital website. Patients were assured that their personal information would be treated confidentially.

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**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people by contributing to local sustainability and transformation plans (STP). STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities.
They were drawn up by senior figures from different parts of the local health and care system, following discussion with staff, patients and others in the communities they serve.

Service leads had worked with commissioners to identify the health needs of the population. This work had resulted in services such as Impact Plus; a team of respiratory nurse specialists working between the hospital and the community. The introduction of this service has led to reduced length of stay in hospital for respiratory patients and a reduced number of hospital admissions.

The hospital facilities and premises were appropriate for the purpose intended, the hospital was well designed, easy to navigate and centrally located.

**Meeting people’s individual needs**

The service generally took account of patients’ individual needs and put systems and processes in place to enable responsive care and treatment.

Equality and diversity and dementia training were included in the hospital mandatory training programme, admission and care records contained information on communication and disability. Some of the electronic patient records could flag patients with communication or other disabilities so information could be shared between hospital wards and departments.

All areas of the hospital we inspected were wheelchair friendly, the hospital provided an indoor buggy to help patients with reduced mobility to get around the hospital.

British sign language (BSL) interpreters were available for people with speech and hearing difficulties and a series of videos were available on the hospital website using BSL interpreters to explain some common procedures such as endoscopy. Blind or partially sighted patients could request information in Braille.

Staff had access to interpreting services for patients whose first language was not English and patient leaflets could be provided in different languages from the trust communications team.

The trust was working towards implementing the accessible information standard, posters were displayed prompting patients and visitors to ask for information in a format they could understand for example, braille, easy read or large font.

Dementia friendly aids were available on all wards such as twiddle muffs, Twiddle muffs are knitted hand muffs with interesting bits such as buttons, different textured fabric and ribbons attached inside and out designed to provide stimulation for active hands. Patients living with dementia find twiddle muffs reassuring and comforting.

The trust had an acute liaison nurse for adults with learning disabilities who could help and support in a number of ways including, planning for admission, helping with communication, help with reasonable adjustments, supporting ward staff, supporting patients and carers and planning for discharge. There was also a specially devised hospital traffic light assessment for adults with a learning disability produced in easy read format detailing things that were important to the patient and their likes and dislikes. A hospital communication book was also available for staff to help them communicate with people who had difficulties understanding.

Staff had 24 hour access to the mental health team, staff told us the mental health team were accessible by telephone and could give advice over the phone, so staff could respond appropriately to the needs of the patient until the mental health team were able to carry out a face to face assessment.

Patients with complex health and social care needs were referred to the intermediate care team who liaised with community health and social services to ensure the patient could be discharged safely and that there was continuity of care.

In the discharge records we reviewed we saw that information about patient’s specific communication and disability was shared with other health care professionals and care services.
Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

We spent some time in the bed bureau office which took calls from health care professionals referring patients to the hospital. GP’s wishing to refer patients to the medical team or wanting to discuss a patient’s symptoms were transferred directly to a medical consultant. The consultant then gave advice on next steps for the patient. This meant that appropriate patients could be admitted directly to a ward or the medical assessment unit (MAU) and avoid the emergency department.

Bed management meetings took place four times a day and medical bed managers had continuous oversight of the bed status in the medical division. The hospital had a clear escalation plan in place which described the different operational pressure escalation levels. The escalation level was decided by the chair of the bed meeting, at the time of our inspection the escalation status was red.

Most medical patients were first admitted to the medical admissions unit where they were examined by a medical consultant and transferred as quickly as possible to the relevant medical speciality ward. Most patients spent between 12 to 24 hours on the medical admissions unit but on occasion if beds were not available they stayed longer. Staff told us that when this happened speciality teams visited the patient daily.

Patient flow was also supported by an electronic admissions system which recorded time of admission and time seen by junior or senior doctor. Junior doctors monitored the system to follow up on investigations, care and treatment recommended by more senior doctors following triage. Daily board rounds took place. Board rounds are short meetings of no longer than 30 minutes during which every patient is briefly discussed including discharge planning.

Discharge planning commenced on the day of admission. The early supported discharge team and the frailty team were involved for frail, vulnerable and elderly patients and those who may require rehabilitation. Discharge support officers were based on the wards and worked with staff and the discharge team, this meant that barriers to patient discharge were identified early and plans put in place to address them.

Medical staff told us they knew where medical outlier patients were and visited them as part of an extended daily board round some speciality teams convened an outlier team who just visited outlier patients where ever they were. The number of medical outliers had reduced with the introduction of two winter pressures wards at the end of January 2019. Before the ward was opened medical outliers were spread across the hospital wherever there was a spare bed but the majority were now admitted to the winter pressure ward. A medical outlier is a hospital inpatient who is classified as a medical patient for an episode within a spell of care and has at least one non-medical ward placement within that spell. Plans were in place to increase the number of medical beds at the hospital.

We asked staff if anything delayed patient discharge and they told us that take-home medicines for unplanned discharges sometimes caused delays and patients who were waiting for a mental health assessment. We spoke with one patient in the discharge lounge who told us they had waited five hours for their take home medication.

During our inspection we observed two rapid access clinics in operation. The combined unwell unit had ten beds/recliner chairs for oncology and haematology patient emergencies. Most patients
(approximately 60%) with symptoms such as uncontrolled pain, and possible neutropenic sepsis could be admitted, examined, treated and discharged on the same day. The trans ischaemic attack (TIA) clinic was a one stop clinic, patients were examined, investigated and treated in one visit. Stroke nurse specialists ran the clinic, they told us that approximately 50% of patient attending the clinic were true TIA patients. Stroke nurse specialists could admit, discharge and prescribe for patient attending the clinic.

**Average length of stay**

**Trust Level**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen's Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust was 5.2 days, which was similar to the England average of six days.

Average lengths of stay for elective specialties:

- Average length of stay for elective patients in hepatology was shorter than the England average.
- Average length of stay for elective patients in clinical haematology was similar to the England average.

**Elective Average Length of Stay – Trust Level**

![Graph showing average lengths of stay for different specialties and comparison to England averages]

*Note: Top two specialties for specific trust based on count of activity.*

For medical non-elective patients, the average length of stay was 6.5 days, which was similar to the England average of 6.3 days.

Average lengths of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in general medicine and cardiology were similar to the England averages.
- Average length of stay for non-elective patients in stroke medicine was longer than the England average.
Non-Elective Average Length of Stay – Trust Level

![Graph showing average length of stay for different specialties.]

Note: Top three specialties for specific trust based on count of activity.

Royal Derby Hospital

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From July 2017 to June 2018 the average length of stay for medical elective patients at Royal Derby Hospital was 4.8 days, which was lower to the England average of six days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in hepatology, gastroenterology and nephrology were shorter than the England averages.

Elective Average Length of Stay - Royal Derby Hospital

![Graph showing average length of stay for different specialties.]

Note: Top three specialties for specific site based on count of activity.

For medical non-elective patients, the average length of stay was 6.5 days, which was similar to the England average of 6.3 days.

Average lengths of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in general medicine and cardiology were similar to the England averages.

- Average length of stay for non-elective patients in stroke medicine was longer than the England average.
Non-Elective Average Length of Stay - Royal Derby Hospital

Note: Top three specialties for specific site based on count of activity.

Referral to treatment (percentage within 18 weeks) - admitted performance

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than the England average in 11 out of 12 months.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the trust performed better than the England average for admitted RTT (percentage within 18 weeks) for six out of eight medical specialties.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>96.2%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.8%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>92.6%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>91.3%</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

Over the same period there were two specialties where the trust performed worse than the England average for admitted RTT:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>90.4%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>87.8%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission

From November 2017 to October 2018, 39.1% of patients on the trust’s medical wards did not move wards during their admission, and 60.9% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From November 2017 to October 2018, there were 8,959 patient moves at night on medical wards. The highest numbers of ward moves were reported in January 2018 (804), December 2017 (801) and May 2018 (789).

The majority of ward moves at night over this period involved the medical assessment unit at Royal Derby Hospital (7,922, 88.4%). Otherwise the highest numbers of ward moves at night were reported for the Coronary Care Unit (118) and Ward 408 (cardiology, 67).

(Source: Routine Provider Information Request)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust had a policy and procedure in place to support staff in the handling of concerns and complaints including duty of candour requirements. Staff we spoke with were familiar with the complaints procedure and felt confident to handle a complaint.

Patients we spoke with hadn’t considered making a complaint and were unsure about how to do so. However, they told us that ward staff were very approachable and they would not hesitate to raise a concern or complaint with staff if necessary. During our inspection we saw leaflets and posters clearly displayed which described the patient advice and liaison service (PALS) and the complaints process.

There was also clear easy to follow information on the hospital website about how to make a complaint with downloadable complaints forms and information about NHS Complaints Advocacy. NHS Complaint Advocacy can provide an advocate, independent of the NHS to help with a complaint at any stage of the process.
There was detailed learning and improvements through the complaints investigation process. The quarterly complaints and concerns reports provided details of actions from individual complaints, along with examples of learning from business units and divisions. These reports were reviewed at the trust quality committee and fed up to the trust board.

Learning from complaints and concerns

Trust level

From October 2017 to September 2018 the trust received 194 complaints about medical care. For the 175 complaints that had been closed at the time of data submission the trust took an average of 47.2 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The 19 complaints that had not yet been closed had been open for an average of 78.8 days at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>61</td>
</tr>
<tr>
<td>Patient Care</td>
<td>45</td>
</tr>
<tr>
<td>Communication</td>
<td>32</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>19</td>
</tr>
<tr>
<td>Admissions and Discharges</td>
<td>16</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>6</td>
</tr>
<tr>
<td>Access to Treatment or Drugs</td>
<td>4</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, Dignity &amp; Well-Being (Pdw)</td>
<td>1</td>
</tr>
<tr>
<td>Trust Admin/Policies/Procedures Including Patient Record Management</td>
<td>1</td>
</tr>
<tr>
<td>No subject</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>194</strong></td>
</tr>
</tbody>
</table>

Royal Derby Hospital

From October 2017 to September 2018 Royal Derby Hospital received 185 complaints about medical care. For the 169 complaints that had been closed at the time of data submission, the trust took an average of 47.8 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The 16 complaints that had not yet been closed had been open for an average of 84.2 days at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.
<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>54</td>
</tr>
<tr>
<td>Patient Care</td>
<td>44</td>
</tr>
<tr>
<td>Communication</td>
<td>31</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>19</td>
</tr>
<tr>
<td>Admissions and Discharges</td>
<td>16</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>6</td>
</tr>
<tr>
<td>Access to Treatment or Drugs</td>
<td>4</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, Dignity &amp; Well-Being (Pdw)</td>
<td>1</td>
</tr>
<tr>
<td>Trust Admin/Policies/Procedures Including Patient Record Management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>185</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

Trust level

From October 2017 to September 2018 the trust received 389 compliments about medical care. The trust did not provide a breakdown by subject for compliments received.

Royal Derby Hospital

From October 2017 to September 2018 the hospital received 134 compliments about its medical care services at Royal Derby Hospital. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Triumvirate leadership was provided at divisional level by a divisional medical director, divisional director and divisional nurse director. Business unit triumvirate leadership consisted of a general manager, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by ward/department managers.

Senior managers and leaders we spoke with demonstrated they had the skills and knowledge to understand the challenges facing the service, identify the risks and put plans in place for improvements.
Staff told us leaders were visible and approachable and were familiar with the names of key board members. Named leaders were in place at board level for key areas such as mental health, safeguarding and sepsis management.

Leadership development was addressed at several levels, the LEAD programme for aspiring leaders, leadership masterclasses for existing leaders and a leadership community forum for more senior leaders to network and exchange information.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust's vision was ‘Exceptional care together’ and was underpinned by four values: compassionate, approachable, respect and excellence. The vision and values were reflected in the trust's five objectives which formed the basis of the trust's five-year strategy.

The trust raised staff awareness of the strategy by producing a ‘plan on a page’ for staff. Staff we spoke with could talk about the vision, values and strategy. The strategy was aligned with the local health and social community including commissioners, providers, voluntary and independent sectors, NHS England and local education institutions.

A detailed operational plan supported implementation of the strategy which was regularly monitored and reported to the trust board.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with told us they felt respected and valued and expressed their pride in working for the organisation. We observed staff working well together as a team, communicating effectively, problem solving and giving each other assistance when required.

The trust had a comprehensive developing our people policy in place which outlined best practice for managers in supporting and developing staff, opportunities for staff to support their development and processes for talent management and succession planning. A capability policy described how managers should address poor staff performance.

There was a culture of openness and honesty, we saw this in the complaints and incident policies we reviewed and in the way incidents were investigated and managed. The hospital had a policy for being open and duty of candour which reflected the ten principles of being open as identified by the National Patient Safety Agency.

Formalised duty of candour training sessions had not taken place the trust told us training had been ad hoc. However, there was now a duty of candour project manager in place who was rolling out face to face training and working towards developing an electronic learning training pack. The trust was aiming to have 90% of staff trained within 12 months of the electronic learning pack being available.

Staff described the principles of whistle blowing and the staff we spoke with felt confident in raising concerns. A freedom to speak up guardian had been in post since July 2017. We saw a report of the numbers and types of staff contacting he guardian including the reasons for doing so. Action was identified to promote awareness of the guardian to the groups of staff not accessing the service.

The health and wellbeing of its staff was a priority for the trust and we saw this reflected in one of the trusts five objectives. The trust aimed to develop a comprehensive range of interventions to
treat, prevent and support optimum staff health. We saw evidence of this in the trusts plan on a page end of year report in the expansion of the occupational health team to include a clinical psychologist, specialist mental health nurse and physiotherapist and compliance with National Institute for Care Excellence (NICE) guidelines for the management of long term sickness and incapacity for work.

Senior managers described support networks and events for oversees staff for example a ‘New to the NHS’ package which gave information on day to day issues such as setting up a bank account and working within the NHS.

Ward managers on the winter pressures/escalation ward arranged meet and greet sessions for new staff including a welcome pack and tea and cake, staff on the ward told us this was very helpful and gave them the opportunity to meet other new ward members.

The trust promoted equality and diversity. Actions to address diversity and representation across the organisation was included in one of the trusts five objectives. An inclusion committee had been formed to ensure that service met the diverse cultural needs of patients and their families. Equality, inclusion and human rights training was included in the mandatory training programme.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust had a governance structure in place with clear links from the board to committees covering key areas such as quality, finance and people. The medicine division also had a governance structure with links to the overall governance meetings.

Although most policies and procedures were still specific to Derby Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust, monthly meetings were taking place to review policies and procedure, prioritising those that were due for review and those where there were clear differences between the hospitals. Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all polices were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

There was a lead for medicines mortality who undertook a review of all deaths. If learning points were identified these were taken to the medical admissions unit senior team meeting and the medicines quality and risk meeting. However, since the acquisition of Burton Hospitals NHS Foundation Trust, senior managers told us that the mortality review process was developing into a more formal programme of mortality review meetings across the trust starting with the formation of a trust mortality committee.

The medicine division reviewed its performance regularly. We reviewed the latest quarterly scorecard consisting of 62 performance indicators ranging from complaint response times, waiting times and staffing levels. Performance was discussed at the trust performance management meeting where areas of concern or for improvement could be escalated to the trust operational group.

Staff we spoke with were clear about their roles, whether this was communicating relevant information or implementing actions arising from governance meetings.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected
Comprehensive assurance systems were in place to escalate performance issues which were regularly reviewed. The board assurance framework had been redeveloped to reflect the trusts five objectives and allow the board to be aware of risks and mitigating actions for each of the objectives.

As part of the acquisition of Burton Hospital NHS Trust, risk management arrangements had been reviewed and strengthened with the production of a new policy and the establishment of a risk and compliance committee.

We reviewed the medicine division risk register. Risks related to those articulated by senior managers, all risks had mitigating actions identified.

The medicine division had a programme of audit which meant that the service was measuring the quality of care and treatment against standards and looking for areas to improve and areas of concern.

We saw evidence in the trust board meeting minutes that sepsis management and performance was discussed at board level. Sepsis was subject to NHS England commissioning for quality and innovation scheme (CQUIN), ‘Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)’. The operational plan detailed further actions to take place over the next twelve months for the trust to receive the financial benefits of the CQUIN.

The medicine division considered seasonal fluctuations in demand and planned well in advance to reduce the risk to patients or staff. Planning for the two winter pressures wards had begun at least six months prior to them being opened.

Robust policies were in place covering emergency and major incident planning and business continuity.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Information from a variety of sources was used to make holistic decisions on service developments for example, patient surveys, operational information, quality and financial information.

Staff had access to information to support them in delivering good quality patient care. Staff told us they could easily access information systems and during our inspection staff demonstrated this on the wards and departments we visited.

The medicine division had a set of clear performance measures which were reported and monitored regularly a data quality team checked information to make sure it was accurate, valid and reliable.

Systems were in place to ensure information was managed in line with data security standards and other legislation. Information governance policies included General Data Protection Regulations, The Freedom of Information Act 2000 and the Confidentiality Code of Practice. Information governance was included in the mandatory training topics for all staff.

Systems and processes were in place to ensure notifications were submitted to external bodies as required, for example serious incidents to both the Care Quality Commission and commissioners of the service.

**Engagement**

The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
People's views and experiences were gathered and acted on to shape and improve services. A staff engagement group and patient experience committee met regularly.

‘Your views matter’ leaflets were displayed in the ward and departments we visited encouraging patients and relatives to give feedback on their experience.

We saw the action plan arising from the national staff survey carried out in 2017. All areas that scored worse than the national average had actions in place to address the key factor. For example, ‘reporting errors, near misses or incidents witnessed in last month’ actions included improving reporting on the electronic reporting system, staff training and protected time for reporting.

Representatives from the medicine division attended the local emergency care boards to gain an understanding of the shared challenges of the health and social care services in the region and contribute to local improvement plans.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust research and development department produced a quarterly newsletter ‘taking part in research’ which contained brief summaries on research projects and clinical trials and other news worthy research related information.

The trust was involved in several accreditation schemes, for example, psychiatric liaison services were accredited by the psychiatric liaison accreditation network, the medical laboratories were accredited by the United Kingdom Accreditation Service and the endoscopy held Joint Advisory Group accreditation.

There were plans in place to assist with the delivery of mental health services. A range of quality improvement measures were being developed such as, improved training, recruitment of a Registered Mental Nurse to work in MAU to improve the care that patients receive who attend the hospital with mental health needs, development of a team of Healthcare Assistants who are specifically trained to work with patients who have mental health needs and require one to one nursing and improving links with local patient groups who represent those suffering from mental health issues.

There was no formal process in place for ward staff to have time out to resolve problems or review team objectives. One ward manager said she had arranged a time out for her team but that it was difficult as some staff still had to work as the ward still needed staffing.

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

We saw several examples of the trust sharing results of improvement work. For example, best practice learning from audit was shared at the East Midlands Clinical Audit Support Network which met 3 – 5 times per year.

The clinical trials support unit hosted a networking event for academic colleagues across the East Midlands to share innovations, ideas and clinical problems.
Maternity

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on 1 July 2018 by the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust. The latter trust acquired the former under its existing registration with the CQC. As such, our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust has 120 inpatient maternity beds across three sites. Of these, 82 beds are located within five wards and units at Royal Derby Hospital:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Inpatient beds/rooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal outpatients</td>
<td>N/A</td>
</tr>
<tr>
<td>Midwifery led unit</td>
<td>4</td>
</tr>
<tr>
<td>Fetal &amp; maternal medical centre</td>
<td>N/A</td>
</tr>
<tr>
<td>Labour ward</td>
<td>22</td>
</tr>
<tr>
<td>Pregnancy assessment unit</td>
<td>9</td>
</tr>
<tr>
<td>Ward 314</td>
<td>47</td>
</tr>
</tbody>
</table>

The 22 beds/rooms on the labour ward at Royal Derby Hospital consist of:

- 12 birthing rooms, including one with a birthing pool
- Four high dependency beds
- A four-bedded induction of labour suite
- A two-bedded assessment bay
- A one-bedded bereavement suite

There are also two obstetric theatres.

The Derby Birthing Centre is a midwife-led unit located at Royal Derby Hospital with four labour rooms, including one with a birthing pool.

The trust runs seven community midwifery teams, which provide community midwifery care and a home birth service.

The trust is part of both the Derbyshire Local Maternity System and the Pan-Staffordshire Local Maternity System.

(Source: Trust Provider Information Request – Acute sites; Acute RPIR – context acute tab; trust website)
As the data on deliveries and gestation periods below cover time periods from prior to the acquisition, separate data are shown for each trust.

**Derby Teaching Hospitals NHS Foundation Trust**

From July 2017 to June 2018 there were 5,445 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

**Number of babies delivered at Derby Teaching Hospitals NHS Foundation Trust – comparison with other trusts in England**

![Graph showing number of deliveries](image)

A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

### Profile of all deliveries (April 2017 to March 2018)

<table>
<thead>
<tr>
<th></th>
<th>DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,261</td>
<td>98.6%</td>
</tr>
<tr>
<td>Multiple</td>
<td>73</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>208</td>
<td>3.9%</td>
</tr>
<tr>
<td>20-34</td>
<td>4,150</td>
<td>77.8%</td>
</tr>
<tr>
<td>35-39</td>
<td>783</td>
<td>14.7%</td>
</tr>
<tr>
<td>40+</td>
<td>193</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,334</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

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### Gestation periods (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pre-term 24-36(^{+6}) weeks</td>
<td>451</td>
<td>8.5%</td>
</tr>
<tr>
<td>Term 37-40 weeks</td>
<td>4,862</td>
<td>91.4%</td>
</tr>
<tr>
<td>Post Term 40-42 weeks</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

#### Total number of deliveries with a valid gestation period recorded

| Total | 5,320 | 498,704 |

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

To protect patient confidentiality, figures between one and five have been suppressed and replaced with “*” (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust per quarter, for the last two years, can be seen in the graph below.

**Number of deliveries at Derby Teaching Hospitals NHS Foundation Trust by quarter**

There were more deliveries at the trust in quarter 1 of 2018/19 (1,412) compared to quarter 1 of 2017/18 (1,304). However, in all four quarters of 2017/18, the number of deliveries in each quarter was less than in the equivalent quarter one year earlier.

(Source: Hospital Episode Statistics - HES Deliveries (April 2016 - June 2018)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

All staff working within maternity were required to complete the trust’s mandatory training modules on an annual basis. Multi-disciplinary emergency ‘skills and drills’ simulation training was compulsory by all midwives and obstetric staff including consultants.

Midwives were required to complete an additional study day which covered relevant and current topics, for example sepsis and safeguarding. Mandatory training was delivered face to face and through e-learning modules which staff took responsibility for undertaking, however managers had oversight of training records and prompted staff when they were due.

The practice development team told us the trust had reviewed their training programme and, in agreement with East Midlands Clinical Network, a decision was made to follow the International Federation of Gynaecology and Obstetrics (FIGO) classification system for the interpretation of cardiotography tracing (CTG) rather than the National Institute for Health and Care Excellence (NICE) classification, they said it focused more on the physiology of the baby. However, since moving to FIGO in October 2018, they had not had a competency framework in place. This was under development at the time of the inspection. Practical Obstetric Multi-Professional Training (PROMPT) for trainers was underway during our visit to the trust and was expected to be delivered to staff by March 2019.

All staff were given the opportunity to attend a CTG masterclass to meet learning needs and CTG champions were available on all shifts during the transition to FIGO to support staff and mediate with any issues. The service said the transition had helped to improve safety regarding fetal heart monitoring, however we did not see any evidence of this.

Face to face training days available to staff were mandatory training days, which included substance misuse, bereavement care, breast feeding and manual handling and Saving Babies Lives training days, which included growth surveillance, fetal monitoring and neonatal resuscitation. We were told all training included real life case studies to enable shared learning. CTG training was included in the Saving Babies Lives training day and covered during PROMPT training.

Royal Derby Hospital

Staff at Royal Derby Hospital, and the Derby community midwifery service, had mandatory training targets of either 90% or 95% for completion of most mandatory training modules. The exceptions were:

- Local induction and medicines management, where the target was 85%.
• The various resuscitation training modules, where the target was 75%.

These targets were inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided these services.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for midwives and qualified nursing staff in maternity at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control level 1</td>
<td>181</td>
<td>181</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - hospital life support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory</td>
<td>169</td>
<td>170</td>
<td>99.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>175</td>
<td>177</td>
<td>98.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>177</td>
<td>181</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 3</td>
<td>176</td>
<td>180</td>
<td>97.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>32</td>
<td>33</td>
<td>97.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>175</td>
<td>181</td>
<td>96.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety &amp; risk awareness</td>
<td>173</td>
<td>181</td>
<td>95.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local induction</td>
<td>31</td>
<td>33</td>
<td>93.9%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, inclusion &amp; human rights</td>
<td>166</td>
<td>181</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dignity at work - harassment &amp; bullying</td>
<td>166</td>
<td>181</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - automatic external defibrillation</td>
<td>161</td>
<td>179</td>
<td>89.9%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling</td>
<td>162</td>
<td>181</td>
<td>89.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>160</td>
<td>181</td>
<td>88.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 94.8% for midwives and qualified nursing staff in maternity at Royal Derby Hospital. The trust’s mandatory training targets were met for 12 of the 16 mandatory training modules for which midwives and qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in maternity at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control level 1</td>
<td>49</td>
<td>49</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Consent</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, inclusion &amp; human rights</td>
<td>46</td>
<td>49</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust had an overall training compliance rate of 81.1% for medical staff at Royal Derby Hospital maternity department. The trust’s mandatory training targets were met for four of the 19 mandatory training modules for which medical staff were eligible.

We discussed training compliance by medical staff during the inspection and were told there were two doctors on long term sick leave, which had impacted on the training figures. The practice development team told us medical staff were sometimes difficult to engage with when arranging training attendance, however they felt the engagement was improving.

**Derby Community midwifery service**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for midwives and qualified nursing staff in the Derby community midwifery service is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control level 1</td>
<td>74</td>
<td>74</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory</td>
<td>74</td>
<td>74</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>73</td>
<td>74</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, safety &amp; risk awareness</td>
<td>73</td>
<td>74</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 3</td>
<td>72</td>
<td>74</td>
<td>97.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - automatic external defibrillation</td>
<td>69</td>
<td>74</td>
<td>93.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The service had an overall training compliance rate of 92.8% for midwives and qualified nursing staff. The trust's mandatory training targets were met for seven of the 14 mandatory training modules for which midwives and qualified nursing staff were eligible.

**Safeguarding**

**Staff understood how to protect women and babies from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

The trust safeguarding team was located at the Royal Derby Hospital and consisted of a nurse as safeguarding lead for both Burton and Derby sites, a social worker as a specialist safeguarding professional for maternity who worked across both sites and a manager for safeguarding services in maternity. There was a full time, band 7 named midwife for safeguarding who was supported by one full time band 6 safeguarding liaison midwife. The safeguarding midwives supported staff across both sites, provided advice for community teams and worked closely with other specialist midwives to help safeguard women in vulnerable circumstances, such as substance misuse and mental health. The safeguarding team sat corporately therefore the team was managed centrally rather than by the maternity manager. Their links with the service were strong and liaison, teaching and supervision was well established in practice.

Safeguarding midwives acted as a resource rather than holding their own caseload and community midwives generally led the care of women subject to safeguarding procedures. Community midwives referred women to their local social services where appropriate and a copy of the referral was sent to the trust safeguarding team. Alerts were created by community midwives and were accessed by all midwives trust wide.

Safeguarding midwives had good working relationships with local social services to ensure timeframes and care packages for women and babies were maintained and staff said they achieved good continuity of care. This meant the team could raise issues and escalate cases to leave fewer families without appropriate input from all agencies. Midwives who specialised in mental health, substance misuse and domestic violence met twice weekly on the wards to plan care for vulnerable women and had oversight of any safeguarding issues, they also liaised with the wards daily. At the time of the inspection we were told by the safeguarding team there were 470 pregnant women with safeguarding alerts.

Policies, procedures, protocols and frameworks relating to safeguarding were in line with national guidance and staff told us they were easily accessible.

Clinical staff working with children, young people and/or their parents received training at level 3, in line with national guidance. This training included an awareness of Child Sexual Exploitation (CSE), modern day slavery and female genital mutilation (FGM) and outlined responsibilities for...
reporting and referring any identified cases. The trust had FGM guidelines to support staff. All staff we spoke with were aware of the policy and knew how to refer and report.

The trust did not specifically record cases of child sexual exploitation (CSE), however all cases of CSE were referred through the multi-agency safeguarding procedures.

Staff told us two safeguarding midwives undertook all community supervision, which were quarterly with every midwife and spent between 20-30 minutes with each although they had opportunity for ad hoc discussions at any time. Group supervision was also provided in hospital during monthly sessions, location of the sessions rotated across all sites to give better access for all midwives.

The trust had a baby abduction policy; however it was for Burton site only as the trust policies and guidelines were in the process of being reviewed and aligned trust wide. Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all polices were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

Safeguarding midwives led safeguarding training, all midwives were trained in level 3 safeguarding which took place once a year for one day, face to face. They also completed two online courses in domestic violence and Prevent. The Counter Terrorism and Security Act 2015 introduced the Prevent duty for various bodies. The Prevent duty's aim is to help stop vulnerable people from being exploited and drawn into terrorism.

**Safeguarding training completion rates**

**Royal Derby Hospital maternity department**

Staff at Royal Derby Hospital, and the Derby community midwifery service, had a training target of 85% for completion of all safeguarding training modules. This target was inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided these services.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for midwives and qualified nursing staff in maternity at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>180</td>
<td>181</td>
<td>99.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>180</td>
<td>181</td>
<td>99.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>165</td>
<td>168</td>
<td>98.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>162</td>
<td>168</td>
<td>96.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 98.4% for midwives and qualified nursing staff in maternity at Royal Derby Hospital. The trust’s mandatory training targets were met for all four safeguarding training modules for which midwives and qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October
2018 for medical staff in maternity at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>45</td>
<td>49</td>
<td>91.8%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>42</td>
<td>49</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>18</td>
<td>29</td>
<td>62.1%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 83.3% for medical staff in maternity at Royal Derby Hospital. The trust’s mandatory training targets were met for three of the four safeguarding training modules for which medical staff were eligible.

**Derby Community midwifery service**

Staff in the Derby Community midwifery service (the midwifery service previously provided by Derby Teaching Hospitals NHS Foundation Trust) had a training completion target of 85% for all safeguarding training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for midwives and qualified nursing staff in the Derby community midwifery service is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 1</td>
<td>74</td>
<td>74</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 2</td>
<td>74</td>
<td>74</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Training (WRAP)</td>
<td>73</td>
<td>74</td>
<td>98.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 3</td>
<td>70</td>
<td>74</td>
<td>94.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The service had an overall safeguarding training compliance rate of 98.3% for midwives and qualified nursing staff. The trust’s mandatory training targets were met for all four safeguarding training modules for which midwives and qualified nursing staff were eligible.

**Cleanliness, infection control and hygiene**

The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.

The systems in place to prevent and protect women and babies from the risk of a healthcare-associated infection were not always robust.

Staff had access to a range of infection prevention and control policies, procedures and guidelines, which were available on the trust’s intranet site. We saw staff adhered to policies in relation to hand hygiene and some infection control. For example, we saw staff observed the ‘bare below the elbow’ rule and used hand sanitising gel or washed hands thoroughly as required. (Bare below the elbow means workwear must not impede effective hand hygiene and should not come into contact with patient care activity).
There was a sufficient supply of hand sanitising gels and sinks throughout the clinical area with
handwashing prompts for staff, women and visitors. We saw fridges on all wards were visibly
clean.

We observed some clinical areas were not visibly clean. For example, dust was seen on suction
apparatus and blood on trollies in two out of six labour rooms, which had been recently cleaned
and identified as ready for use. We saw a hanging rope in a birthing room in the Birthing Centre
which contained bodily fluids, including blood. This was immediately escalated, and it was
removed straight away. Staff said it should have been cleaned after each use, however it was also
dusty, which indicated it had not been used for some time.

Most areas had cloth curtains and we saw some of the curtains did not have any dates written on
them to remind staff when they needed to be replaced. However, we were told and saw cleaning
schedules which showed they were cleaned regularly. When curtains were seen to be soiled, staff
tied them in a knot to signify to the cleaning staff they required laundering. Cleaning staff removed
and replaced any soiled curtains and performed a curtain check every week to remove any soiled
curtains which may have been missed. All curtains were removed for laundering and replaced
every six months in any event. Infection prevention and control audits were carried out on ward
areas by a manager from another ward who then fed back to the ward and any issues were acted
upon.

The housekeepers on the wards had access to a steam cleaning machine, which they used after
assessing which areas required it and how often. Housekeepers were responsible for cleaning of
equipment in support of the care assistants on Labour Ward.

Following the inspection, the trust provided data showing audit outcomes relating to infection
prevention and control for the last 12 months. This included audits of aseptic non-touch technique
(ANTT), cross infection, hand hygiene and isolation rooms, which were all within the trust’s
targets. There were some exceptions for each ward such as antenatal services, Labour Ward and
Ward 314, who all had at least one month of low scores for peripheral cannulas, and both
antenatal services and Ward 314 had at least one month of low scores for infection control mini
audits. On balance, the data showed good compliance in relation to infection prevention and
control which was contrary to the cleanliness issues we found on the Labour Ward and did not
assure us the audit process was robust.

Staff had access to and used suitable personal protection clothing such as gloves, aprons and
face guards to protect women and babies from a healthcare associated infection.

The trust did not provide records of surgical site infection rates or rates of puerperal sepsis for
maternity and we saw this information was not recorded on the maternity dashboard for this
hospital.

**Environment and equipment**

The service had suitable premises and equipment, however equipment checking was
inconsistent.

The maternity unit at Royal Derby Hospital had its own entrance for women to arrive and go
straight to Labour Ward or to the antenatal or postnatal areas. The unit was modern and complied
with the Department of Health’s recommendation that birthing rooms should include en-suite
facilities (DH Children, young people and maternity services. Health Building Note 09-02:
Maternity care facilities, 2013.) The antenatal clinic, Labour Ward, a midwifery led unit and birth
centre (Derby Birth Centre), obstetric theatres and neonatal unit were all located on the ground
floor. The maternity wards were situated on a separate floor; however, they were in close proximity and within the maternity and gynaecology unit.

Derby Birth Centre was accessible through the Labour Ward and consisted of four birthing rooms. We saw the environment had been updated to promote a more ‘home from home’ feel with wall art, ambient lighting and birthing rooms were less clinical with equipment stored away in cupboards rather than on trollies. Emergency equipment was shared with the Labour Ward.

The Labour Ward consisted of 12 delivery rooms, one bereavement room, four beds for induction of labour, two assessment rooms and four beds for women requiring enhanced care.

The Pregnancy Assessment Unit (PAU) had five midwives, including three midwife sonographers in post. It consisted of five beds in one bay, one bed and chair in another bay and three single rooms, one of which was allocated to community midwives. Referrals were received from the community team and all women were advised to call with any concerns from 20 weeks gestation, prior to that they were advised to contact gynaecology services. Women were typically seen within 24 to 36 hours of receiving a referral, which was well within the standard of 72 hours.

Emergency and essential equipment was easily accessible and checked daily in accordance with the trust’s policy. However, some checks had not been completed appropriately as we found some expired items on trollies despite checklists being signed to say all equipment was present and in date.

Ward 314 (Postnatal and antenatal) had 47 beds. Staff told us the ward used to have more beds, however they were removed to relieve winter pressures. They used to have a flat for bereaved ladies to stay in but they had lost that too, which they said was a shame. Staff told us the loss of beds on the ward had impacted on them as they were often full and due to the complex nature of many of the women in the area, discharges were sometimes delayed.

Staff told us and we saw equipment and supplies required for the early treatment of sepsis were readily available in the clinical areas. Sepsis is a life-threatening illness caused by the body’s response to illness.

We saw there were daily task signature sheets in most areas to ensure essential tasks were completed regularly, for example fridge temperature and equipment stock checks. Staff checks of fridges were consistent and recorded the minimum and maximum temperatures, staff documented they took action when temperatures were outside of the expected range.

Cardiotocography (CTG) machines were available for women who required continuous electronic fetal heart monitoring. A CTG machine is used to record both the baby’s heart rate and uterine contractions during pregnancy and labour. Its purpose is to monitor the baby’s wellbeing and allow early detection of distress. Staff were also able to directly monitor the baby’s heart rate in labour using a fetal scalp electrode (FSE). This is a device which is attached to the top of the baby’s head and provides a more accurate picture of the baby’s heart rate.

An intercom and security camera system was used to gain entry to the Labour Ward, obstetric theatres and maternity wards to identify visitors and staff so women and their babies were protected from avoidable harm and the exits were also controlled.

There was one birthing pool in The Birthing Centre and one on the Labour Ward. The pools were well maintained. We saw there were nets to evacuate a woman from the pool in an emergency.

We examined 20 pieces of equipment. All of the equipment had a recent service testing or medical engineering date. This meant equipment was maintained in line with relevant safety standards and staff could be assured it was safe to use.
We made random checks on sterile single use equipment such as syringes, blood bottles and needles and found most had intact packaging, however we found nine blood bottles and 12 intravenous saline on the Labour Ward and the Birthing Centre out of date. We found oxygen masks and suction equipment exposed ready for use. We escalated this, however service leads said they had discussed with their resuscitation team and infection control and the trust did not feel it was necessary to cover the masks until use.

Intravenous fluids were kept on trollies which were not secure and were not in tamper evident packaging, which was escalated to senior managers on inspection. The intravenous fluids and the out of date items were removed immediately by staff. Following our inspection, the trust informed us intravenous fluids were now stored in locked cupboards in each of the labour rooms.

Suitable arrangements were mostly in place for the management of clinical specimens and waste disposal. Clinical waste bins were emptied regularly and contaminated sharps were segregated according to their nature. However, we saw sharps bins and anatomical waste bins were stored on the floor in the sluice of the Labour Ward. Portable oxygen cylinders were stored on the floor and unsecured in the same area. Oxygen cylinders should be stored in a stand or cart to prevent tipping and falling.

The antenatal clinic, pregnancy assessment unit and fetal medicine unit had shared emergency equipment for adults and babies.

We saw computers on wheels in corridors which appeared unlocked, however we were shown they were unlocked to enable timely access to guidelines and general information and a smartcard was required to access any confidential information.

There were two theatres for use in maternity. Lists for elective caesarean sections were performed Monday to Friday in the gynaecology theatre and emergency procedures were performed in the obstetric theatre. The theatre teams worked well together to ensure all procedures were carried out in a timely way. The staffing consisted of two midwives, a nurse, a support worker an anaesthetist and a surgeon. Staff told us the theatre provision was improved to limit delays for elective caesarean sections and since the elective list moved to the gynaecology theatre, the service worked far better. We were not aware of any concerns in relation to theatre provision or access to theatres during our inspection. If a second theatre was required to be used in maternity, an obstetrics team would be used, since there was a resident consultant they would usually know in advance to put staffing in place.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman. They kept clear records and asked for support when necessary.

During the initial booking appointment, community midwives took a comprehensive medical, obstetric and family history from women. The booking record was kept in the hand-held records and an electronic copy was created. Copies of any ultrasound scan reports and results of any blood tests were kept as part of the hand-held record. As part of the initial booking, midwives made assessments of women’s social situation, tobacco, drug and alcohol use and carried out a mental health assessment.

Assessments of venous thromboembolism and of immunisation history were also recorded. Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most
common in a leg vein, where it is known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE).

These assessments, together with the medical and obstetric history, were used to classify women as ‘low’ or ‘high’ risk. Low risk women continued with midwifery-led care, whilst high risk women were referred to consultant-led care. The trust were flexible with the use of the Birthing Centre, although we did not see evidence of booking women there with high risk factors, we did observe staff assessing a woman who was considered high risk being transferred from the Labour Ward to the Birthing Centre as her risk factors had minimised. Staff said they had the same approach for women who would choose to have a home birth. They were reassessed regularly to ensure they were in the most appropriate environment.

At each antenatal contact women’s individual risks were reviewed and reassessed. Only women risk assessed as low risk could usually plan to give birth at The Birthing Centre or within their own home.

The service provided antenatal services, women could be referred by community midwives, GPs, A&E or women could self-refer. All women who might be in labour, had pain or were bleeding or felt reduced fetal movements were initially referred to the service, including women who required additional monitoring of their baby or review of women with other conditions such as raised blood pressure.

Women who were not booked were able to present at Labour Ward and would be assessed on arrival or over the telephone before attending. Most women had their handheld notes with them to inform the staff regarding clinical and social needs.

Induction of labour (IOL) was offered at Royal Derby Hospital utilising four beds on the Labour Ward. The service also offered outpatient inductions to women assessed as low risk. This allowed women to return home during the early stages of the induction process, reducing the amount of time women spent in hospital. We asked the trust to provide data in relation to the number of delayed IOLs, however the trust was unable to provide this as they did not record it. We were told delaying IOL was part of the escalation pathway. A clinician prioritised which inductions were safe to delay. Women were offered additional monitoring until their induction took place to mitigate the safety risk.

Staff used both electronic and paper-based methods for recording the handover of women’s care. They used the Situation, Background, Assessment and Recommendation (SBAR) forms for handover when women were moved from any of the wards, Labour Ward and after a shift change. SBAR is a technique which can be used to facilitate and prompt appropriate communication especially amongst healthcare professionals. SBAR stickers were used in the paper records or recorded in the electronic version, and in both versions, both staff members were required to sign or acknowledge the handover.

Obstetric theatres used a modified version of the World Health Organisation (WHO) ‘Five Steps to Safer Surgery’ safety checklist prior to and during each procedure. This is a process recommended by the National Patient Safety Agency (NPSA) for every woman undergoing a surgical procedure. The process involves several safety checks before, during and after surgery to avoid errors. For each woman’s procedure, we were told the checklists were followed and completed in full. We saw the initial stages of the WHO safety checklist were completed correctly and were recorded on an electronic record. In the event of an emergency procedure, staff told us sufficient checks would be carried out to proceed without compromising the safety of the woman or baby by delaying the start of the procedure.
Audit data was provided by the trust following the inspection in relation to WHO checklist compliance in theatres at Royal Derby Hospital during 2018. The audit showed overall compliance was good. Staff said data input was time consuming, therefore the trust were considering purchasing tablets which would relieve some pressure. An issue that we found documented in the audit and in our review of labour ward forum minutes was communication in theatre. Staff were not always engaged and listening and the theatre was very noisy, however this had been disseminated to staff and leaders said they had seen an improvement.

There were blood gas analysers on the Labour Suite, in line with national recommendations. This meant staff could quickly analyse blood products from both women and babies to assist with planning care.

We reviewed five cardiotocograph (CTG) traces at Royal Derby Hospital. We saw documentation standards were consistent and in line with the trust’s fetal monitoring guideline. We saw events were documented on the paper traces, signed and dated and staff documented the baby’s heart rate had been heard with a pinard stethoscope or sonic aid prior to starting the CTG, which is best practice. Staff carried out hourly ‘fresh eyes’ on the CTG traces. ‘Fresh eyes’ is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed. The process is recommended by NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth.

Midwifery staff used a paper based early warning assessment tool known as the modified obstetric early warning score (MEWS) to assess the health and wellbeing of all inpatients. This paper-based assessment tool enabled staff to identify and respond to a woman whose health was deteriorating and summon additional medical support if required. We reviewed five MEWS records which were completed appropriately.

Baby’s observations were documented on a new-born early warning score track and trigger chart (NEWS). Pulse oximetry was performed on all new-born babies (to measure the oxygen levels) which helped identify babies whose heart and lungs were less healthy.

Midwives on the postnatal wards and in the community had completed training in performing the new-born and infant physical examination (NIPE) checks. There were 24 midwives trained at the time of the inspection and five undertaking the training. The checks were within the role of the midwives, particularly in the Birthing Centre, although many were undertaken by paediatric doctors on the wards. Community midwives held clinics for NIPE checks for any home births and outpatient appointments were available Monday to Friday for women who chose to go home before six hours after delivery, however all were seen within 72 hours. We saw from the antenatal and new born KPIs there were two NIPEs that were not completed within 72 hours, however both were beyond the service’s control and both had NIPE done before neonatal discharge.

Women booked for elective caesarean section were seen in antenatal clinic for a pre-operative assessment, where blood tests and screening were performed. On the day of their caesarean section they were welcomed on Ward 314 and the anaesthetist visited them on the ward before walking down to theatre.

Following an incident or difficult experience the shift coordinator or manager spoke with all staff affected to assess whether they could complete the rest of their shift. They held multidisciplinary debriefs where appropriate and following a traumatic event an emergency department consultant led a debrief facilitated by emergency department staff showing how they cope with similar events. Staff spoke enthusiastically about this and explained how beneficial they found it and said they felt very supported following an incident.
Midwifery staffing

The service had midwifery staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment, however staffing levels did not always meet the planned levels in some areas.

Staffing levels were planned and reviewed to calculate midwifery staffing levels, however some staff we spoke with including midwives and medical staff told us the midwifery staffing levels were low, particularly on Ward 314 (postnatal ward). We did not find any evidence of impact on care as service leads told us they managed it using the trust’s escalation policy.

In 2016, the maternity department used the National BirthRate Plus acuity tool, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a woman). The Birthrate plus tool was used locally in February 2018 and identified that the overall difference between BR+ whole time equivalent staffing calculations and local midwifery establishment was a deficit of 15.67 whole time equivalent midwives & appropriately trained support staff at Royal Derby Hospital. At the time of the inspection we saw the trust was actively recruiting midwives, they had recently employed 11 preceptorship midwives and staffing was on the risk register. The service prioritised workload to ensure acuity levels were appropriately addressed, staff were rotated to meet demand as required and a local bank system was in place to address unplanned activity needs. The pregnancy assessment unit managed antenatal outpatients which reduced inpatient antenatal admissions.

Staffing levels were displayed in all areas, we saw and were told during the inspection expected staffing levels were not in line with actual staffing numbers on some wards. Staff worked a mixture of shifts including earlys, lates, long days and nights and the planned number of qualified staff for the Labour Ward for each shift was 12 midwives both during the day and at night. During the inspection, staff appeared to be able to fulfil their roles.

Staff told us there was always two experienced band 7 midwives on every shift, one acted as the Labour Ward coordinator who was usually supernumerary and the other provided cover for breaks and supported staff.

The Birthing Centre core staff were midwives with three on each shift. Due to the decreasing workload, staff helped in other clinical areas as required and demand allowed. Ward 314 (postnatal and antenatal) had additional staffing pressures as social services made the decisions whether a mother and baby required one to one care postnatally and the ward had to provide the service. Social services could not provide the necessary cover, therefore staff had to incorporate this into their workload. The ward had seven midwives during the day and four during the night for 47 women and potentially 35-40 babies, of which the majority were complex cases, and often did not meet the planned staffing level, therefore the ward manager often worked clinically to support staff. Staff said they were unaware of any recent staffing review in light of decreased use of the Birthing Centre and increased workload for staff working on Ward 314. Staff told us they felt under immense pressure.

Staffing escalation measures included cancelling some mandatory training, pulling midwives from the ward and specialist midwives or other staff rostered for non-clinical duties.
All ward managers worked an on-call rota for one week per month to ensure there was always cover night and day. Coordinators on Ward 314 were supernumerary during the day shifts; however they were clinical for night shifts and had their own case load.

The Derby Community Midwife Team consisted of five sub teams providing 24-hour cover for home births. Their day shifts were 8.30am to 4.30pm and from 4.30pm to 8.30am midwives were on call for home births. Across the five teams were three senior midwives at band 7 who managed teams according to their size and did not have their own caseload. There were band 6 team leads in each team who did have their own caseload.

Each team had support workers who assisted with antenatal visits, infant feeding support, parent education and postnatal visit. The support workers undertook their training with support workers from the hospital and attended annual updates. Community midwives said their caseloads were typically 80-120 women at any one time which was amended accordingly for part time staff. They told us the establishment was correct, however due to vacancy, maternity leave and sickness they felt under pressure to give enough time to women considering their complex clinical and social needs.

**Planned vs actual**

In March and October 2018, the trust reported their staffing numbers for midwives and qualified nursing staff working in maternity as below.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>October 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
<td>Actual staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>162.1</td>
<td>174.5</td>
<td>92.9%</td>
<td>157.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 7.0% for midwives and qualified nursing staff working in maternity. The trust had a target vacancy rate of 6%.

The breakdown by site was as follows:

- Royal Derby Hospital: 7.4%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 9.3% for midwives and qualified nursing staff working in maternity. This was within the trust’s target rate of between 8% and 12%.

The breakdown by site was as follows:

- Royal Derby Hospital: 9.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 4.8% for midwives and qualified nursing staff working in maternity. This was higher than the trust’s target rate of 3.8%.

The breakdown by site was as follows:

- Royal Derby Hospital: 3.9%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank staff usage

The trust provided bank staff usage data for qualified midwifery and nursing and unqualified midwifery and nursing, in maternity.

From November 2017 to October 2018, the trust reported that 4.1% of qualified midwifery and nursing hours in maternity were filled by bank staff. In addition, 2.1% of qualified midwife hours were not filled by bank staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>%</th>
<th>Unfilled Hours</th>
<th>%</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>10,997</td>
<td>10.7%</td>
<td>8,845</td>
<td>8.6%</td>
<td>103,029</td>
</tr>
</tbody>
</table>

Over the same period, the trust reported that 5.5% of unqualified nursing and midwifery staff hours across the trust were filled by bank staff. In addition, 1.0% of hours for this staff group were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>%</th>
<th>Unfilled Hours</th>
<th>%</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>10,368</td>
<td>8.1%</td>
<td>2,002</td>
<td>1.6%</td>
<td>128,346</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Midwife to birth ratio

From July 2017 to June 2018 Derby Teaching Hospitals NHS Foundation Trust had a ratio of one midwife to every 15.8 births. This was higher than the England average of one midwife to every 25.5 births.

(Source: Electronic Staff Records – ESR Data Warehouse; Routine Provider Information Request (RPIR) P77 – Queen’s Hospital Burton maternity dashboard)

Medical staffing

The service had medical staff with the right qualifications and skills, however the service did not always make sure all medical staff completed their mandatory training.
Access to medical support was available seven days a week. Consultants were resident on the labour suite from 9.00am to 10pm Monday to Friday and from 9.00am to 1.00pm at weekends and bank holidays. This was in line with the safer childbirth/Royal College of Obstetricians and Gynaecologists (RCOG) recommendations for the minimum number of hours of consultant presence on the Labour Suite per week. Outside of these hours the consultant obstetricians and anaesthetists worked a non-resident on-call system.

Between April 2018 and December 2018, there was an average of 79.5 hours of consultant presence hours per week. An anaesthetist was always available immediately when required for the maternity unit and was free from other duties.

We were told and saw handovers were multi-disciplinary and the on-call consultant obstetricians and anaesthetists usually attended, together with more junior doctors and a midwife co-ordinator. Doctors we spoke with were happy in their roles, they felt valued and supported and held good communication with the rest of the team. They often offered to help the maternity wards when evenings on the neonatal unit were not as busy by advising over the telephone or babies were taken to NNU to be seen.

**Planned vs actual**

In March and October 2018, the trust reported their medical staffing numbers for maternity as below.

All these medical staff were allocated to Royal Derby Hospital in the trust’s staffing data.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>October 2018</th>
<th></th>
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<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>25.2</td>
<td>27.0</td>
<td>93.4%</td>
<td>27.9</td>
<td>27.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 4.6% for medical staff in maternity. The trust had a target vacancy rate of 6%.

As explained above, all these staff were allocated to Royal Derby Hospital in the trust’s staffing data.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 19.0% for medical staff in maternity. This was higher than the trust’s target rate of between 8% and 12%.

As explained above, all these staff were allocated to Royal Derby Hospital in the trust’s staffing data.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

**Sickness rates**
From November 2017 to October 2018, the trust reported a sickness rate of 4.8% for medical staff in maternity. This was higher than the trust’s target rate of 3.8%.

As explained above, all these staff were allocated to Royal Derby Hospital in the trust’s staffing data.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From November 2017 to October 2018, the trust reported that no medical staff hours in maternity across the trust were filled by bank staff. Over the same period 0.2% of medical staff hours (109.5 hours) were filled by locum staff. In addition, five medical staff hours (less than 0.01% of total medical staff hours in maternity) were not filled by bank or agency staff to cover staff absence.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

In September 2018, the proportion of consultants reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the 77.4 whole time equivalent staff working in maternity at University Hospitals of Derby and Burton NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date and available to all staff providing care.

The trust used a combination of paper and electronic records for women who used the maternity service. Most of the care was recorded on paper records and included WHO checklists, consent
and handover maternity sheets. Women were given their own set of hand held antenatal care
records (known as the part one) at the initial booking appointment to bring into the hospital with
them. For postnatal care women were given a different set of records known as the part two. Staff
recorded every contact within these records. The hospital also held medical records relating to
each woman. Women's booking and delivery details were recorded electronically.

We reviewed seven sets of hand held records in detail and saw they were generally in line with the
trust’s maternity record keeping standard (November 2018). Women’s individual care records
were written and managed in a way which kept them protected from avoidable harm. Information
needed to deliver safe care and treatment was available to relevant staff in a timely and accessible
way. Staff stored medical records securely in restricted areas or in lockable trolleys in line with
data protection policies.

A summary of care was included in the postnatal notes for the community midwife following
discharge from hospital. A discharge summary was included in the notes to be sent to the GP and
health visitor prior to discharge from the community midwife.

Medicines

The service followed best practice when prescribing, giving, recording and storing
medicines and women received the right medication at the right dose and at the right time.

We checked drug cupboards and trolleys on all wards and areas and found them to be locked and
secure which minimised the risk of theft or tampering. We found drug cupboards which contained
non-emergency medicines were locked when staff were not present.

We saw there was consistent checking of the temperature of fridges used to store medicines. We
saw the daily check list was always signed and staff always recorded the minimum and maximum
temperatures and any action taken when the temperature was outside of the normal range. This
meant staff were assured medicines were being stored at the correct temperature. Most
intravenous fluids were stored in locked areas which minimised the risk of them being tampered
with, however we found some intravenous fluids kept on unsecured trollies. We saw emergency
drugs and fluids were stored with other emergency equipment which was not locked away, but
was stored in tamper evident containers or wrapping, in line with guidance from the Resuscitation
Council UK.

Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001),
were stored appropriately in locked cupboards and the keys held separately from the main keys.
We checked the physical stock of the CDs against the stock level recorded in the register and saw
evidence of daily checking by two members of staff in each clinical area.

The hospital used paper prescription and medication administration record charts for women. We
looked at six prescription charts. Staff recorded women’s allergies on the prescription chart. The
records showed women were getting medicines when they needed them, and any reasons for not
giving women their medicines were recorded. This meant women were receiving their medicines
as prescribed. Midwives were giving agreed patient group directives (PGD) which were located on
the electronic system and identified by clinical area. Therefore, only medicines authorised for each
specific clinical area would be seen on the system. All midwives had access to the system and
once they had been given, they recorded it on drug prescription charts in the specified area.
Community midwives had access to a variety of PGDs.

Incidents
Staff recognised incidents and they were graded appropriately; however they didn't always report all incidents. Managers shared lessons learned with the whole team and the wider service.

Staff reported incidents through the trust’s electronic incident reporting system. Whilst some staff understood their responsibilities to raise concerns and record safety incidents and near misses and to report them where appropriate, we saw not all incidents were reported as staff said they did not always have time to do it. Therefore, we were not assured service leads had full oversight of all the incidents and risks of their service.

We saw root cause analysis investigations had taken place in relation to serious incidents. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We reviewed the serious investigation reports for three maternity incidents across the service and saw there had been a full investigation with input from the multi-disciplinary. Learning from the incident had been recorded along with agreed actions, for example reviewing guidelines or changes to practice and escalating concerns to senior medical staff.

Staff told us learning from incidents was shared through email and newsletters and could ask for one to one feedback. We saw information displayed in staff areas which gave staff information about incidents and the lessons learned. There was a message board which was read out at handovers which contained information on clinical changes following incidents and reviews. There were multiple topics, however staff did not know how often it was updated.

We saw an example of where changes had been made in practice, such as documentation regime amendments due to an increasing trend in fetal bradycardia (Fetal bradycardia is fetal heart rate (FHR) below 100 beats per minute for more than five minutes).

Staff we spoke with understood their responsibilities about the Duty of Candour (DOC) regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. DOC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw DOC had been carried out in our review of the three RCAs.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From January to December 2018, the trust reported one incident which was classified as a never event for maternity.

This was a retained foreign object post-procedure and occurred in October 2018.

The never event reported related to a gynaecological procedure, we did not inspect gynaecology on this occasion.
Breakdown of serious incidents reported to STEIS

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Maternity/obstetric incident: baby only (this include foetus, neonate and infant): four.
- Confidential information leak/information governance breach: one
- Maternity/obstetric incident: mother and baby (this include foetus, neonate and infant): three
- Surgical/invasive procedure incident: one
- Maternity/obstetric incident: mother only: one

We reviewed the circumstances relating to the unfortunate deaths of the three women. None were attributed to care received by the hospital.

Six of these SI’s were reported to STEIS within 14 days of occurrence. The other four took between 15 and 30 days to report.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, women and visitors. Managers used this to improve the service.

Maternity services took part in both the classic and the maternity national safety thermometer scheme. The Classic Safety Thermometer is a measurement tool for improvement which focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, urinary tract infections (inpatients with a catheter) and blood clots. Data for this was collected on an identified day each month to indicate performance in key safety issues and we saw this data displayed on the wards.

The Maternity Safety Thermometer is a national system designed to support improvements in women’s care and experience. The maternity thermometer also records data on one day a month, the proportion of mothers who have experienced harm free care. It records harm associated with maternity, such as perineal trauma, abdominal trauma, postpartum haemorrhage, infection and women’s psychological perception of safety.

Is the service effective?

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence of its effectiveness.

Local policies and guidelines were written in line with evidence-based standards and guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE), Nursing and Midwifery Council (NMC) and the Royal College of Obstetricians and Gynaecologists (RCOG). Midwives and medical staff we spoke to were able to describe how their practice was informed by evidence and guidance. We reviewed 14 guidelines and found three out of date for review and nine had out of date references, meaning references were not reviewed when the guidelines were updated and indicated their process for review may not be robust. We spoke with leaders of the service about the misalignment of processes and policies across the trust, they told us they had started the process of alignment; however, it was a lengthy one which could not be completed within a few months and each service was working hard to achieve it. We spoke with local leaders during the inspection who confirmed they were working on updating and aligning guidelines for their service.

Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all policies were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.7. This was more than 10% higher than the average for the comparator group rate of 5.0 and is categorised as much worse than expected.

We requested the trust provided us with their action plan following the inspection, however we were only provided with information relating to the Burton sites.

Following the inspection, we requested a copy of the service’s internal clinical audit programme. These included an obstetric management of sepsis, 3rd and 4th degree tears, massive obstetric haemorrhage, standardisation of intrapartum swab count and reason for induction of labour. In their January 2019 audit of reason for induction of labour, they found IOL’s were according to the trust guidelines in 100% of women. The outcome of their audit of 3rd and 4th degree tears was to encourage the use of ventouse instead of forceps as the 3rd degree tears rate was 3% using ventouse as opposed to 15% when using forceps.

Antenatal and new-born screening key performance indicators (KPI) monitored performance against six maternity screening areas. Performance was monitored for six of the nine of the standards against either acceptable, achievable standards, or standard not achieved. The trust provided, following the inspection, data for quarter one of 2018/19, showed performance against all six of the standards were acceptable. Three of the standards were not rated and stated, ‘to be set’.

The Pregnancy Assessment Unit (PAU) service was audited on compliance with meeting small for gestational age (SGA) pathway, which was completed by the audit and guidelines midwife. They had set up a local SGA pathway, which was similar to the national growth assessment protocol (GAP/GROW) initiative. (The assessment is used to improve detection rates of fetal growth restriction, which can help to prevent stillbirth). There was also one dedicated consultant who was working to improve pathways and two registrars or consultants on weekdays for the service, weekends relied upon support from on call team.
Detection and management of poor fetal growth are nationally recognised key elements in reducing the still birth rate. The Trust carried out a baseline audit in 2016 and since the implementation of new clinical practice and guidelines based on RCOG guidance and guidance from the national Saving Babies Lives Care Bundle there has been a continued audit including all babies born within the Trust with a birth weight below the 10th centile. In January 2018 the positive impact was shown with an increase in the detection rate. In July analysis of the data demonstrated further increase in detection rate but also a decrease in the number of babies born with birth weight below the 10th centile (first quarter 2017; 8.8% to second quarter 2018; 7.5%). The trust identified areas where change in timing, for example scans, could further improve detection and management, therefore the guidelines were amended in October.

**Nutrition and hydration**

Staff gave women enough food and drink to meet their needs.

Intrapartum care plans included an assessment of hydration and nutrition and staff told us women were encouraged to eat and drink normally in labour if it was safe to do so.

The wards had ‘family rooms’ or dining rooms for women to use as required. Women had access to snacks between meals and we saw tea, coffee, water and fresh fruit was available.

The maternity service at Royal Derby Hospital had achieved full accreditation in the UNICEF Baby Friendly initiative accreditation programme. They were first accredited as Baby Friendly in 1998, and subsequently re-accredited in 2000, 2003, 2006, 2010, April 2015 and November 2018. The service was due for their next re-assessment in November 2021. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding and raise standards of care for all babies. The UNICEF UK Baby Friendly Accreditation has four levels which starts with a certificate of commitment. Stage one assessment is building a firm foundation, stage two is an educated workforce and stage three is full accreditation. We saw posters displayed within the unit to promote breastfeeding.

Staff monitored the expressed breast milk stored in the milk fridge. During our inspection there was milk in the fridge, which we saw to be labelled adequately and dated. We saw all milk was signed in and out by women, together with a member of staff. Staff told us it could remain in the fridge for up to 24 hours and then would be disposed of appropriately. The fridge was unlocked, but it was kept within a locked room. This reduced the risk of the milk being tampered with or being given to the wrong baby.

There were several café’s, restaurants and vending machines within close proximity of the wards for the use of women and their partners and relatives. There were two shops close to the labour ward which provided hot and cold food and drinks.

**Pain relief**

Staff assessed and monitored women regularly to see if they were in pain and administered pain relief in a timely manner.

Women could access pain relief during birth and post operatively in a timely manner.

There were birthing pools on the Labour Ward and The Birthing Centre the women could use to ease their pain in labour. The trust offered an aromatherapy service to facilitate relaxation in early labour, active labour and postnatally. Some women found aromatherapy helped them to cope with
pain, anxiety and tension. Staff were offered a competency package to complete in order to provide the service and staff spoke enthusiastically about it.

Epidurals (an injection of anaesthetic into the spinal area) were available for women on the delivery suite 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. An anaesthetist we spoke with told us women generally received epidurals within 30 minutes however we were told there was no routine audit of this and we did not see evidence of this in the trust clinical audit programme.

An assessment of pain was included and scored on the MEWS chart and we saw staff escalated to anaesthetists if they were caring for women and could not control their pain, for example post caesarean section.

Women we spoke with were happy with the options they had been given for pain relief and did not report a long waiting time for any pain relief.

Nitrous oxide (a pain-relieving gas) was piped in all birthing rooms on the delivery suite. Stronger painkiller by injection was available for women who required stronger pain relief.

**Patient outcomes**

Managers monitored the effectiveness of some care and treatment provided and used the findings to make improvements. Managers compared local results with those of other services to learn from them.

The service maintained a maternity quality dashboard, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. We reviewed the dashboard which included six months rolling data from July 2018 to December 2018.

The dashboard included data on the number of deliveries, broken down into mode of delivery, trauma at delivery (postpartum haemorrhage; excessive blood loss or perineal trauma 3rd and 4th degree) and neonatal unexpected admission to the neonatal unit. The dashboard captured the number of women who had an induction of labour, and the number of antenatal bookings performed before 10 weeks gestation.

The service submitted data to the National Maternal and Perinatal Audit (NMPA) The audit captures results for key measures of maternity care. These include instrumental delivery, episiotomy rates (a cut to aid delivery of the baby), induction of labour, early elective caesarean section, babies who were small for gestational age at 40 weeks, low Apgar scores (a guide for staff as to whether the baby needs additional resuscitation at birth), post-partum haemorrhage (bleeding after birth) and 3rd and 4th degree tears.

Since the introduction of episiotomy scissors, the rate of 3rd and 4th degree tears had significantly reduced according to their audit.

There was an average of 490 births per month at Royal Derby Hospital during the six month period of July 2018 to December 2018, however the trust did not separate the deliveries by location of Labour Ward and Birthing Centre births.

The maternity quality dashboard showed the average induction of labour (IOL) rate for the six months prior to December 2018 was 37.43%. The service had not set a target on its dashboard. Staff carried out an audit of the IOL process at the Royal Derby Hospital and were reviewing the process at both sites to improve the process and reduce delays.
The service participated in the National Neonatal Audit Programme and met the national recommendation for both measures relevant to maternity. Royal Derby Hospital results were in the top 25% of all maternity units for women who delivered babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery.

During the summer of 2018, a CQC questionnaire was sent to all women who gave birth in February 2018 (and January 2018 at smaller trusts). Responses were received from 151 patients at University Hospitals of Derby and Burton NHS Foundation Trust. We asked people to answer questions about different aspects of their care and treatment. Based on their responses, we gave each NHS trust a score out of 10 for each question (the higher the score the better), each trust also received a rating of ‘About the same', ‘Better’ or ‘Worse'.

Better: the trust is better for that particular question compared to most other trusts that took part in the survey. About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey. Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

Compared to others that took part in the survey, the trust was rated about the same for labor and birth, staff and care in hospital after birth.

National Neonatal Audit Programme

Royal Derby Hospital

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

In the 2017 National Neonatal Audit, Royal Derby Hospital’s performance in the two measures relevant to maternity services was as follows:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 179 eligible cases identified for inclusion. Of these, 89.2% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit’s recommended standard of 85% for this measure.

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 36 eligible cases identified for inclusion. Of these, 61.1% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5% and put the hospital in the top 25% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Standardised caesarean section rates and modes of delivery
As the data on standardised caesarean sections rates and modes of delivery below cover time periods from prior to the acquisition, separate data are shown for each trust.

**Derby Teaching Hospitals NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From April 2017 to March 2018 caesarean section rates were similar to expected for both elective and emergency caesareans.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>767</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>885</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>1,652</td>
</tr>
</tbody>
</table>

In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England average from April 2017 to March 2018:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>1,652</td>
<td>31.0%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>611</td>
<td>11.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>3,071</td>
<td>57.6%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,334</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

**Maternity active outlier alerts**

As of the 4\(^{th}\) December 2018 the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)**

As this audit was carried out before the acquisition, separate data are shown for each trust.
Derby Teaching Hospitals NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because it relates to the same legal entity as the merged trust it is used to form part of our judgement.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.72.

This was more than 10% higher than the average for the comparator group rate of 4.95. This flagged as much worse than expected in CQC Insight.

We did not see where action had been taken by the service as a result of the MBRACE audit.

(Source: MBRRACE UK)

Competent staff

The service mostly made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff attended annual multi-disciplinary training sessions. Midwives were required to attend Saving Mothers Lives Study Day, which included skills and drills, high fidelity simulation, basic life support, human factors and learning from local case studies. They also attended Saving Babies Lives Study Day, which included symphysis fundal height and fetal surveillance, diabetes, smoking cessation including very brief advice, fetal physiology and case study review for intrapartum fetal monitoring (CTG and Intermittent auscultation), recognition of the Ill Baby (including ATAIN, sepsis, hypothermia care and hypoglycaemia) and neonatal resuscitation. Up to date training data was provided following the inspection which showed 301 midwives had completed the Saving Mothers Lives Study Day and 298 midwives had completed the Saving Babies Lives Study Day.

A Maternity Study Day was provided where midwives had mentorship updates, Baby Friendly updates, mental health updates, moving and handling updates, risk and various e-learning packages including fetal monitoring, antenatal screening and anti-D (Anti-D immunoglobulin is an antibody component of human blood in some people who are blood type Rh(D) negative).

There was no annual HDU training, however six midwives had been funded to attend a University Course module in High Dependency Care of the Childbearing Woman 2018/2019.

The planned Practical Obstetric Multi-Professional Training (PROMPT), was planned to be implemented during February 2019. It was planned to replace the Saving Mothers Lives Study Day. The focus being on multi-professional training (obstetricians, anaesthetists and midwives). In that people who work together, train together within the systems within which they work.

All staff had a ‘training passport’ which held all of their training information of what they had achieved, and future training arranged.

The role of the supervisor of midwives (SoM) was discontinued on 1 April 2017 following changes to legislation. The trust implemented the new A-EQUIP (advocating education and quality improvement) model of midwifery supervision, with professional midwifery advocates (PMAs). The service employed four PMAs to provide support to midwives at Royal Derby Hospital.
Practice development midwives (PDM) told us there was an annual training plan which was under review, however they were working with band 5 midwives and provided sessions during inductions as well as a resilience study day annually.

Training needs analysis was carried out with a metrics to show any updates which were required. PROMPT was planned to be added to the metrics.

There was a dedicated theatre team including operating department practitioner (ODP) and ‘scrub’ nurses. These staff also recovered women post-operatively.

The maternity unit provided level two maternal critical care on the Labour Suite. The high dependency area was always staffed by band 6 midwives, however not all had completed a master’s module and Management of Obstetric Emergencies and Trauma (MOET) course in high dependency care but would always ensure at least one was available on shift. We were told by leaders the training numbers were increasing. In addition, staff were supported by the critical care outreach team who would automatically review women who had been stepped down from intensive care to high dependency. This was in line with the requirements of the Obstetric Anaesthetist Association, Maternity Enhanced Care guidance (2015).

There were a variety of ‘link’ midwife roles, for example for tissue viability and infection prevention and control.

The trust submitted an annual report on new-born screening spot management, which showed the recall rate had improved from 10.8% in 2017 to 1.8%. We were told this had been achieved by having one to one sessions and training with staff and following up on all insufficient samples on first reporting. Midwives also perform ‘fresh eyes’ on all samples by midwives checking each other’s in the community. The service presented their achievements externally at the Royal College of Midwifery Conference in October 2018.

**Appraisal rates**

From November 2017 to October 2018, 91.3% of staff within maternity at the trust received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion target of 100% for medical staff was not met.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>316</td>
<td>344</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>107</td>
<td>118</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>478</td>
<td>524</td>
<td>91.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Over the same period, 88.9% of staff within maternity services at Royal Derby Hospital received an appraisal. Training targets were not met for medical staff or additional clinical services staff.

<table>
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Doctors we spoke with during the inspection said they were responsible for booking their own training, however their supervisor had oversight and challenged if training had not been booked. There were two doctors on long term sick, which had significantly impacted on their training figures. Service leads told us there was no allowance made for long term sickness or maternity leave, therefore figures did not accurately reflect the actual percentage.

**Multidisciplinary working**

**Staff on the wards and in the community, worked together as a team to benefit women. Doctors, midwives and other healthcare professionals supported each other to provide good care.**

All necessary staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. For example, neonatal teams worked with obstetricians and fetal medicine specialists during the antenatal period to produce care plans for babies. Community and hospital staff liaised for continuity of care for women.

The twice daily multidisciplinary handover meeting involved a registrar, consultant, Labour Ward coordinator and midwifery staff sharing information and planning care using the Situation, Background, Assessment and Recommendation (SBAR) methodology. We observed a discussion between midwives and medical staff prior to handover, who demonstrated professional behaviour with some humour, they showed mutual respect for each other and were inclusive of all members of the team. Trainees appeared comfortable to challenge and ask questions in a formal process, however undertaken in a relaxed, professional way. The handover included discussions regarding women throughout the unit.

Staff working in the gynaecology and obstetrics theatres worked collaboratively provide an effective service for women. We saw there was good communication and teamwork throughout the unit.

The service held two multidisciplinary meetings weekly where they discussed safeguarding issues and vulnerable women. One meeting was held on Mondays where they discussed issues from the weekend and planned for the week ahead. The other meeting was on Thursdays to plan the management of the issues for the following weekend and mitigate any risk of avoidable harm to women and babies. Midwives specialised in safeguarding, mental health, domestic violence and substance misuse were included as well as ward managers and medical staff.

**Seven-day services**

Community midwives made home visits and held antenatal and postnatal visits seven days a week and were available 24 hours per day, seven days per week to facilitate home births.

Consultant obstetricians and anaesthetists were either resident on the unit or on-call 24 hours per day, seven days per week. In addition, delivery suite had access to middle grade obstetric staff 24
hours a day. Outside consultant hours there was a minimum of twice daily ward rounds, including bank holidays and weekends.

The obstetric theatres were always available for emergency procedures and there was a dedicated middle grade anaesthetist for the maternity unit.

**Health promotion**

Initial booking risk assessments and ongoing screening monitored and identified abnormalities or risk factors for example raised body mass index, low blood haemoglobin levels and smoking. These were then discussed and care planned with all relevant parties, including women and partners.

Staff told us they encouraged women to stop smoking. Carbon monoxide monitoring is part of the Saving Babies Lives care bundle, testing was offered to all women at booking regardless of their smoking status and handheld records were a prompt for monitoring. However, the trust did not have a carbon monoxide guideline at the time of the inspection.

Healthy eating and weight management advice was also provided as part of diabetic care for women during pregnancy. Specialist midwives held clinics and provided training for midwives to care for and support women. The trust's standard menu for inpatients offered healthier choice items.

Midwives with a special interest in diabetes and infant feeding worked across the trust. The trust had a range of specialist midwives and midwives with special interests in substance misuse, antenatal screening, fetal medicine, postnatal screening and newborn infant physical examination, bereavement, practice development and safeguarding who worked only at the Royal Derby Hospital, however the service leads said they expected a more fluid working across the trust.

Specialist midwives supported women in vulnerable circumstances to access health and social care services which would improve outcomes for women and babies.

We saw posters in the antenatal clinic promoting a range of parent education classes, including antenatal and postnatal exercise classes.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections or instrumental deliveries. We observed written consent was obtained from women prior to surgery and checked by theatre staff prior to commencing procedures. Staff asked for verbal consent from women prior to any procedures or care.

We saw staff documented when consent for procedures had been gained.

**Mental Capacity Act and Deprivation of Liberty training completion**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.
Royal Derby Hospital

Staff at Royal Derby Hospital and the Derby Community midwifery service were eligible for a single combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training module, with a completion target of 75%. This requirement was inherited from the predecessor trust.

Compliance for this module for the period from November 2017 to October 2018 level for midwives and qualified nursing staff in maternity at Royal Derby Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>179</td>
<td>179</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for qualified nursing staff in maternity at Royal Derby Hospital.

Compliance for this module for the same period for medical staff in maternity at Royal Derby Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>90</td>
<td>98</td>
<td>91.8%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for medical staff in maternity at Royal Derby Hospital.

Derby community midwifery service

In the Derby community midwifery service there was only one member of midwifery and qualified nursing staff that was eligible for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training for the period from November 2017 to October 2018. This member of staff had completed the training.

Therefore the 75% target was met for midwives and qualified nursing staff in the trust’s community midwifery service for Mental Capacity Act and Deprivation of Liberty Safeguards level 2 training.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Is the service caring?

Compassionate care

Staff cared for women with compassion. Feedback from women confirmed staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of women and those important to them. Women and their relatives we spoke with, without exception, told us they were treated with dignity, kindness and respect. We spoke with eight women and their relatives across the maternity unit who made complimentary comments, such as ‘staff work so hard, I don’t
want to bother them but they always insist that I ask for anything I need and when I do, there they are to always lend a hand and offer support with a smile.’

We saw cards of thanks displayed on all of the wards with remarks such as, ‘thank you so much for your help and support, you have given her THE BEST start!’

We observed face to face and telephone interactions between members of staff and women, their relatives and visitors. We saw all staff including midwives, receptionists and midwifery support workers took time to interact with women who used the service and those close to them in a respectful and considerate way.

Staff mostly preserved women’s privacy and dignity, however we saw there were no signs to indicate rooms were occupied, which meant there was a risk of people walking into rooms, particularly birthing rooms. There were curtains in the observations and ward areas and single rooms available for confidential conversations in most areas.

Staff drew curtains around women being assessed and cared for on the wards and in the antenatal areas to maintain their privacy.

The bereavement service had access to a pram from the neonatal unit which they used to transfer babies through the hospital to the chapel of rest and the staff made a walkway between the doors of the Butterfly Suite and the exit of the Labour Ward doors to maintain their privacy and dignity.

**Friends and Family test performance**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Please note that no data for the four maternity Friends and Family Tests were published by NHS England for November 2017 due to data quality concerns. Therefore, in the charts below, data for October 2017 to October 2018, excluding November 2018, have been included to provide 12 months of data.

**Friends and family test performance (antenatal), University Hospitals of Derby and Burton NHS Foundation Trust**

![Graph showing Friends and Family test performance (antenatal) for University Hospitals of Derby and Burton NHS Foundation Trust]

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was quite consistent. The trust never scored below 94% and its performance was consistently better than or similar to the England average.

**Friends and family test performance (birth), University Hospitals of Derby and Burton NHS Foundation Trust**
From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was quite consistent. The trust never scored below 95% and its performance was consistently better than or similar to the England average.

Friends and Family Test data was displayed on the wards, for example the Labour Ward showed 96% of women would recommend their maternity services in January 2019.

**Friends and family test performance (postnatal ward), University Hospitals of Derby and Burton NHS Foundation Trust**

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (postnatal) performance (% recommended) was consistent. The trust never scored below 95% and its performance was consistently better than or similar to the England average.

**Friends and family test performance (postnatal community), University Hospitals of Derby and Burton NHS Foundation Trust**

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (postnatal) performance (% recommended) was consistent. The trust never scored below 94% and its performance was consistently similar to the England average.

**Burton Hospitals NHS Foundation Trust**
Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

Please note that no data for the four maternity Friends and Family Tests were published by NHS England for November 2017 due to data quality concerns. Therefore, in the charts below, data for October 2017 to October 2018, excluding November 2018, have been included to provide 12 months of data.

**Friends and family test performance (antenatal), Burton Hospitals NHS Foundation Trust**

![Graph showing Friends and family test performance (antenatal)](image)

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was consistent. The trust never scored below 95% and its performance was consistently better than or similar to the England average. In both January and February data were suppressed to protect patient confidentiality, due to low numbers of responses.

**Friends and family test performance (birth), Burton Hospitals NHS Foundation Trust**

![Graph showing Friends and family test performance (birth)](image)

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistent. The trust never scored below 96% and its performance was consistently better than or similar to the England average.

**Friends and family test performance (postnatal ward), Burton Hospitals NHS Foundation Trust**
From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was consistently better than or similar to the England average. The trust scored 100% in February, April and May 2018 and never scored below 98%.

**Friends and family test performance (postnatal community), Burton Hospitals NHS Foundation Trust**

The trust scored 100% for maternity Friends and Family Test (postnatal community) in October 2017. However, from December 2017 to June 2018, the trust’s performance (% recommended) was consistently worse than the England average. The trust’s performance deteriorated to 65% in February 2018 compared to the England average of 98%, before improving to 93% in March 2018, and 90% in June 2018.

(Source: NHS England Friends and Family Test)

**CQC Survey of women’s experiences of maternity services 2017**

**Derby Teaching Hospitals NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Derby Teaching Hospitals NHS Foundation Trust performed better than other trusts for one of the 16 questions in the CQC maternity survey 2017:

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most</td>
<td>8.2</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Care in hospital after the birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>comfortable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.8</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.8</td>
<td>Better</td>
<td></td>
</tr>
<tr>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.0</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.3</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.4</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.5</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time?</td>
<td>8.8</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.7</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.5</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.1</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.1</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>5.7</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.6</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.2</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>6.4</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.1</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.9</td>
<td>About the same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Friends and Family Test data was displayed on the wards, the Labour Ward showed 96% of women would recommend in January 2019.

**Emotional support**

Staff provided emotional support to women to minimise their distress.
Staff provided compassionate care for women and relatives who had suffered a bereavement. A specialist bereavement midwife directly supported women and provided support and guidance to staff to enable them to meet family’s needs. The service provided spiritual care and religious support for women and relatives as required. For example, women could be referred to the chaplaincy service for support 24 hours a day, seven days a week. The bereavement midwife worked 37.5 hours per week and her shift times were dependent upon when she was required at the Royal Derby Hospital, she did not work trust wide as there was another team to provide the service at Queens Hospital. On occasions when they were not available, and the service was required, there were enough other midwives with a special interest in bereavement to provide the service in their absence. Following bereavements which affected staff as well as the families the service was available for as long as they needed. For example, the bereavement midwife arrived at 7.00am and stayed until late at night on occasions, however they told us management were very supportive and made it possible to take back the time.

Home visits were offered to support families at any stage. The bereavement midwife worked closely with families to support them in numerous ways, for example emotional support and access to other services such as counselling but also practical things such as paperwork. Staff told us the bereavement midwife supported a relative with weekly calls and with practical tasks relating to returning to work and they were able to make direct contact if they required it.

Parents who preferred to return to the hospital but not to the ward were offered the use of a private room in another area of the hospital where they could meet with the bereavement midwife or the chaplaincy service.

Staff regularly assessed women’s mental health, both in the antenatal and postnatal period, using recognised assessment tools in line with National Institute for Health and Care Excellence (NICE) guidance.

Staff told us and we saw women’s physical and psychological needs were regularly assessed and addressed whilst in the maternity unit. These assessments included nutrition, hydration, pain, personal hygiene and anxiety. Women we spoke with told us all their needs had been met.

Understanding and involvement of women and those close to them

Staff involved women and those close to them in decisions about their care and treatment.

Staff routinely involved women who used the services and those close to them in planning and making shared decisions about their care and treatment. All women we spoke with told us they were given sufficient information to make choices about their care.

Birthing partners were included and involved in the care of their partner and new-born baby. The service had introduced ‘Overnight Supporters’ on Ward 314 to allow birth partners to remain on site 24 hours a day, seven days a week to provide additional support to postnatal women and keep families together. We spoke with three partners who told us they felt involved and included in the decisions about their partner’s care.

One woman told us ‘I always had everything explained in a way I could understand and felt involved in care planning. I had complete trust in the obstetrician’.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local women.
Women could access a range of antenatal and postnatal care. Midwife led community clinics were mostly held in GP surgeries. Midwifery led and consultant led clinics were available across the trust. Some of the consultant led clinics were multidisciplinary diabetes in pregnancy, fetal medicine, perinatal mental health and postnatal perineal trauma. However, we did not see adjustments or support in place for young women aged under 20 to use antenatal care services.

Women assessed as low risk from across the trust could choose the alongside midwifery led unit (MLU) at Royal Derby Hospital or Queens Hospital Burton. (Alongside means next to or very near to an obstetric unit). The MLU at Royal Derby Hospital was called The Birthing Centre and had four birthing rooms, of which one was a pool room.

The trust maintained links with Derby Initial Accommodation Centre, which opened as initial accommodation for asylum seekers. The maternity service worked with the centre to ensure asylum seekers who were pregnant had the same access to maternity services.

The service undertook a Theatre Challenge where staff from the multi-professional team were encouraged to lie on the theatre table to provide some insight into how it feels for women to be transferred to theatre and generated discussions of how they could improve the experience for them. The learning helped them to understand how small things could impact on birth experience. The service were nominated for an award at the Celebrating Success Awards within the trust.

The trust were working on a project to raise awareness of the importance of the golden hour following delivery and the impact on the birthing experience by keeping families together rather than separating partners. Discussions included neonatal cannulation and intravenous antibiotics, alongside cots which had been provided, return to theatre events, performing blood spot, vitamin K and hypo, skin to skin in theatre and how they could improve while supporting families when a baby went to the neonatal intensive care unit. Staff said the project had helped to raise awareness among staff and challenged them to think differently about practice.

The trust employed several midwives in specialist interest posts to provide care for women and support staff to care for women with additional needs.

A fetal medicine service was offered at Royal Derby Hospital and was a tertiary referral centre for the region. Staff received referrals for women whose babies had been identified with life threatening or severe disabilities.

The trust provided a range of maternal and fetal medicine clinics Monday to Friday with extra lists on most weeks to accommodate the demand, however the day and consultant varied. Morning lists started at 8.15am and afternoon lists finished at approximately 5.00pm.

The bereavement specialist midwife worked the hours the service demanded, however they supported and trained staff to provide care for families after a pregnancy loss. They provided guidance to staff to ensure all women and families were offered appropriate care at all times and supported to make informed decisions at a difficult time. The bereavement midwife had provided training and raised awareness with both internal and external contacts.

We visited The Butterfly Suite, a bereavement suite situated in a quiet area away from labour rooms and self-contained at the end of the Labour Ward which was available to women from 20 weeks gestation. The suite comprised one labour room/bedroom to allow for partners or relatives to stay overnight. It had a kitchenette and an outside space. Women and their families could stay for as long as they wished, and staff provided cuddle (cold) cots to ensure babies could stay longer with their parents. Staff said the environment was not ideal and had put forward ideas for improvements which were under consideration. The bereavement midwife had secured charitable
funds to enable the works to be carried out and plans had been drawn up to alter the suite to include a clinical area separate from a ‘home from home’ room for women and their families. It would also include a dedicated kitchen area and bathroom.

The fridge was stocked with sandwiches and drinks prior to women arriving and were restocked regularly as well as offering hot food orders and hot drinks available in the room.

The service had close links with the chaplaincy service, bereavement office and local funeral services for example, Derby Islamic Funeral Community who provided additional support for families of their faith and helped to facilitate communication and arrangements in a timely way.

Memory boxes, which included photographs and hand and footprints were made up for parents who suffered a pregnancy loss. A local charity provided a photography service for families to have taken, as many photographs as they liked, and parents were given a memory card containing all images for them to keep. The boxes also contained a lock of hair and information about additional support services as well as two blankets and two small teddy bears, one to be given to parents and one to stay with the baby.

The bereavement midwife reported to the Child Death Overview Panel and the Perinatal Mortality Review Panel as well as MBRRACE and followed the National Bereavement Pathway.

**Bed Occupancy**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From April 2017 to September 2018 the bed occupancy level for maternity at Derby Teaching Hospitals NHS Foundation Trust (from July 2018 the new merged trust) was higher than the England average in four out of six quarters. The trust had 65.6% occupancy in quarter 2 2018/19 compared to the England average of 59.7%.

The increase in occupancy in quarter 2 of 2018/19 was more pronounced than the equivalent increase one year earlier. This reflected the inclusion of Queen’s Hospital Burton’s maternity beds in the data for the new combined trust for the first time.

The chart below shows the occupancy levels compared to the England average over the period.

![Occupancy chart](chart.png)
Meeting people’s individual needs

The service took account of women’s individual needs.

All women were assessed at booking for birth place choice. Community midwives supported and promoted home births. We reviewed the service dashboard and saw in the six months between July 2018 and December 2018, an average of 0.9% of births were home births. There was no trust target set on the dashboard, service leads told us they always promoted the home birth service; however the numbers were usually low due to the clinical and social complexities of women. Women assessed as low risk could also access one of two midwifery led units across the trust.

Mental health and wellbeing was discussed with all women throughout pregnancy. These discussions included difficult and sensitive issues such as previous experience of poor mental health, domestic violence, sexual abuse, drug use, female genital mutilation and child sexual exploitation.

There was a wide range of information available on the trust’s website accessible to women and their families including Our Service, Maternity Video Tour, Your Pregnancy, Health Eating and Lifestyle, Labour and Birth and After Baby is Born. All information tabs opened up to show further information in a variety of formats and languages. There were information leaflets available on the website, specifically relating to maternity. All information was available is a range of languages and information videos had a choice of subtitles. All were available in a hard copy when requested from a midwife or at an antenatal clinic.

An interpreting service was available for non-English speaking women. Staff we spoke with knew how to access the interpreting service and we saw two interpreters working on the wards during the inspection. Staff said they use their services often, although staff had a small folder with common phrases for everyday use in Lithuanian, Arabic, Punjabi and Urdu.

We saw there was a wide range of leaflets available and up to date information displayed in all of the clinical areas, they included sleep safe, breastfeeding, bottle feeding, flu vaccine and skin to skin contact with your baby. Women we spoke with said they found them useful and liked the
variety of classes available to them locally. Postnatal exercise classes, breast feeding cafe, water birth workshops, home birth sessions and events for parents of multiple births were some of the opportunities promoted on the wards.

Community midwives told us they provided parent education classes in the form of open meetings at different sites and at varied time of day to enable women to book on when it is most convenient for them. These included two-hour sessions covering labour and birth, baby care and parenthood.

Women could choose from a range of meals including food suitable for specialist diets and cultural preferences, for example halal, vegetarian, gluten free and for those with a nut allergy. Menus were also available in a range of different languages.

The antenatal clinic waiting area was spacious with information boards displaying educational topics such as ‘healthy eating’, ‘diabetes’ and staffing information and had classes available to women such as smoking cessation and healthy eating for women with a raised body mass index. The trust’s local clinical commissioning group aimed to increase the accessibility of smoking cessation programmes for pregnant women.

Ward 314 had a large family room where there was a ‘physiotherapy stand’ stocking information leaflets for women to take away including pelvic floor exercises, third and fourth degree perineal tears, activity pacing as well as support to manage weight or stop smoking.

Whooping cough and flu vaccines were offered to women attending PAU or ANC for scans so they did not need to make a separate appointment. The uptake had improved since this was introduced and funding had been received to provide the service.

**Access and flow**

Women could access the service when they needed it.

Women had timely access to initial assessment, test results, diagnosis and treatment. Between July 2018 and December 2018, 76% of maternity bookings at Royal Derby Hospital were performed before 10 weeks of pregnancy. The trust did not indicate a target on their dashboard. However, we did not see women waiting for long periods of time for appointments in antenatal clinic or for assessment in the Pregnancy Assessment Unit (PAU).

The Pregnancy Assessment Unit (PAU) was accessible from 8.30am to 7.00pm Monday to Friday, with no service on weekends or bank holidays. If a woman required access to the PAU at weekends or bank holidays they would be assessed by either their community midwife or referred to the hospital if required.

The Birthing Centre had four birthing rooms for women assessed as low risk and appropriate for midwifery led care. Staff told us the births on the unit were decreasing due to the number of women eligible for such care. More women were presenting with complexities assessed as high risk, therefore the unit wasn’t used as often as it was. However, staff and managers were proactive in optimising women booking and birthing on the low risk pathway.

Elective caesarean sections were carried out in the gynaecology theatres, which left obstetric theatres for emergencies. There were elective caesarean sections planned Monday to Friday with dedicated staffing. This meant women booked for an elective section did not have to wait for staff to complete any emergency procedures before their surgery could proceed.

The neonatal intensive care unit was situated within close proximity to the Labour Ward and had access through a dedicated door across the corridor for transfer purposes. Royal Derby Hospital Neonatal Unit (NNU) is a level 3 unit comprising of 24 cots, 4-6 were for babies requiring high
dependency (HDU) or intensive care (ICU) and the remaining 18-20 for babies requiring special care. This meant the unit could care for babies born at the unit at any gestation, depending on capacity.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

The service monitored complaints, concerns and compliments as part of the divisional clinical governance. We reviewed the governance and development group meeting minutes from September 2018 and saw complaints and themes were included in the discussions.

Staff said they discussed learning from incidents and concerns during training days and regularly discussed in team meetings as well as information through emails and leaders disseminating too all ward staff. For example, some complaints were about staff attitudes and behaviours, which had been shared with staff.

We saw the service responded to women’s feedback by the display of a ‘you said, we did’ board.

**Summary of complaints**

**Trust level**

From October 2017 to September 2018 the trust received 38 complaints about maternity. For the 37 complaints that had been closed at the time of data submission, the trust took an average of 40.9 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The one complaint that had not yet been closed had been open for 164 days (approximately five and a half months) at the time of data submission. This was also not in line with the policy statement above.

At the time of the inspection there were 13 complaints open. Service leads accepted multi-service complaints often led to prolonged times for complaints to be fully investigated and close as well as having no divisional coordinator for complaints. They told us the process was under review as part of the acquisition as the electronic systems across the trust were disjointed and frustrating.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>14</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Communication</td>
<td>6</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>4</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>4</td>
</tr>
<tr>
<td>Trust admin/policies/procedures</td>
<td>2</td>
</tr>
</tbody>
</table>
Royal Derby Hospital

From October 2017 to September 2018 the hospital received 36 complaints about maternity. For the 35 complaints that had been closed at the time of data submission, the trust took an average of 41.1 working days (mean) to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The one complaint that had not yet been closed had been open for 164 days (approximately five and a half months) at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>12</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Communication</td>
<td>6</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>4</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>4</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 the trust received 71 compliments about maternity. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. However, staff did not fully understand the new structure since the acquisition and were not aware of future plans for the service.

University Hospitals of Derby and Burton NHS Foundation Trust provided maternity services as part of the Division of Women and Children Services. The division was split into Business Units which were maternity and gynaecology, paediatrics, neonates, sexual health and fertility. The division was led by a clinical director, a divisional general manager, a deputy general manager, a
director of midwifery (DOM) and a head of midwifery (HOM). The HOM had direct access to the
trust board and was supported. The division was split into individual specialities. The HOM was
supported by matrons across both sites. Each of the maternity wards had a band 7 ward manager
and a band 6 deputy manager.

The senior leadership was based at Royal Derby Hospital site but worked across all sites as
necessary. However, staff at Royal Derby Hospital did not feel they were always visible at the
Derby site.

There was a non-executive director for maternity, who staff described as enthusiastic and
proactive in engaging with staff. Service leads told us they were in the very early stages of
implementing changes following the trust’s acquisition of Burton Hospitals NHS Foundation Trust
and had plans to create a more robust management and governance structure.

Most staff we spoke with did not describe the senior leaders in maternity as visible, however they
did tell us the felt they were approachable and had access to them when they needed to. Staff
described feeling supported and valued by local leaders but middle management and senior
leadership team less so.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into
action developed with involvement from some staff, women, and key groups representing
the local community.

Senior leaders told us the vision was that at the end of three years women would receive the same
service and level of care across all the trust. The vision was for the trust to have fully integrated
care for all woman.

The trust were working towards a strengthened model of midwifery clinical leadership and
governance, including safe staffing levels, alignment of guidelines, improved perinatal mortality
review, good communication and education. They aimed to maintain recognition of individuals and
teams who performed well, support for staff involved in incident investigations, strengthened and
visible leadership and associated leadership development, enhanced clinical pathways and
multidisciplinary team working with shared development opportunities.

The maternity service was to be aligned to ‘Better Births’, the report of the National Maternity
Service leads told us there were different work streams, working with other providers and
commissioners in the local maternity system.

Culture

There was a positive culture that supported and valued staff at a local level, creating a
sense of common purpose based on shared values, however we were told by staff the
senior leadership team and some middle management were less so.

Services on both sites and the community were run by one maternity management team. They
were regarded and reported upon by the trust as one service. There were few common
governance and policies and staff reported there felt a degree of separation in relation to trust’s
maternity units.

The staff we spoke with told us the needs and experience of the women and babies were
paramount and most midwifery staff we spoke with felt supported, respected and valued. Staff on
Ward 314 (postnatal/antenatal) felt under immense pressure to be able to provide the standard of
care they would like when they had potentially 47 women and 35-40 babies to care for between seven midwives during the day and four during the night. Although we did not find evidence of any impact on safety during the inspection, staff told us the impact was felt by the staff themselves. Some staff described the environment as sometimes very stressful and they were concerned for the wellbeing of some of their colleagues, especially more junior staff. Some staff said they were worried they may miss something due to having limited time with each woman, most of whom had complex clinical and social needs and subject to safeguarding intervention.

The staffing issues had been escalated on more than one occasion, yet staff did not feel they had been listened to and no support has been provided from service leaders despite the staffing levels being well below the recommendations of Birth Rate Plus. Leaders said and we saw the trust were actively recruiting, however this was not disseminated to staff for reassurance they were listened to.

There was no formal rotation of staff at the time of our inspection, however staff said the service did offer the opportunity and some did rotate often. The rotation could be for a matter of days or six months depending on their preference and the demands of the service. Some staff enjoyed the rotation, while others did not participate. The service had engaged with other stakeholders such as NHS Improvement and the local clinical commissioning groups (CCGs) and had worked to improve the culture, although there was an acknowledgement this was an ongoing process.

The trust had a nominated freedom to speak up guardian (FTSUG) who worked trust wide, who encouraged and enabled staff to speak up safely within the workplace. Staff knew who their FTSUG was and how to contact them. The FTSUG had been contacted by midwives two years ago who felt ‘downtrodden and said some elements of management styles impacted on staff morale. The deputy chief nurse held open forums with staff as a result of whistleblowing concerns and staff said things improved. However, there had been no further action and no expected review or behaviour training since. During the inspection we did not hear concerns of this nature from most staff, however some said there had been two more whistleblowing concerns relating to attitudes and behaviours raised over the previous two weeks.

The trust had a function within their reporting system which allowed staff to tick a box to highlight their report was categorised as whistleblowing and it went directly and confidentially to the FTSUG, which encouraged staff to report and access support.

Most medical and midwifery staff we spoke with told us there was good multidisciplinary working and were proud of the service they provided. Junior doctors told us they were well supported by their seniors and by midwives on the unit. Midwives we spoke with felt they were able to challenge decisions made by their medical colleagues and feel listened to and considered.

As part of the trust’s involvement with the West Midlands Patient Safety Collaborative, they had agreed to take part in the SCORE survey. The survey is a way of measuring the culture which exists within maternity. It showed positive scores for most domains, however burnout climate was scored highest on the negativity scale.

**Governance**

The approach to continually improving the quality of its services and safeguard high standards of care was not fully robust, however we saw plans in place to make improvements.

Since the acquisition, services were not yet fully aligned, however leaders told us they had seen improvements and they were working on creating a robust governance structure divisionally and
liaising corporately to achieve consistency across the whole trust. We reviewed an action plan which outlined actions to be taken and progress against the key targets. They acknowledged it was a work in progress and they had a lot more work to do as a trust.

There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken.

A variety of local clinical governance groups fed into monthly divisional meetings to discuss audits and reviews. Service leads said they were working on a new agenda and for the governance meetings in future.

We reviewed minutes from the governance and development group meetings and saw all aspects of governance were scrutinised, including incident reporting and management, infection prevention and control, complaints, friends and family data, clinical document control and the risk register. We saw there was a clinical governance action log, to ensure all agreed actions were completed and closed. We saw there were plans to align guidelines and ensure all were up to date as well as a range of discussions around working towards creating a feel of one trust over time.

Professional Midwifery Advocates (PMA) reported to the head of midwifery and submitted reports for clinical governance. Staff told us the PMAs received details of all the serious incidents which occurred within the unit, so staff could be supported if required.

Concerns, themes and trends from the clinical governance meetings were escalated to the executive board. However, we were not assured the service had full oversight of all their risks and trends from incidents as not all incidents were reported.

Information received following our inspection demonstrated concerns identified during the inspection had been given appropriate consideration. The service had set up a ‘task and finish’ group to look at a number of concerns including; staffing models for all staff groups, ward processes around observation reviews of women, paediatric reviews of babies, escalation of concerns both clinically and staffing and exploring the use of other roles. The task and finish group was expected to produce an action plan setting out plans for delivery and expected timeframes.

**Management of risk, issues and performance**

**The trust had systems for identifying risks and were planning to eliminate or reduce them.**

The trust operated a corporate risk register, which included the ongoing risks identified for the maternity service. Risks were recorded and managed using the trust's electronic incident reporting system. Upon review of the register prior to our inspection, the division had 32 risks on the register for the division. Of these, 14 were directly related to maternity and seven specifically for Royal Derby Hospital.

We found some risks had been on the register for a significant period of time, for example a risk of sharps injury to staff on Labour Ward which had been on there since October 2013. Service leads said there had been no incidents relating to the risk and they could not tell us why it had remained on the risk register.

Another risk was the trust's inability to provide the required consultant presence on the Labour Ward for in line with the safer childbirth standards and RCOG recommendations for a maternity service which delivers more than 5000 births per year. Service leads said they did provide at least 65 hours of resident cover; however they could not tell us what the required cover was to meet the standard. During our inspection and since reviewing data provided by the trust, we found they did in fact meet the standard, therefore the risk should have been removed from the register had it
been reviewed. The trust informed us following the inspection, funding had been received to increase the workforce numbers and these hours would increase to full days at weekends in the near future.

We interviewed service leads with responsibility for the risk register across the maternity service. Service leads said they operated a local (‘live’) risk register, which was up to date. The trust provided their up to date risk register following the inspection, which we reviewed and found it was more relevant and up to date.

Service leads said they were reviewing the risk register; however we were not assured at the time of the inspection they had good oversight of all risks in maternity or their review processes were robust. The trust provided us with their ‘live’ risk register following the inspection, which showed work had already commenced in creating a more robust process.

At the time of our inspection there was an obstetric lead for risk, one band 7 midwifery risk lead and two band 6 risk midwives trust wide. Staff told us all incidents were reviewed by the midwifery risk lead and matrons daily, if determined as no harm then were closed or they completed their toolkit if the risk required further investigation. Each Monday the midwifery risk lead had a meeting with the Labour Ward manager, Birth Centre manager, PAU and antenatal manager, postnatal ward manager and a clinical educator to discuss the incidents which had been highlighted as required further investigation.

The midwifery risk lead and risk midwife collated the information and reported to an incident review meeting with an impartial clinician a midwife and the risk lead for women and children’s services to agree an action plan. We found it was an entirely internal process with no external scrutiny, leads said they asked difficult questions of the staff involved, however they acknowledged external input may give a better perspective of the incidents.

The risk lead consultant told us the service was using the national standardised Perinatal Mortality Review Tool (PMRT) to support systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death. The lead and staff held round table reviews of all stillbirths to look at the circumstances and to discuss improvements to be made.

The trust had approximately 40 incidents outstanding at the time of the inspection and typically reviewed an average of around 150 per month for the division. The grading of incidents was in line with the trust’s policy and duty of candour was being carried out in an appropriate and timely manner in line with the requirements of the regulations.

On the first Monday of each month, leads from the trust attended the perinatal mortality meeting and held a lunchtime mortality meeting on the third Monday of each month for feedback. All staff were invited to attend to learn from serious incidents. It varied on the number of attendees depending on the ward demands, however it was said to be fairly well attended. They held an additional meeting each Wednesday morning for obstetrics and gynaecology learning, external speakers were invited often and discussed current serious incidents. The meeting was attended mostly by doctors rather than midwives.

We saw incident themes and trends, together with any actions arising from completed or ongoing investigations were discussed at the divisional quality and safety meetings and an audit trail of all actions taken in relation to any incidents was kept in the electronic incident reporting system.

The service maintained a maternity quality dashboard, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology
RCOG) 2008. We reviewed the dashboard and discussions during our inspection gave us some assurance there was oversight of outcomes for women and babies and from our review of the minutes of the clinical governance meetings we saw the dashboard formed part of the discussion.

The trust provided us with copies of the current dashboard and a proposed one for 2019/2020 which showed there were processes in place for ensuring data was captured and the dashboard updated, however work was being carried out on developing the data level. They had a maternity project underway which was specifically looking at a merged set of tables which would include trust wide data for maternity services. These tables would replace the current data feeds for the dashboard and as data from all sites will be included this would automatically give them a merged dashboard. The trust were ensuring that site codes were included in all data tables so that the data could also be viewed as the previous organisations if required. They expected the dashboard to be completed and in a merged format during May 2019.

The service monitored a range of quality and performance measures through ward metrics. Performance was assessed monthly and included medication assessments, infection control, privacy and dignity, postnatal observations, blood clotting risks, emergency equipment checks, pain control and discharges and transfers. In their most recent, December data they identified they needed to improve their performance relating to blood clotting risk as it scored 89% and they told us they were discussing ways to make improvements in the area.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The maternity service collected data around women’s activity and outcome. Service performance measures were reported and monitored through the maternity dashboard, this included red, amber, green ratings for some measures to enable staff to identify outcomes which were better or worse than expected.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible through the trust’s intranet facility and the external website. Staff had access to the women’s records and diagnostic tests they needed in a timely way.

Arrangements to ensure the confidentiality of identifiable data were generally robust. Across all clinical areas we saw medical records were always secured in a locked trolley or stored in a secure area where staff were working.

The trust were working towards aligning their electronic record systems trust wide, which would incorporate antenatal, intrapartum and postnatal care for women. They planned to have a joint dashboard for the whole trust by May 2019.

We saw computers were left turned on for timely access to guidelines and general information, however staff required a smartcard to access any confidential information. We looked at five computers across the wards at random and saw they were all secure.

Engagement

The service engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively, however did not always engage effectively with staff.
The senior leadership team had engaged with staff on the Burton sites more than Derby, which was felt by most staff and acknowledged by leaders. We saw this lack of engagement had led to a disconnect between staff and the management team and between the trust sites as staff did not fully understand the plans for the service or the changes which had been implemented since the acquisition.

We saw service leads had shared details of improved maternity survey with all staff to highlight the improvements and thank the staff.

We saw boards on all wards displaying achievements and where improvements were highlighted, however much of the information was relating to Royal Derby Hospital only and the trust ran ‘Pride of Derby’ for anyone to nominate staff. We also saw information about staffing and recruitment, with details of advertisements for positions and the number of new staff joining. Service leads told us they were working towards one trust; however, they were still in the early stages of the acquisition and the combination of the two former trusts would take time to become embedded.

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

The service provided support for staff including a staff wellbeing programme and the RCM Caring for You Campaign. The trust provided a range of support within their wellbeing programme which included counselling and access to external support.

The trust observed the RCM Caring for You campaign, which encouraged staff to comment on ways the working could be improved for staff and attempts were made to implement some of the suggestions. These included changing handovers and updating the staff room. Resilience study days were arranged for staff to enhance mental health and Caring for You sessions allowed staff to attend for relaxation, massage and health advice. Water bottles were also made available for staff to encourage hydration when on shift.

The service worked with Maternity Voices Partnerships, which was established to listen to women and families to gain feedback the service could use to make improvements. It is a working group of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of maternity care.

The maternity service were nominated for two awards at the Celebrating Success Awards within the trust for the Theatre Challenge and for their Maternity Services Safety Improvement Plan.

Women’s feedback was generally obtained through the NHS Friends and Family test (FFT). In addition, all the wards we visited displayed ‘thank you cards’ from women and members of the public.

Wards and departments held staff meetings on a regular basis, to share learning and highlight areas for improvement, which staff told us was useful and they attended when they were able.

**Learning, continuous improvement and innovation**

The trust improved services by learning from when things went well and when they went wrong, promoting innovation.
The service was nominated for two Celebrating Success Awards for their innovative approach to identifying areas for improvement and implementing changes for a better experience for women using the service. The trust told us they had received positive feedback from women and birth partners following their introduction of ‘overnight supporters’.

We saw there was a range of information on the trust’s website, which gave women information about all aspects of the women’s journey antenatal, labour and postnatally as well as health promotion and practical advice. It included a video tour which was available with subtitles in a variety of languages.

Practice development midwives told us they had made innovations to the training programme to make the sessions more interactive and engaging for staff, over time the new training was to be evaluated to assess how effective it was.

Two midwives had completed an accredited training course and offered aromatherapy to women through inhalation and/or massage to facilitate relaxation in early labour, active labour and afterwards. The service had recently been audited, however we are unaware of the result, although feedback from women was positive. Staff worked with pharmacy and clinical governance to produce detailed guidelines which covered recommended oils and any contraindications. Aromatherapy is a complimentary therapy which may aid relaxation and reduce stress and anxiety in labour and is often used as an alternative to more traditional forms of pain relief.

Following feedback from women, the service introduced NICU Feeding Packs. Feeding support packs were provided to women when their baby was transferred to NICU. They included syringes for EMB and knitted squares for mum and baby to create a sense of togetherness even when apart and facilitating lactation. They also included a leaflet discussing the importance of colostrum for poorly babies and how to initiate expressing breastmilk. The packs were available to any women to help establish feeding and not limited to NICU.

The service implemented a Thermal Care Bundle in 2016 and recently reviewed and updated the guideline in 2018 as it had proven to be successful in reducing NICU admissions for ‘cold’ babies (babies whose temperature reduces significantly following birth). Babies were assigned colour coded hats to indicate their level of risk in terms of NEWTT observations required and whether a baby requires the hypoglycaemia policy. A matching sticker was placed in the care plan for the baby.

Leaders told us and we saw posters indicating their new focus on human factors awareness, which was incorporated into staff learning. They provided regular ‘Learning on a page’ newsletters from the risk team with the support of the PMA team to facilitate restorative and reflective practice. As a trust they said they were very much focussed on generating a culture where shared learning becomes the focus, however acknowledged this would take some time given the large changes as a trust.
University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1st July 2018 following the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust. The former trust acquired the latter under its existing registration with the CQC. As such, our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

We have included data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust. Because it relates to the same legal entity as the merged trust we have used this to form part of our judgement.

Where we have included data from the acquired Burton Hospitals NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity, we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust provides end of life care at two sites – Royal Derby Hospital and Queen’s Hospital Burton. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,407 deaths from August 2017 to July 2018.

(Source: Hospital Episode Statistics)

End of life care is delivered through the trust’s department of palliative medicine with distinct teams on each acute hospital site.

Royal Derby Hospital Campus

There are 5.5 WTE consultants in palliative medicine at the Royal Derby Hospital (RDH) campus. The service consists of a 21-bedded specialist palliative care in-patient unit with day unit facilities, with outpatient services at RDH and community hospitals.

There is a 7.6 WTE hospital palliative care team based at RDH and outreaches to Kingsway Mental Health Service, promoting early symptom control, supporting patients and carers adjusting to disease progression and facilitating discharge from hospital.

There are also 3.0 WTE end of life care facilitators providing training, education and service improvement to both hospital and community; and a nine WTE community palliative care team (CPCT) to support patients in their own homes, care homes and community hospitals. These teams work in collaboration with the patient’s primary care team, optimising symptom control and supporting patients to express and achieve their preferences for their care.

There is a team to support enhanced nursing home beds for palliative care to prevent crisis admissions for patients and carers. This is by providing emergency care near a patient’s home and facilitating early discharge from hospital. It currently provides short stay admissions for palliative care, including care in the last days of life.
The Nightingale Macmillan unit (NMU), at Royal Derby hospital, was a 21 bedded specialist palliative care unit, for patients with complex symptoms requiring specialist palliative care and symptom control management. Patients requiring palliative or end of life care were either nursed on NMU or nursed throughout the hospital if the unit was full.

The provision of end of life care services to patients was not the sole responsibility of the hospital palliative care team (HPCT). It was provided by general nurses and doctors who work on the wards throughout the hospital.

The hospital palliative care team (HPCT) provided face to face support seven days a week from 08:30 to 4:30. Outside of these hours, there was a dedicated advice line held by inpatient trust staff for specialist advice.

### Is the service safe?

#### Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

#### Mandatory training completion rates

The trust set a target of 90% or 95% for the completion of most mandatory training modules. The exceptions were:

- Local induction, safeguarding, preventing radicalisation and medicines management, where the target was 85%.
- Resuscitation training modules, where the target was 75%.

These training targets were inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided these services.

#### Royal Derby Hospital

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in end of life care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>63</td>
<td>63</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load handling</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>63</td>
<td>63</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>48</td>
<td>49</td>
<td>98.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>59</td>
<td>63</td>
<td>93.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dignity at work - harassment &amp; bullying</td>
<td>59</td>
<td>63</td>
<td>93.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, inclusion &amp; human rights</td>
<td>59</td>
<td>63</td>
<td>93.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 3</td>
<td>53</td>
<td>57</td>
<td>93.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health, safety &amp; risk awareness</td>
<td>58</td>
<td>63</td>
<td>92.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Training module</td>
<td>Number trained</td>
<td>Number eligible</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>--------</td>
<td>-----</td>
</tr>
<tr>
<td>Trust induction</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>54</td>
<td>63</td>
<td>85.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>40</td>
<td>48</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - hospital life support</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local induction</td>
<td>13</td>
<td>16</td>
<td>81.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling</td>
<td>49</td>
<td>62</td>
<td>79.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - automatic external defibrillation</td>
<td>48</td>
<td>61</td>
<td>78.7%</td>
<td>75%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 4</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 90.7% for qualified nursing staff in end of life care at Royal Derby Hospital. The trust’s training targets were met for seven of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in end of life care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aseptic non-touch technique</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient handling</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection control level 4</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion theory</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution &amp; security awareness</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dignity at work - harassment &amp; bullying</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Resuscitation - automatic external defibrillation</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>75%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality, inclusion &amp; human rights</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health, safety &amp; risk awareness</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Falls prevention for doctors in training</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Resuscitation -immediate life support</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>75%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dementia awareness</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Local induction</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
<td>85%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 86.6% for medical staff in end of life care at Royal Derby Hospital. The trust’s training targets were met for 14 of the 18 mandatory training modules for which qualified nursing staff were eligible.
End of life care was not classed as mandatory training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of all safeguarding training modules. This target was inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided these services.

**Royal Derby Hospital**

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in end of life care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 2</td>
<td>62</td>
<td>63</td>
<td>98.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding – level 1</td>
<td>62</td>
<td>63</td>
<td>98.4%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In end of life care at Royal Derby Hospital, the 85% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in end of life care at Royal Derby Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding - level 2</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding - level 1</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In end of life care at Royal Derby Hospital, the 85% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

Safeguarding training was part of the trust's mandatory training programme.

Staff had a good understanding of how to protect patients from abuse and could describe what safeguarding was and the process to refer alerts. For example, one staff member told us of a referral they had made to the safeguarding team concerning the alleged financial abuse of an end of life care patient.

The trust had a dedicated safeguarding team, who supported staff with all aspects of the safeguarding process.

There were up-to-date safeguarding policies and procedures in place, which were accessible to staff through the trust’s intranet site.

Staff were aware of the trusts whistleblowing procedures and what action to take if they had concerns.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The service had clear policies in place for infection prevention and control which were accessible through the hospital intranet.

There were reliable systems in place to prevent and protect people from a healthcare-associated Infection. For example, Gel dispensers and hand washing facilities were available in all clinical areas we visited. We observed staff completing hand hygiene between patient contacts. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

Ward areas and the Nightingale Macmillan Unit (NMU) appeared visibly clean and there was evidence of cleaning regimes displayed and visible to the public.

Nursing staff could describe good infection control and hygiene practices before, during and after patient contacts. This demonstrated that staff could practise good standards of hygiene and minimise risk to patients from cross infection.

There was a trust policy for staff to follow when performing last offices (the process involved in preparing a body for transfer to the mortuary). Staff told us if they had any specific concerns, they would contact the staff in the mortuary or infection prevention and control team for advice.

Staff had access to personal protective equipment (PPE) and were aware of how to dispose of used equipment safely and in line with infection control guidelines.

We saw ward and departmental staff wore clean uniforms with arms bare below the elbow. Personal protective equipment (PPE) was available for use by staff in all clinical areas.

The mortuary waiting room was visibly clean, modern and provided facilities for relatives such as comfortable seating and information booklets about bereavement, the trust's bereavement service and organ donation.

Mortuary staff were aware trust's infection prevention and control policy and procedure for care of the deceased.

The mortuary had sealed body bags, for deceased persons who had notifiable infections to prevent the spread of infection.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The trust had a specialist palliative care 21 bed inpatient unit named The Nightingale Macmillan Unit (NMU). The unit was located on the ground floor of the hospital and provided end of life care for patients with complex symptoms requiring specialist palliative care and symptom control management.

The trust used syringe pumps for end of life patients requiring a continuous infusion to control their pain. A continuous infusion is a controlled method of administering intravenous medicines without interruption. Syringe pump equipment met the requirements of the Medicines & Healthcare
Regulatory Agency (MHRA). Patients were protected from avoidable harm when a syringe driver was used to administer a continuous infusion of medication; as the syringe drivers used were tamperproof and had the recommended alarm features.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Overall staffing rates

Where end of life care patients were nursed on the wards and not on the NMU, nursing vacancy rates were reported within the individual directorates.

The trust reported their staffing numbers for qualified nurses in end of life care below for the period from April 2017 to March 2018 and from November 2017 to October 2018. All of these staff were based at Royal Derby Hospital.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>44.5</td>
<td>46.8</td>
</tr>
</tbody>
</table>

Within end of life care at Royal Derby Hospital, there was a staffing level of 98.1% from November 2017 to October 2018, with a deficit of 0.9 WTE nursing staff. The staffing level was slightly higher than the level in the earlier time period, April 2017 to March 2018, of 95.1%.

Nursing staff data for Nightingale Macmillan Unit, Royal Derby Hospital

The total numbers of qualified nurses in post as of March and October 2018 are shown in the table below.

<table>
<thead>
<tr>
<th>Unit</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Nightingale Macmillan Unit</td>
<td>25.3</td>
<td>27.8</td>
</tr>
</tbody>
</table>

From November 2017 to October 2018 the annual vacancy rate for qualified nurses was 4.6%.

Over the same 12-month period the annual turnover rate for qualified nurses was 9.4%.

Over the same 12-month period the annual sickness rate for qualified nurses was 7.6%.

From November 2017 to October 2018, the trust reported that 11.1% of qualified nursing staff hours on the unit were filled by bank staff, while 0.1% were filled by agency staff. In addition,
2.1% of qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

Over the same 12-month period, the trust reported that 24.7% of non-qualified nursing staff hours on the unit were filled by bank staff, while none were filled by agency staff. In addition, 6.1% of non-qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>5,920.5</td>
<td>11.1%</td>
<td>33.0</td>
<td>0.1%</td>
<td>1,144.0</td>
<td>2.1%</td>
<td>53,430.2</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>8,086.1</td>
<td>24.7%</td>
<td>0.0</td>
<td>0.0%</td>
<td>2,003.0</td>
<td>6.1%</td>
<td>32,765.8</td>
</tr>
</tbody>
</table>

Staff on The Nightingale Macmillan Unit (NMU), said there were no significant staffing issues and patients said staff always responded in a timely manner. However, some nurses told us that when the ward was fully staffed, they could be reallocated to other wards within the trust that were not fully staffed, thereby making up the shortfall. This in-turn increased pressure on the NMU staff.

The NMU had a safe staffing board that displayed the planned and actual number of staff on duty. On the day of our inspection, we saw the unit was fully staffed.

The hospital palliative care team (HPCT) provided support, advice, training and care to patients and staff throughout the hospital. The team establishment was 7.6 (WTE) whole time equivalent nurses.

There were also 3.0 WTE end of life care facilitators providing training, education and service improvement to both hospital and community. These teams worked in collaboration with the patient’s primary care team, optimising symptom control and supporting patients to express and achieve their preferences for their care.

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 3.2% for qualified nursing staff working in end of life care. The trust had a target vacancy rate of 6%. All staff were based at Royal Derby Hospital.

**Turnover rates**

Turnover rates for nursing staff were reported within the individual directorates.

From November 2017 to October 2018, the trust reported a turnover rate of 11.9% for qualified nursing staff working in end of life care. This was within the trust’s target of having a turnover rate of between 8% and 12%. All staff were based at Royal Derby Hospital.

**Sickness rates**

Sickness rates were reported within individual directorates.

From November 2017 to October 2018, the trust reported a sickness rate of 5.8% for qualified nursing staff working in end of life care. This was higher than the trust’s target rate of 3.8%. All staff were based at Royal Derby Hospital.

Staff we spoke to did not raise any concerns about short or long-term sickness levels within
NMU.

Bank and agency staff usage

Bank and agency rates were reported within individual directorates

The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in end of life care. All hours were worked at Royal Derby Hospital.

From November 2017 to October 2018, the trust reported that 11.1% of qualified nursing hours in end of life care at Royal Derby Hospital were filled by bank staff while there were 33 hours (0.1%) of agency staff usage. In addition, 2.1% of qualified nursing hours were not filled by bank or agency staff to cover staff absence.

Over the same period, the trust reported that 24.7% of unqualified nursing staff hours at Royal Derby Hospital were filled by bank staff, while no hours for this staff group were filled by agency staff. There were 6.1% of hours that were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Agency</th>
<th>Unfilled</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
</tr>
<tr>
<td>Qualified</td>
<td>5,920.5</td>
<td>11.1%</td>
<td>33</td>
<td>0.1%</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>8,086.1</td>
<td>24.7%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>14,006.6</td>
<td>16.2%</td>
<td>33</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Staff on NMU told us they did not use agency or bank nurses very often, however at the times when they needed to request nurses or healthcare assistants through this route, they did not usually have any difficulties in filling these positions.

Medical staffing

Planned vs actual

Medical staffing rates were reported within individual directorates

The trust reported their medical staffing numbers for end of life care for March and October 2018 as below.

The number of medical staff in post at Royal Derby Hospital decreased from 5.4 whole time equivalents (WTEs) in March 2018 to 4.1 WTEs in October 2018. As a result, the fill rate fell from 107.8% to 82.4%. There was a more modest increase in the number of medical staff in post at Queen’s Hospital Burton, from 24.6 WTEs in March 2018 to 28.4 WTEs in October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>5.4</td>
<td>5.0</td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>5.4</td>
<td>5.0</td>
</tr>
</tbody>
</table>

There were 5.4 WTE consultants in palliative medicine across the hospital.
Doctors were located on The Nightingale Macmillan Unit (NMU), from 8am until 6pm.

There was an on-call consultant available out of hours to provide end of life advice for the trust. There was one palliative medicine consultant who was a central member of the hospital palliative care team (HPCT). There was an extended team of palliative care consultants who could also provide cover if needed.

Medical cover for other ward areas was through each directorate. Out of hours a hospital at night system operated with a variety of different medical and nursing specialities covering this period. Divisional medical staff had access to end of life care consultants and registrars at all times for specialist advice and support. Doctors on the ward voiced no concerns accessing specialist palliative care support

Vacancy rates

Vacancy rates were reported within the individual directorates

From November 2017 to October 2018, the trust reported a vacancy rate of 9.6% for medical staff in end of life care. The trust had a target vacancy rate of 6%.

The breakdown by site was as follows:

Royal Derby Hospital: 6.9%

Turnover rates

Turnover were reported within the individual directorates

From November 2017 to October 2018, the trust reported a turnover rate of 0% for medical staff in end of life care. The trust has a target turnover rate of 8% to 12%. All of the staff were based at Royal Derby Hospital.

Sickness rates

Sickness rates were reported within the individual directorates

From November 2017 to October 2018, the trust reported a sickness rate of 0.4% for medical staff in end of life care. This was lower than the trust’s target rate of 3.8%. All of the staff were based at Royal Derby Hospital.

Bank and locum staff usage

Bank and locum staff usage were reported within the individual directorates

The trust provided bank and locum staff usage data for medical staff in end of life care. All hours occurred at Royal Derby Hospital

From November 2017 to October 2018, the trust reported that 32 medical staff hours (0.3%) in end of life care at Royal Derby Hospital were filled by bank staff. There was no locum staff usage or hours that were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Locum Hours</th>
<th>Locum %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>32.0</td>
<td>0.3%</td>
<td>0.0</td>
<td>0.0%</td>
<td>0.0</td>
<td>0.0%</td>
<td>10425.0</td>
</tr>
</tbody>
</table>
Staff generally felt end of life care patients, especially those who had been recognised as in their last days of life were prioritised where possible, and most wards told us they had enough staff to enable them to do this.

**Records**

*Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.*

Medical and nursing notes were stored securely on all the wards we inspected. We saw risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.

Patient notes were a combination of electronic and paper records. These were separated into medical and nursing care records. Health care professionals wrote in both medical and nursing records, which were stored in cabinets in each patient bay or at the nurses’ station. These were not locked but were always visible to the nurses. Nursing records, assessments and care plans were kept at the bedside.

We reviewed the medical and nursing notes for ten patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.

All the records we viewed included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the hospital palliative care team (HPCT) information and advice was clearly recorded so that staff could easily access the guidance given.

We saw evidence, when attending a multidisciplinary meeting; the hospital palliative care team (HPCT) were reviewing records of patients who were at the end of life. The hospital palliative care team reviewed the records of their patients daily to gain information on the patient's condition.

During our inspection, we saw the trust was using individualised care plans for end of life care patients. The individualised care plans replaced the Liverpool Care Pathway documentation, which was phased out in July 2015.

The end of life care medical documentation contained detailed discussion and decision making with the patient and/or family and outlined the professionals involved in the care. The document also provided guidance and flowcharts for clinicians on symptom control such as management of pain, nausea, agitation and breathlessness. The end of life medical documentation was used in conjunction with the end of life nursing documentation. This was a specialised care plan. It addressed five fundamental questions about the patient’s needs each day; their deteriorating condition; symptoms associated with dying; nutritional needs; physical needs; and capacity and consent. In addition, as part of the intentional daily rounding paperwork, the document included an evaluation chart which was completed every two hours when checks were made on the patient’s comfort, symptoms and any concerns or questions raised by the patient or family.

Within the ten sets of records we reviewed, we also found ‘Recognising Dying forms’. These forms were completed by medical staff when it was identified patients were entering their last few days of life. This form prompted medical staff to ensure the conversation had been had with relatives of the patient as well as specifying a plan of care for the patient. Out of the three forms identified, we found two forms had been completed well, with one form containing no details other than patient identifiable information.
At the time of our inspection, the trust was in the process of transferring all patient records to an electronic system. None of the staff we spoke to knew of a date when records would become completely paperless.

ReSPECT had been introduced at Derby Teaching Hospitals NHS Foundation Trust in June 2018 and trustwide, for the new organisation, in April 2019 to replace the do not attempt cardio pulmonary resuscitation policy and paperwork. These documents recorded patient’s wishes regarding escalation of care (whether they wanted to be admitted to intensive care or remain on ward level care) if their condition deteriorated, their priorities relating to end of life care (for example symptom control, preferred place of death) as well as the decision of whether they wished to be resuscitated.

On the NMU, the medical notes were stored in the doctor’s room, the nursing notes were stored in the nursing room, and the nursing assessment notes stored at the end of patient bed, however, nursing staff told us that when the patient was diagnosed as being terminally ill, the nursing assessment notes were removed from the end of the patient’s bed and kept in the nurse’s office, so as not to cause any upset to both patient and visitors should they decide to read them.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Anticipatory medicines for patients were prescribed for the five key symptoms in the dying phase. These symptoms are pain, agitation, excessive respiratory secretions, nausea and vomiting, and breathlessness. By prescribing medicines, ‘just in case’, before the patient experiences any symptoms, this allowed patients to receive effective symptom control in a timely manner.

Patients who were prescribed continuous symptom control medicines through a syringe pump had these medicines prescribed on the electronic prescribing system, however the medicines and strengths were also recorded on the syringe pump chart. This document was reviewed and countersigned by the pharmacist regularly.

The trust used an electronic prescribing and medication administration system for all patients in all ward areas. We reviewed the electronic record for ten patients who had been identified as being in the last days of life and found all medications, including anticipatory medications had been prescribed appropriately and strengths and frequencies were regularly reviewed. We also reviewed the documents of three other end of life patients who had been admitted into hospital for pain management and found evidence of appropriate prescribing of analgesia (pain relief) which was regularly reviewed by medical staff and the HPCT.

There were appropriate systems for the safe custody and checking of controlled drugs and syringe drivers. We saw on the wards we inspected that all medicines were stored safely and the record keeping was in line with the trust’s policy. We found controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013.

On the wards we visited, there were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care.

Patients and their relatives were regularly informed about medication changes or when new medications were added to treatment regimes. Staff also told us, all medications were explained to the patient and their relatives on discharge from the hospital. Medication information was included.
on the discharge summary for patients, which GPs received an electronic copy of immediately on the patient’s discharge.

**Incidents**

*The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.*

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for University Hospitals of Derby and Burton NHS Foundation Trust is included in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From January to December 2018, the trust reported no incidents classified as never events within end of life care.

**Breakdown of serious incidents reported to STEIS**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for University Hospitals of Derby and Burton NHS Foundation Trust is included in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care at Royal Derby Hospital which met the reporting criteria set by NHS England from December 2017 to November 2018.

The hospital palliative care team (HPCT) were familiar with the process for reporting incidents, near misses and accidents using the trust electronic incident reporting system. The HPCT understood their responsibilities to raise concerns and report incidents and near misses. Any serious incidents would be investigated using root cause analysis and where necessary further training would be arranged. We didn’t see any evidence that there had been any serious incidents within end of life care that had required a root cause analysis.

Mortality and morbidity meetings took place monthly. This supported the trusts learning from the deaths review process.

All staff we spoke with had a good understanding of Duty of Candour. Staff talked of being open and honest when things went wrong. Staff were not able to give example of where Duty of Candour had been applied, as they could not remember a time when an incident had occurred requiring a response under Duty of Candour.
The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

**Safety thermometer**

The NHS safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline, is intended to focus attention on patient harms and their elimination, for example, at the nurse’s handover or during ward rounds. The NHS safety thermometer helps teams in a wide range of settings, from acute wards to a patient’s own home, to measure, assess, learn and improve the safety of the care they provide.

Safety information and performance was displayed in the ward areas including hand hygiene, infection control and patient feedback.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

End of life care at Royal Derby Hospital followed the National Institute for Health and Care Excellence (NICE) Quality Standards relating to best practice in end of life care for adults. However, the hospital did not comply with Statement 10 of those standards: People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night’ as, the hospital palliative care team did not provide a seven-day face-to-face service.

Following the withdrawal of the Liverpool Care Pathway, the trust had developed and implemented individualised care plans for patients on the end of life care pathway. The individualised care plans recognised the five priorities for end of life care as set out by the Leadership Alliance for the Care of Dying People (2014). Staff were using the trust’s end of life-individualised care plans consistently where patients had been identified as end of life to ensure they received evidence based end of life care.

The trust was using the AMBER care bundle throughout the hospital wards to support the identification of patients with an uncertain recovery. This approach encourages staff, patients and families to continue with treatment in the hope of a recovery; while talking openly about people’s wishes and putting plans in place should the worst happen.

Data collected from a sample of patients referred to the HPCT from 1st January 2018 to 30th June 2018 showed the majority (75%) of patients were seen by the SPCT were seen within 24hrs with 37% of patients reviewed on the same day as referral to HPCT. A small number of patients (16%) were not seen face to face until two or three days after referral. There were documented reasons for this – mainly that a patient was referred on a Friday afternoon.

Staff were clear about how to undertake a referral to the hospital palliative care team (HPCT). They told us the usual referral system for seeking hospital palliative care team input was by completing an electronic referral form. However, if they had any urgent referrals or requests, they would contact the team through the teams secretary.
After attending a meeting with the HPCT, we observed one of the HPCT nurses review a referral on the electronic system and discuss its contents with a colleague.

Referrals to the HPCT were mostly made electronically, however, the HPCT told us that some staff phoned through their referrals and some staff referred patients both electronically and by phone.

The trust had implemented the use of electronic icons to alert the palliative care team and end of life facilitators to patients at the end of life, supported by the amber care bundle or known to HPCT.

The service had an extensive audit programme which included audits on the use of the AMBER Care Bundle, pain and the preferred place of care or death

**Nutrition and hydration**

*Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences,*

All patients were risk assessed for their nutritional needs on admission using a recognised tool (Malnutrition Universal Screening Tool). The results of this risk assessment then prompted staff on further actions to take, for example whether the patient was referred for dietetic support.

Patients considered to be in the last days of life were assessed on an individual basis for oral or clinically assisted hydration.

Protected meals times were in place on all the wards we visited and the NMU. We observed all end of life care patients had access to drinks, which were within their reach. All the care records we reviewed, showed staff had supported and advised patients who were identified as being at nutritional risk and those patients approaching the end of their life.

Where patients were unable to eat due to their ill health, we saw that care plans were in place for staff to monitor their food and nutrition.

We saw evidence on the intentional rounding chart that nurses regularly offered patients drinks. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental health, medication, nutrition and care needs.

The relatives we spoke with said the food was good or satisfactory and that there were plenty of drinks available.

End of life care patients could have any food from the menu including the children’s menu. This was to take account of reduced appetites and changing eating habits.

A green tray system was in use on the NMU. If a patient was identified as needing assistance with their nutrition and hydration, a green tray would be allocated to them to alert staff to the patients’ needs.

Nutrition and hydration status for end of life care patients who were identified to be within the last days of life was regularly reviewed during the intentional rounding. Within this document, there were specific checks which staff were required to complete. If patients could eat and drink, they would be regularly offered provisions and where necessary, help would be given to eat and drink. If patients were not able to eat and drink due to their medical condition, mouthcare would be performed.
Staff on NMU, told us they would do whatever was possible to provide the food of choice for patients.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

On all the wards and the NMU, staff considered pain relief for end of life care patients to be a priority and where needed, they sought guidance and input from the hospital palliative care team.

Staff demonstrated an awareness of symptom control and the use of anticipatory medication. They told us everyone who was recognised as being at the end of life were prescribed anticipatory medication. (Medication that patients may need to take to make them more comfortable).

Patients within end of life care had their pain control reviewed daily or more often as was needed. Regular analgesia was prescribed in addition to ‘when required medication’ (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief. These actions were compliant with NICE Guidance CG140 Palliative care for adults, strong opioids for pain relief, states patients should have access to frequent review of their pain control.

We saw examples in the records of pain control managed with anticipatory medication. Drugs were administered by a syringe pump where the oral route had become inappropriate and symptoms become continuous.

Pain relief was reviewed for effectiveness and changes were made as appropriate to meet the needs of individual patients.

Patients told us staff had discussed pain relief with them and they understood what they were taking and the effect the medicine would have.

Staff confirmed syringe pumps were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief.

Medical and nursing staff told us they would refer patients with complex pain management needs to the hospital palliative care team (HPCT). Additionally, there was a trust wide pain team which could be contacted for advice.

All the clinical nurse specialists within the hospital palliative care team were non–medical prescribers. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional’s field of expertise.

The trust used the Pain Assessment in Advanced Dementia (PAINAD) to aid communication for patients with a dementia, sensory loss or had communication needs and are judged to potentially be in pain. The PAINAD assessment tool is designed to be used with both nonverbal and verbal patients.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
The trust audited patients preferred place of care or death for end of life care patient. The trust Preferred place of care (PPOC) audit was taken from a sample of patients seen by the Hospital Palliative Care Team (HPCT) from 1st March 2018 – 30 September 2018 A sample of 66 patient’s notes were reviewed. In this sample, 96% of patients could identify their PPOC. Of these, 85% achieved their PPOC; this is compared with 68% in 2016 and 80% in 2017.

The hospital palliative care team contributed data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the purpose of providing a precise representation of specialist palliative care service activity. The MDS data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS allows trusts to benchmark against a national agreed data set.

The trust took part in the National Care of the Dying Audit 2016. A new audit was currently being undertaken, there were therefore no up-to-date results at the time of our inspection. Internal audits such as the preferred place of care had been carried out since the audit.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

The trust set a target of 90% for the completion of non-medical staff appraisals. They noted that the medical staff appraisal target is set at 100% by the General Medical Council for those who are due an appraisal within a year (this does not include staff on long-term sick leave, end of life care leave or a sabbatical of greater than six months)

**Trust Wide**

From November 2017 to October 2018, 83.3% of staff within end of life care at the trust received an appraisal.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff - hospital</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical staff</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>46</td>
<td>52</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services staff</td>
<td>15</td>
<td>20</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical staff</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and ancillary staff</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
<td><strong>96</strong></td>
<td>83.3%</td>
<td></td>
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</tr>
</tbody>
</table>

Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. However, qualified nurses had an appraisal rate of 88.5% which was just below the 90% target

**Royal Derby Hospital**
From November 2017 to October 2018, 82.8% of required staff within end of life care at Royal Derby Hospital received an appraisal. This included five medical staff members who worked across the Royal Derby Hospital and London Road Community Hospital sites.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff - hospital</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical staff</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>46</td>
<td>52</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical staff</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services staff</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and ancillary staff</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>93</td>
<td>82.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. However, qualified nurses had an appraisal rate of 88.5% which was just below the 90% target.

Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. All qualified nursing, medical and health care support workers we spoke with confirmed they had received a meaningful appraisal within the past year. Appraisal dates were aligned to staff increment dates.

All members of the hospital palliative care team told us they had received a meaningful appraisal within the previous twelve months.

End of life care was not part of the trust mandatory training programme. However, there was an on-going end of life education programme, provided by the end of life team and supported by the HPCT, to equip staff throughout the hospital with the skills and knowledge required to provide care to patients at the end of their lives.

Education and training on palliative and end of life care was provided across the trust by the end of life team and supported by the HPCT, both in the form of planned teaching in the trust’s education centre and ad-hoc sessions to wards.

Staff received training through e-learning as well as face to face teaching. Staff were positive about the training they received, they told us they had received in-depth training in end of life care and felt they were competent to undertake their work within the service. There was a range of developmental training available and staff told us they had been supported by the trust with their continuing professional development.

The HPCT provided ‘shadowing’ opportunities for staff. This allowed more inexperienced staff to work alongside a member of the HPCT to develop their own skills and knowledge.

Palliative care link nurses from the wards, met for a discussion group every three month to update their knowledge and understanding of new practice.

On each ward we inspected, we saw they had an end of life care resource box, which included information on end of life care, offering staff information on where they could obtain additional support or advice and details of symptom management.
Staff also had access through the trust’s intranet to the Derbyshire Alliance for End of Life toolkit. The toolkit had been developed within the local region and provided a substantial resource of relevant, evidence based, current information on planning and delivering care for people in their last months, weeks and days of life.

New staff attended an induction programme which included end of life care. Porters received training by way of shadowing more experienced staff around end of life care and transporting deceased patients to the mortuary.

**Seven-day services**

The hospital palliative care team (HPCT) consisted of 7.6 full time (WTE) whole time equivalent staff. This allowed the team to provide cover seven days a week. The specialist palliative care nurses provided a service between 08:30 and 4:30.

There was a dedicated advice line, held by trust staff for out of hours support.

There was a consultant in specialist palliative medicine on call 24 hours a day seven day a week. The on-call consultant was contactable through the hospital switchboard.

Physiotherapists and occupational therapists provided prearranged assessments and care to patients throughout the hospital during the weekdays. At weekends there was an on-call system in place for urgent physiotherapy treatment.

End of life care was provided by general nurses and medical staff on the wards and NMU throughout the hospital seven days a week and 24 hours a day.

The chaplaincy service provided pastoral and spiritual support and was contactable out of hours. The mortuary provided a 24-hour, seven day a week service to the trust and to the coroners office.

Bereavement services were open Monday to Fridays from 08:30am until 4:30pm except Bank Holidays. An out of hours service was available for cases at the discretion and availability of the staff on duty.

The hospital worked with local authority social care with regards to funding assessing and securing ongoing care and the patients’ needs on discharge from the hospital such as equipment and adaptations to their home environment.

An out of hours viewing service was provided by the mortuary for cases at the discretion and availability of the staff on duty.

**Health promotion**

Staff supported patients who were end of life or receiving palliative care to maintain healthy choices and healthy lifestyles. Information about healthy diets was given to all patients. There were specialist nurses and other allied health professionals to support patients. For example, occupational therapists and dietitians were involved in promoting healthy lifestyles for patients.

On the wards we saw that nutrition and hydration posters were clearly visible for patients and displayed information on how to undertake a healthy diet.

On the Nursing Macmillan Unit (NMU) there was a complimentary therapy suite which provided a range of complimentary therapy services for patients. For example, reflexology, aromatherapy, hypnotherapy and relaxation.
NMU provided a drinks trolley which contained both alcoholic and non-alcoholic drinks. Additionally, there was patients smoking room, these both provided patients with mental, emotional and spiritual health promotion.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff did not assess whether a patient had the capacity to make decisions about their care in relation to do not attempt resuscitation orders. They did however, follow the trust policy and procedures when a patient could not give consent.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust’s mandatory training data show all qualified nursing and medical staff in end of life care trust wide.

Staff at the trust were eligible for a single combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training module, with a completion target of 75%. This requirement was inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided these services.

Compliance for this module for the period from November 2017 to October 2018 level for qualified nursing staff in end of life care at the trust is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards</td>
<td>60</td>
<td>63</td>
<td>95.2%</td>
<td>75%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 75% target was met for qualified nursing staff in end of life care at the trust.

Over the same period there were four members of medical staff in end of life care that were eligible for this training module. All four had completed the module.

We saw one palliative care patient deprived of their liberty during this inspection. We observed one of the doctors undertake the mental capacity and deprivation of liberty safeguards paperwork and discuss these with a member of the safeguarding team on the phone to seek further advice on the procedure and process. When we later reviewed the paperwork, we saw it had been undertaken correctly and in detail.

Mental capacity assessments were included as part of the last days of life care plan for end of life care patients. Patients and relatives told us and we saw staff did not provide any care without first asking their permission. Signed consent forms were evident in all the patient records we examined.

Nursing and medical staff told us they had received training on the Mental Capacity Act and how to complete mental capacity assessments.

ReSPECT forms were stored in the front of the patients’ notes. the DNACPR section had a red border so were easily identifiable and accessible.

During our inspection, we looked at 15 ‘Do Not Attempt Cardio Pulmonary Resuscitation’
(DNACPR) orders across the hospital, and found there were inconsistencies in how these were completed. We found that out of 15 DNACPR orders we looked at, ten were completed correctly, (65%) and were those on the nightingale macmillan unit. Five that were not completed correctly (33 %) were on the wards throughout the hospital and had not included documented evidence that mental capacity assessments had been carried out prior to completion of the DNACPR form completion.

The Mental Capacity Act 2005 first and main principle is that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that an assumption must not be made that someone cannot decide for themselves just because they have a particular medical condition or disability.

This meant the trust were not adhering to the principles of The Mental Capacity Act 2005. The trust did not currently audit the mental capacity assessments. This meant that any training needs may not be identified on a formal basis and any changes in legislation or guidance on best practice might not be identified and implemented.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed consistently throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008). Staff spoke about the patients they cared for with compassion, dignity and respect. Without exception we observed patients being treated with compassion, dignity and respect. All the relatives we spoke to told us staff treated their loved ones respectfully and their privacy was also respected.

The trust had a bereavement service and we saw staff providing support for relatives, following the death of a patient.

The Chaplain assisted nursing staff to ensure that care and treatment was provided to patients with due regard to their religious persuasion. We saw staff seeking advice from the chaplain during our inspection.

We observed the mortuary porters treating the deceased with the greatest of respect when transferring them from the ward to the mortuary. The process was dignified and compassionate. They left the concealment trolley on the landing outside of the ward until the curtains could be drawn around the patient’s beds and then removed the deceased in a quiet and dignified manner which promoted both dignity and privacy to the deceased and ward patients.

Within the Nightingale Macmillan Unit (NMU) we observed staff interacting with patients in a caring and respectful manner. We observed staff speaking with patients and providing care and support in a kind, calm, friendly, dignified and patient manner. We observed that privacy and confidentiality was maintained throughout their admission. For example, we observed staff drawing curtains around patients when providing personal care, and we saw that staff ensured that any confidential conversations were completed in rooms away from other patients and relatives on the ward.

We observed staff were consistently dedicated to ensuring all patients were treated with dignity, both before and after death. We observed that staff ensured they found out about patient wishes
and respected these always. For example, staff told us about a patient who regularly visited the unit who liked to bring in their own handmade throw over to put on the bed, as it made it less like a hospital. We spoke with the patient and their partner later that day and observed the throw over on the bed. The patient told us, “It feels more like home and less like a hospital with the throw over, which helps me feel calmer”

Staff went above and beyond to ensure care they gave to their patients was individualised and met their expectations. For example, we spoke with one family in a side room and their dog. The patient told us they had recently been admitted to the unit and was feeling lonely as they missed their dog, who was “part of the family”. They mentioned this to one of the nurses who advised them that each time their family visited, the dog could accompany them. The patient told us “I feel so much better knowing my dog is here and really appreciate the nurses letting me bring him in”

On a different ward, staff told us about a patient who was due to get married but this had been abandoned due to their advancing condition and difficulty in achieving appropriate symptom management, this had distressed the patient considerably. Staff arranged for the patient to have their wedding on the ward instead.

We saw staff using the ‘celebration boxes’, to support end of life care patients with personal services. ‘Celebration boxes’ were boxes with resources to facilitate occasions such as weddings. These were shared across the hospital.

All the patients and relatives we spoke with were exceptionally positive about the care and treatment they had received from ward staff and the hospital palliative care team (HPCT). One patient told us “the staff are simply outstanding”. The relative of a patient who was identified as being within the last days of life told us “staff were excellent”

In the Intensive Care Unit (ICU) we saw staff using homemade blankets which had been knitted by volunteers for end of life care patients beds, this provided patients with more homely surrounding and was an example of staff going that extra mile to support compassionate care.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Family members we spoke with told us they felt involved in the care delivered. We saw staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient’s notes.

Guidance literature was available for patients and their relatives. We saw staff supporting patients and relatives by going through this booklet with them. It included information about end of life and what they might expect to happen. There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life which we saw staff encouraging relative to use. Staff provided opportunities for relative to ask questions following the reading of this information.

The trust had a chaplaincy service which could cater for several different faiths. Dedicated places of worship were available for different faiths next to the chaplaincy offices in the hospital.

Support for care givers, family and friends were provided by the chaplaincy and bereavement services.

Although not licensed to conduct weddings for end of life care patients, the chaplaincy team could facilitate weddings with a community registrar within four hours of a referral for an end of life care patient and their partner.
The chaplaincy liaised with local faith leaders to ensure deceased patients were cared for following their cultural and religious requirements.

The NMU had its own dedicated chaplain and multi-faith chapel

Volunteers from the chaplaincy service, sat with end of life care patients as required.

The viewing of deceased patients was carried out in a dedicated area in the mortuary divided into a waiting room and two viewing rooms.

‘Memory boxes’ were available in critical care for the parents of children who had died, as well as adults. In addition, memory boxes could be accessed through the end of life team and the bereavement service at Queens Hospital Burton.

The memory boxes included several different items, including a teddy bear and a blanket. Inside each memory box. The Chaplain worked with the bereavement midwife to ensure good end of life care for both the babies and parents of babies who had died

There were no services performed in the multi-faith centre. The chaplain visited the wards to determine which patients would like to have a service at their bedside.

All the people we spoke with told us they felt emotionally supported by all the staff involved in their care.

There were spiritual well-being care plans in some NMU patient notes that stressed the beliefs and needs of the patient.

Arrangements for viewing could be made directly with the mortuary staff by the ward or department staff concerned and by relatives when appropriate. This ensured that a time could be agreed for the viewing to take place and was normally between 8.30 am and 4.30 pm Monday to Friday. Mortuary staff told us every effort was made to ensure the viewing room was arranged sensitively. The viewing room was non-denominational with no religious articles although these were available if required depending on the individual’s religious beliefs.

A dedicated telephone line was available in office hours for relatives to ring if this was required to arrange a viewing. Mortuary staff were available to escort families and provide sensitive support when viewing their loved ones.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Staff told us they ensured they were always available to provide the required emotional support for end of life care patients and their families. Some staff had completed additional training which enabled them to further understand the requirements of patients and their families who were not just end of life, but within the last days of life. One relative we spoke with told us staff were always coming into the room to ensure both the patient and they were ok and offered any assistance and support they wanted.

Family members and relatives told us they felt involved in the care delivered. We saw that staff discussed care issues with patients and relatives where possible and these were generally, clearly documented in patient’s notes.

Guidance literature was available for patients and their relatives. This included a booklet about the
end of life and what they might expect to happen. There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life.

Mortuary staff understood where religious needs required a prompt burial and worked to facilitate this.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The hospital palliative care team (HPCT) provided three outpatients clinics to offer treatment for patients being cared for by the team.

The end of life team and lead nurse attended the Derbyshire Alliance for End of Life Care regional group and an end of life implementation meeting whose purpose was to improve end of life care across the local area. For example, current care and plans across Derbyshire were discussed with the community and external bodies such as the Southern Derbyshire Clinical Commissioning Group, Derbyshire County Council and local hospices.

The end of life team and lead nurse told us that they met regularly with the Southern Derbyshire Clinical Commissioning Group and worked together to plan end of life services.

The bereavement officer provided a responsive service to bereaved families and provided further advice as required. For example, the service gave an information folder to the relatives of the deceased. The pack included information about burials, post-mortems, stopping junk mail to the deceased and contained all the essential paperwork required. Inside the folder was a small brown ‘Forget me not’ envelope. On the front of the envelope were the words “I may not be with you. You may miss me dear. Plant these forget me nots. I will always be here”. Inside the envelope there were forget me not seeds to be planted in memory of the loved one who had died.

The bereavement office was committed to the needs of the local people both the deceased and the living. For example, they were made aware last year of a 95-year-war veteran who had died in the hospital without any family or friends. The Bereavement office contacted the local regimental group, to see if any relatives could be found. After an appeal was put out by the regimental group, over 200 people attended the war veteran’s funeral, where the service was conducted with full military honours. The local paper reporting “There was standing room only at the funeral service”.

The bereavement office understood how certain religions required patients were buried as soon as possible after death. In such circumstances, they tried to ensure that all the relevant paperwork was completed as soon as possible to issue the death certificate and release the body within the appropriate time. The mortuary had a ‘release of bodies’ policy document which included a section detailing the process for the early release of the deceased out of normal working hours to comply with the wishes of families whose faiths required quick funerals.

Staff provided ‘Carers comfort packs’ for families of patients if they had to stay in hospital unexpectedly to be with relatives who were approaching the end of their lives. These included items such as toothpaste, toothbrush, comb, soap, a discounted voucher for the hospital restaurant and other essentials. Staff would support families by having open visiting and the use of a camp bed, should family members wish to stay overnight. Staff said they made regular
drinks for families and made sure they had enough to eat. In addition, the packs contained free car parking, restaurant vouchers, leaflets giving information on "what to expect when someone is dying", maps of the hospitals, an information sheet on "pop-up bedrooms", and the volunteer "sitting service", and a follow-up contact card for relatives to ask any questions they may have regarding their loved one's care.

In the intensive care unit (ICU), there were three separate self-contained apartments for relatives to stay free of charge. Each apartment had a bed, sofa, television and coffee and tea making facilities. Relatives could live in the apartments for as long as their loved one was in the intensive care unit.

The nurses from the HPCT sent sympathy cards to bereaved relatives of patients for whom they had cared for and made follow up telephone calls to families to offer any further support that they could. In addition, some specialties for example, renal, respiratory, the coronary care unit and critical care sent sympathy cards to bereaved relatives. The HPCT also made follow-up telephone calls.

The mortuary manager ran regular ‘mortuary tour’, for both staff and stakeholders such as the police and the fire brigade. The mortuary tour involved a full tour of the mortuary and the observation of a post-mortem by consent of the coroner. We saw number of very positive feedback sheets stating how, interesting post mortems were and how much the mortuary tour had taught people.

The mortuary had a ‘release of bodies’ policy document which included a section detailing the process for the early release of the deceased out of normal working hours to comply with the wishes of families whose faiths required quick funerals.

End of life patients were predominantly cared for on the wards not the Nightingale Macmillan Unit (NMU) (90% on wards). NMU was a specialist palliative care unit. Staff told us they always tried to admit end of life care patients into a side room, however patients with infection prevention and control risks took priority.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The trust achieved the implementation of "One Chance to get it right" outlined in The Leadership Alliance for the Care of Dying People 2014, by the introduction of "Priorities for Care through the Essential to Role training and education programme" and the "Trust Approach to End of Life Care" including the "Birds Model". The “Birds Model" comprises recognising dying forms endorsed by the patient’s consultant, when staff identified when a patient was potentially in the last hours/days of life. The form allowed staff to consider a person’s views and preference for care, whilst regularly reviewing and responding to change in plan of care. Whilst this is not mandated, the trust consider this best practice.

The model also included a personalised care plan for the last days of life based on Priorities for Care of the Dying Person (LACDP 2014). The care plan was used in conjunction with an intentional rounding chart used to record hourly interventions.

The “Birds Model" provided support for careers through a carers comfort pack, available in 6 other languages. The pack detailed information for families on what might happen when someone is in the last few days of their life. In addition to this, the trust provided a carers diary, a non-nursing document to aid communication between families and ward staff.

Patients were discussed at the weekly hospital palliative care multidisciplinary team meetings.
We observed a multidisciplinary meeting, where relevant professionals were involved in the assessment, planning and delivery of patient care. We observed all patients and their families and care givers were discussed. Discussions included all aspects of pain and symptom control, as well as all aspects of care relevant to the end of life care pathway such as discharge planning and psychological needs.

Patients were approaching the end of their life were supported to make informed choices about their care. This was part of their personalised care plan.

The NMU had its own secluded garden. The garden had electric plugs situated in several places in the garden. These were for immobile patients who were nursed on pressure relieving mattress who could be brought out on their beds and the mattresses could be plugged into the electricity.

There was a day room with a television, books and games; free Wi-Fi; a courtyard garden; a spiritual room; and a smoking room for patients to use.

There was a special vegetable patch in the garden where patients and loved ones were encouraged to plant vegetables supplied by the NMU.

Staff told us that at Christmas, they arranged for reindeer to visit the NMU garden for patients to see.

Two complimentary therapists provided therapy for inpatients at either the patient’s bedside or within the complimentary therapy room on NMU depending on the patient’s mobility. The therapies offered included massage, aromatherapy, reflexology, hypnotherapy, Reiki and Indian head massage.

The ward had an ‘alcohol trolley’ which patients were welcome to whilst admitted. Staff were aware many patients had their traditions and routines which included an alcoholic beverage and did not want to restrict them from this whilst admitted. The trolley was locked away whilst not in use, and staff would adapt their practices if they had patients admitted on the ward with illnesses related to alcoholism.

The NMU had its own private multi-faith room and for patients and loved ones and relatives to attend if they wished to. There was a chaplain assigned specifically to the NMU.

The emergency department had a treatment room next to the resuscitation area that was especially designed as a viewing room. It provided a private area where relatives and friends could be alone with the deceased before leaving the department. There were two doors to the room, which meant that relatives and friends could leave without going back to the resuscitation area.

At the back of the emergency department there was a ward where patients were admitted while they waited to be transferred to a ward in the main hospital. Part of the ward was a side room especially designed for end of life care patients. The ward had carer comfort packs for the care givers, whilst they were on the ward.

If patients were suitable they could participate in the Tai Chi group run by the physiotherapists, or receive hydrotherapy sessions, to help relieve pain and promote relaxation.

The trust had a “pop up bedrooms” scheme, which is an initiative to enhance the environment of the end of life care patients room. This consisted of a screen which was pulled across the wall with an image that can be used to transform the room from a hospital into a ‘softer place. For example, there could be projected onto the screen a field of poppies, or a bluebell wood or a bench in a park.
There was a relative’s room on every ward where more sensitive conversations could be undertaken. Normal visiting times were waived for relatives of patients who were at their end of life.

At the time of our inspection, we saw the trust were in the process of building a bereavement garden. The garden contained sculptures of various animals which had been commissioned by the trust. Once the bereavement garden was finished, the trust intended to invite relatives of those who had died at the hospital back three times per year to plant bulbs in memory of their loved ones.

There was a translation service available throughout the hospital.

**Access and flow**

*People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.*

Records showed evidence of patients being reviewed by the HPCT within 12 hours, some of which were seen within eight hours. Patients who required ongoing support by the HPCT were usually seen on a regular basis (every two to three days) unless the condition of the patient required more regular input. Staff on the wards were extremely positive about the input they received from the team.

Referrals were undertaken to the HPCT electronically, by phone or using both systems. If referrals were received by phone, normally in urgent cases, all information was logged by the specialist nurse on to the electronic system. For example, we saw three urgent cases that had been referred and logged by a member of the HPCT during our inspection.

The trust had a rapid discharge pathway in place. This is where patients, who were rapidly deteriorating and wanted to go to their preferred last place of care or death could do so quickly.

Where a patient had a rapidly deteriorating condition and may be entering a terminal phase, an application could be made on their behalf and with consent for the NHS to fund their care (Fast Track Pathway for NHS Continuing Health Care funding). The purpose of this pathway was to expedite care provision in the setting of the patient’s choice. However, staff told us that some discharges were delayed by the lack of provision of equipment such as a hospital bed, which were ordered by the district nursing service, or the lack of a care package in the community or nursing home bed. This could happen especially at weekends or out of hours.

Nursing staff told us fast track discharges usually took up to 48 hours to arrange but in some cases, this could take longer. Fast track discharge is a process implemented for patients identified to be within the last days of life and who had a preferred place of death outside of the hospital.

The trust audited their fast track discharges. Over an 18-week period September to December 2018 data for n=204 patients Fast Tracks discharge was reviewed across Royal Derby Hospital (Fig 4).

**Fig 4**

<table>
<thead>
<tr>
<th>Average Age</th>
<th>LOS</th>
<th>LOS before FT decision</th>
<th>FT Process</th>
<th>Home</th>
<th>N/H</th>
<th>CH</th>
<th>EB</th>
<th>Readmission</th>
<th>Survival</th>
</tr>
</thead>
</table>

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<th>Average Age</th>
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<th>FT Process</th>
<th>Home</th>
<th>N/H</th>
<th>CH</th>
<th>EB</th>
<th>Readmission</th>
<th>Survival</th>
</tr>
</thead>
</table>

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The audit data for this quarter revealed a reduction in length of stay from baseline data of 6 days (from 22 days to 16 days) and a reduction in admission to clinical decision to Fast Track by 2 days (from 15 days to 13 days) and the Fast Track process time has reduced from 7 days to 3 days.

Within the “Birds model” rapid discharge was available for patients in the last hours of their lives and whose preference is to spend their last hours at home.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff. However, the trust took an average 45 days to investigate two recent complaints, against the trust complaints policy of 25 days.

**Summary of complaints**

**Trust level**

From October 2017 to September 2018 there were three complaints about end of life care services, which represented 0.4% of the complaints across all services trust wide. All three of these complaints related to end of life care at Royal Derby Hospital.

The trust took an average of 45 working days to investigate and close two of the complaints. This is not in line with their complaints policy, which states complaints should be resolved within 25 working days.

The one complaint still open at the time of reporting had been open for 38 working days. This was also not in line with the policy statement that complaints should be resolved within 25 working days.

The subjects of the complaints are shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Proportion of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Number of compliments made to the trust**

From October 2017 to September 2018 there were 11 compliments within end of life care.

The breakdown by site is shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>7</td>
<td>63.6%</td>
</tr>
<tr>
<td>Queens Hospital Burton</td>
<td>4</td>
<td>36.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
The trust had an up-to-date complaints policy. The policy was available for staff to access on the trust intranet. The policy and procedure provided guidance and standards for the handling of complaints.

Information on how to raise a concern or make a complaint was available in the wards we visited. On each ward we saw a poster ‘Making your moment matter’. These were posters signposting people with complaints or compliments to PALS

Patients and relatives told us they would feel comfortable raising a complaint with ward or the Patient Advice and Liaison Service (PALS)

In the NMU Inpatient Care leaflet there was information about how to share views regarding NMU and how to complain via the trusts patient advice and liaison service.

Staff were informed about the outcome of complaints and incidents within their area of practice. Staff told us that if a patient or relative had concerns about care being delivered they would try and address the issue at the time to resolve the concerns as quickly as possible.

We saw informal complaints received by NMU were discussed at the monthly unit meeting. Compliments and complaints were also shared with staff through the ward staff information board.

NMU had several thank you cards on the ward from patients and loved ones.

Any lessons learned from complaints were highlighted in the report produced by the investigating manager handling the complaint. This information was then shared with the clinical team leaders at the governance meetings.

**Is the service well-led?**

**Leadership**

**Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care**

On 1 July 2018 Derby Teaching Hospitals NHS Foundation Trust acquired Burton Hospitals NHS Foundation Trust. This meant that all priorities for ensuring sustainable, compassionate, inclusive and effective leadership and succession planning were currently being reviewed to amalgamate into a trust wide strategy.

Leaders had the skills, knowledge, experience and integrity that they needed to run the end of life care service. Managers felt supported by the executive team and their own management team.

Challenges to quality and sustainability within the end of life care service were recognised and understood by leaders which included, an executive and non-executive director (NED) for end of life care at board level. This meant the provider had designated persons at board level to champion the strategic direction of end of life care within the organisation.

The delivery of end of life care on the wards was led by registered nurses. A team of nurses and doctors specialising in palliative care, assessed patients in hospital and supported the ward teams in providing palliative care. In addition, The Nightingale Macmillan Unit (NMU), a specialist palliative care inpatient unit, had 21 beds for people living with an incurable and progressive illness.
Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

At the time of our inspection, the trust had an end of life care vision and strategy called “You have only one chance to get it right” the strategy document included the development of end of life care pathways in line with guidance and recommendations from the National Gold Standards Framework in End of Life Care and NICE guidelines.

There were several strategic objectives, for example

- To raise awareness of the approach to end of life care at the trust and to be aware of how this approach can be applied to end of life care for patients in the acute setting
- To fully implement the ReSPECT paperwork.
- Further progress the AMBER care bundle
- Develop the individualised care plans, based on the priorities for care of the dying person, using the nursing process of assess, plan implement and evaluate
- Earlier discharge to the preferred place of care with less avoidable readmission for the patient
- Improved discussions about end of life care between patients, families and the healthcare team.

The hospital palliative care team were knowledgeable about the strategy document and staff were generally able to articulate the overall vision for end of life care at the trust, as ‘Improving end of life care for all patients, involve families and care givers and improve communication and decision making’.

At Royal Derby Hospital wards and departments had information displayed on dedicated boards for staff to refer to concerning the birds model for end of life care, which was also the picture on the front of the strategy. The picture used to identify end of life care patients. We saw the picture discreetly placed on patient’s side rooms on the wards.

The trust was part of Dying Matters campaign, which is a coalition led by the National Council for Palliative Care. It supports changing knowledge, attitudes and behaviour towards death, and aims to make living and dying well the norm.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff throughout the trust, spoke with passion about their work and were proud of what they did. There was a culture of openness flexibility and willingness among all the staff we met.

There was a strong patient centred culture throughout the service. Patient stories were used in team meetings and at meetings of the board, so staff could reflect on what could be improved or share good practice. Staff said using patient stories helped them to focus on why they do job and ensure the patient was at the heart of everything they did.

Staff reported positive working relationships, and we observed that staff were respectful towards each other. All staff said they felt confident to raise concerns with their managers.
The trust had a nominated freedom to speak up guardian (FTSUG) who encouraged and enabled staff to speak up safely within the workplace.

Senior staff were knowledgeable about The Duty of Candour process.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

On 1 July 2018 Derby Teaching Hospitals NHS Foundation Trust acquired Burton Hospitals NHS Foundation Trust. This meant that all priorities for ensuring sustainable, inclusive and effective governance were currently being reviewed.

Palliative and end of life care was part of the division for medicine and cancer at the trust. Governance for end of life care was part of the integrated governance structure. There were clear lines of accountability including a structure for cascading information to the senior management team and back down to staff delivering care. For example, the end of life care team had weekly meetings, this then fed into the end of life operation group which met bi-monthly, which in turn fed into the end of life programme board which reported to trust board.

The trust had good multidisciplinary working relationships with the local hospice who had previously provided out of hours support for patients at the end of their lives and advice for the trust staff. All out of hours support was now provided in-house on rotation by palliative medicine consultants for the trust.

Representatives from local hospices took part in the end of life care steering group meetings. In addition

The trust were central members of the Derbyshire alliance for end of life care, which is a toolkit designed collaboratively by professionals who work across Derbyshire for end of life care to help teams plan and deliver care for people in their last months, weeks and days of life.

New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. All the staff involved with the provision of end of life care, could demonstrate they received regular communication from the board, heads of service and team leaders. This meant there were clear lines of accountability including a structure for cascading information to the senior management team and back down to staff delivering care, and that staff could keep up to date with current practice and national guidance.

There was an extensive number of policies and procedures available each stating the roles and responsibilities of staff within the organisation. Staff could access these documents through the intranet. All the documents we reviewed were up to date and relevant to service delivery, but were in the process of being reviewed, due to the recent acquisition of a neighbouring trust.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, And coping with both the expected and unexpected.
Governance arrangements were in place for risk management and staff told us that they received feedback after incidents had been investigated. Staff also felt confident that incidents led to learning and changes being made.

Managers were aware of the risk pertinent to end of life care, most of which were captured as part of the divisional risk registers. Risks were aligned. Managers told us the use of the RESPECT documentation was on the risk register, this was because work was required to embed that training which had only recently commenced. We requested the risk register following our inspection but did not see this risk specifically for end of life care. The end of life care risk register included Patients at NMU are at risk of not receiving their prescribed medication, in the form of a syringe driver, within an acceptable time frame when the syringe drivers are supplied late from pharmacy. We did not see this occurring during our inspection.

The hospital palliative care team (HPCT) had regular team meetings where issues, potential risks and general communications were discussed. However, the hospital palliative care team did not undertake any audits of the quality of care they provided.

There was a trust end of life steering group meeting which met every two months, the chair of the group was a member of the patient experience committee to help provide governance and accountability of patient and public feedback regarding end of life care.

There were monthly ward assurance audits to highlight compliance with clinical risk assessments, for example pain and resuscitation status, these were reported into the divisions and action plans created on the back of poor compliance. End of life care was not formally captured although basic care tasks associated with end of life care were captured as part of each ward score card.

Mortality meetings took place monthly, where staff discussed patient deaths within end of life care. The meetings identified the circumstances of the patient the diagnosis and prognosis the initial and follow-up care and treatment they had received and the circumstances of the death. Palliative care staff took part in mortality and morbidity reviews to offer advice on whether better care could have been provided for patients who had died in the hospital.

Policies and procedures were available, each stating the roles and responsibilities of staff within the organisation. Staff could access these documents through the intranet.

We saw a process for “End of life care ward accreditation” to ward. This accreditation was awarded to wards who had completed the trust ward accreditation programme which included aspects such as, end of life care training and communication skills.

In 2018, the mortuary had a new cold room installed with the room for 20 extra bodies in case of a major incident.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Information governance training was mandatory for all staff. Trust policies and procedures were available for all staff and accessible via the trust intranet. Information about end of life and palliative care patients were discussed, at the HPCT daily huddle, handover and multidisciplinary meetings.

The trust used an electronic software system which had information on all end of life care patients. This meant the identification of known patients and their specific needs were identified daily.
Referrals to the HPCT were undertaken on an electronic system, or if urgent, by phone. The trust had recently implemented the use a new electronic system which enabled the tracking and location of all end of life care patients. This meant the identification of known patients and their specific needs were identified daily.

GP’s made referrals for palliative and end of life care patients using into the trust using an electronic referral system. There were sufficient computer terminals on the wards to enable staff to access the trust’s intranet and external internet information.

Patient confidentiality arrangements were in place, for example, on all the wards we inspected we saw medical records were stored in a locked trolley or kept in a secure area where staff were working.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The emergency department wrote to families of patients who had died in the department two weeks after the death. They offered their condolences and extended the opportunity to speak with the bereavement care team, either by telephone or in person and supply a feedback form.

The service undertook an annual bereavement survey and identified areas of improvement needed where the responses were negative. Information from the bereavement services questionnaire was discussed during end of life steering and operational group meetings and used to reinforce positive action and improve services.

End of life and palliative care was provided on The Nightingale Macmillan Unit (NMU) and general wards throughout the hospital. All wards we visited had at least one end of life care champion who had received additional training in end of life and palliative care. They acted as a local source of information and advice for any other staff members caring for end of life or palliative care patients.

The trust was involved in the wider community and were members of the Derbyshire wide strategy group and was also a member of the Derbyshire Alliance for end of life care; this group coordinates education across the county and the Derbyshire end of life toolkit

The bereavement team provided an information pack to bereaved families, within this pack there were several different information leaflets, on different subjects for example to do with the death of their loved one. For example, how to organise a funeral and help and advice on bereavement. Sometimes relatives of the deceased would contact the team to find out more information about how their relative died. The bereavement team would arrange for the medical notes to be delivered and if required a consultant and matron to meet with the family.

There were end of life care link nurses at Bands 4, 5, 6 and 7 on all wards, including the intensive therapy unit.

The trust was part of the Dying Matters campaign which is a national campaign and encourages people to talk about dying, death and bereavement and to have those uncomfortable discussions.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
The trust had a “pop up bedrooms” scheme, which is an initiative to enhance the environment of the end of life care patients room. This consisted of a screen which was pulled across the wall with an image that can be used to transform the room from a hospital into a ‘softer place. For example, there could be projected onto the screen a field of poppies, or a bluebell wood or a bench in a park.

The hospital palliative care team had previously developed a training DVD with examples of end of life discussions between patients, relatives and health care professionals, to accentuate the importance of good communication.

The trust was part of the ‘pyjama paralysis’ campaign to get people up, dressed and moving whilst in hospital. The campaign aims to give patients back one million days of their time that would otherwise be wasted in bed.

The approach taken by Royal Derby Hospital to implement the AMBER care bundle is one of the case studies reported in the Transform programme 'Route to Success' handbook.
Acute services Queens Hospital

Urgent and emergency care

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1st July 2018 following the acquisition by Derby Teaching Hospitals NHS Foundation Trust of Burton Hospitals NHS Foundation Trust. The former acquired the latter under its existing registration with the CQC. Our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Details of emergency departments and other urgent and emergency care services

- Royal Derby Hospital emergency department
- Queen’s Hospital Burton emergency department
- Minor injuries unit, Sir Robert Peel Community Hospital, Tamworth
- Minor injuries unit, Samuel Johnson Community Hospital, Lichfield

Both the trust’s emergency departments are open 24 hours a day, seven days a week.

Queen’s Hospital Burton emergency department includes an acute assessment centre, ambulatory emergency care centre, minor injuries area and paediatric assessment room. Average attendances through the Emergency Department are 200 patients.

(Source: Routine Provider Information Request (RPIR) – Sites tab Acute RPIR - Context tab)

Queen’s Hospital Burton is a large district general hospital located in Burton -upon- Trent. The urgent and emergency services consist of the emergency department (ED) an acute assessment centre (AAC) and an Ambulatory Emergency Care (AEC) unit.

The ED has two triage rooms, 12 major cubicles, five minor cubicles, two ‘fit to sit’ rooms, a plaster cubicle, three resus bays, three rapid assessment and treatment (RAT) cubicles (pit stop), one waiting room and a relative’s quiet room.

AEC is open Monday to Friday, 10am to 8pm and has six clinic rooms and a seated area. The AAC area has 6 inpatient beds that are managed by the emergency department consultants. However, these can be increased dependent on patient need.

Queen’s Hospital Burton emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.
Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospitals of Derby and Burton NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018

The chart above includes data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust. From August 2017 to July 2018 there were 144,613 attendances at the trust’s emergency departments as indicated in the chart above.

(Source: Hospital Episode Statistics)

Total number of urgent and emergency care attendances at Burton Hospitals NHS Foundation Trust compared to all acute trusts in England, August 2017 to June 2018

The chart above shows urgent and emergency care attendances data for the pre-acquisition period for Burton Hospitals NHS Foundation Trust. From August 2017 to June 2018 there were 117,721 attendances at the trust’s urgent and emergency care services as indicated in the chart.
Urgent and emergency care attendances resulting in an admission at Derby Teaching Hospital

The chart above shows data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust. As the data cover periods prior to the acquisition, the data above relates to attendances at Derby Teaching Hospital only.

The percentage of A&E attendances at this hospital that resulted in an admission remained similar in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission at Burton Hospitals NHS Foundation Trust
The chart above shows data from the pre-acquisition period for Burton Hospitals NHS Foundation Trust’s urgent and emergency care services.

The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2017/18 compared to 2016/17. In both years, the proportions were similar to the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method at Burton Hospitals NHS Foundation Trust, from August 2017 to July 2018

- Admitted to hospital: 18,767
- Discharged*: 84,71
- Referred*: 11,500
- Transferred to other provider: 1,917
- Died in department: 77
- Left department#: 662
- Other: 81
- Not known

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.

Queen’s Hospital Burton emergency department

Staff at Queen’s Hospital Burton had a mandatory training completion target of 90% for all mandatory training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in the emergency department at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>93</td>
<td>93</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Food safety</td>
<td>93</td>
<td>93</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>92</td>
<td>93</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>91</td>
<td>93</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion theory (nursing)</td>
<td>90</td>
<td>92</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Departmental induction</td>
<td>90</td>
<td>93</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient handling online</td>
<td>89</td>
<td>93</td>
<td>95.7%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>89</td>
<td>93</td>
<td>95.7%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion competency (administration)</td>
<td>152</td>
<td>160</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>88</td>
<td>93</td>
<td>94.6%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>87</td>
<td>93</td>
<td>93.5%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Information governance</td>
<td>87</td>
<td>93</td>
<td>93.5%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Infection control 2</td>
<td>84</td>
<td>93</td>
<td>90.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Blood transfusion competency (collection)</td>
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<td>92</td>
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<td>90%</td>
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<tr>
<td>Basic life support</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>79</td>
<td>93</td>
<td>84.9%</td>
<td>90%</td>
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<td></td>
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<tr>
<td>Training module</td>
<td>Number trained</td>
<td>Number eligible</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met Yes / No</td>
<td></td>
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<tr>
<td>Trust induction</td>
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<td>90%</td>
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<tr>
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<td>24</td>
<td>29</td>
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<td>90%</td>
<td>No</td>
<td></td>
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<tr>
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<td>82.6%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Fire lecture (full evacuation)</td>
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<td>79.3%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Conflict resolution</td>
<td>23</td>
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<td>90%</td>
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</tr>
<tr>
<td>Blood transfusion theory (doctors)</td>
<td>23</td>
<td>29</td>
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<td>90%</td>
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<tr>
<td>Doctors manual handling awareness</td>
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<td>29</td>
<td>69.0%</td>
<td>90%</td>
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<tr>
<td>Equality and diversity</td>
<td>20</td>
<td>29</td>
<td>69.0%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Immediate life support</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
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<tr>
<td>European paediatric advanced life support</td>
<td>8</td>
<td>12</td>
<td>66.7%</td>
<td>90%</td>
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<tr>
<td>Adverse incident reporting</td>
<td>19</td>
<td>29</td>
<td>65.5%</td>
<td>90%</td>
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<tr>
<td>Information governance</td>
<td>19</td>
<td>29</td>
<td>65.5%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Basic life support</td>
<td>15</td>
<td>24</td>
<td>62.5%</td>
<td>90%</td>
<td>No</td>
<td></td>
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<tr>
<td>Infection control 2</td>
<td>18</td>
<td>29</td>
<td>62.1%</td>
<td>90%</td>
<td>No</td>
<td></td>
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<tr>
<td>Paediatric basic life support</td>
<td>7</td>
<td>15</td>
<td>46.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 93.1% for qualified nursing staff in Queen’s Hospital Burton emergency department. The trust’s mandatory training targets were met for 14 of the 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in the emergency department at Queen’s Hospital Burton is shown below:

The trust had an overall training completion rate of 74.8% for medical staff at Queen’s Hospital Burton emergency department. The trust’s mandatory training targets were met for two of the 17 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The service provided mandatory training in key skills to all staff. However, they did not and make sure everyone completed it.

Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff through mandatory training. Mandatory training subjects included for
example, fire safety, moving and handling, basic life support, safeguarding vulnerable adults and safeguarding children. Mandatory training was delivered face-to-face and through an online learning management system.

The Trust mandatory target was 90% compliance, at the end of October 2018, it stood at 74.8% for medical staff. We spoke with the department leads who told us of increased medical staff training figures. The figures provided post inspection had increased slightly but did not reach the trust target for compliance in more than three modules.

However, during our inspection mandatory training for medical staff was added to the department risk register in order that this would be closely monitored until the senior team were satisfied with the completion rate.

All nursing staff we spoke with and we reviewed evidence they were released for mandatory training and were up to date. Nursing staff mandatory training compliance was linked to pay progression and access to further accredited training courses. Staff told us this encouraged completion in a timely manner.

The emergency department practice development lead reported training compliance rates quarterly at the clinical effectiveness meeting. They sent out dates of all training to nursing staff and regular email reminders to individual staff who were not up to date with mandatory training. They supported staff and conducted peer reviews for handwashing and aseptic non-touch technique competency assessments.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Prevent Duty training was mandatory for staff and included in both children and adults safeguarding training. The aim of Prevent is to give staff an awareness and knowledge of what extremism and radicalisation are and how people may be drawn into terrorism.

Safeguarding children standards produced by the Royal College of Emergency Medicine (RCEM) were met in the emergency department (ED); medical and nursing staff had been trained to an appropriate level and staff told us they had good, 24-hour, access to a senior paediatrician and/or senior consultant within the ED for any child welfare issues.

The lead ED consultant was the deputy chair of trust paediatric safeguarding group. Policies, procedures, protocols and frameworks relating to safeguarding were in place and readily available to staff. Staff we spoke with had a good understanding of safeguarding and could describe the actions they would take if they suspected a patient required safeguarding.

There were processes in place for the identification and management of people at risk of abuse (including domestic violence). We reviewed 15 patient assessments and could identify within the electronic assessment record that children and adults had been considered against a vulnerability criterion. Staff were not able to progress through the electronic record before completing the vulnerability/safeguarding screen. This then changed colour according to the response. Further assessment and referral guidelines were then available within the document.

The ED had the NHS Digital Child Protection Information Sharing System (CP-IS) in place. CP-IS allows health and social care staff to share information securely to protect vulnerable children.

Systems were in place for recording and reporting suspected female genital mutilation (FGM). Staff received training as part of their children and adults safeguarding training and demonstrated
to us a good understanding of FGM and could describe the actions they would take if they suspected FGM had taken place. FGM is defined as the partial or total removal of the female external genitalia for non-medical reasons.

The service had identified nurses as safeguarding link nurses, supported by the safeguarding nurse for the trust. They also had trained nurses to be safeguarding champions.

There were up-to-date safeguarding policies and procedures in place, which were accessible to staff through the trust’s intranet site, all of which were in line with local and national guidance and in date. Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise. This included how to make a safeguarding referral, contact details and all forms needed. Link nurses supported staff to make safeguarding referral where appropriate.

Staff we spoke with could explain how they would respond to a safeguarding concern and knew how to access further information and support. They knew who the safeguarding link nurses were and stated they felt confident raising concerns and asking for support.

During our inspection we saw appropriate information about specific safeguarding cases was shared with staff. We saw nurses making each other aware of safeguarding issues in the handover between nursing staff.

Appropriate arrangements were in place to enable a patient assessed to be at risk of suicide or self-harm to remain safe. Staff used an ‘Emergency Department Adult Mental Health Risk Assessment Form’ designed to help staff consider the risk to the patient of self-harm or suicide and referred to the mental health liaison and/or crisis teams where required.

The trust had policies and procedures in place for extra observation or supervision, restraint and, if needed, rapid tranquilisation and these were easily accessible to staff. All nursing and medical staff we spoke with were aware of the policy for Section 136 detentions. (Section 136 is an emergency power which allows you to be taken to a place of safety from a public place, if a police officer considers that you are suffering from mental illness and in need of immediate care). We were told that usually there was a physical reason for admission, so section 136 detention was not usually required.

**Safeguarding training completion rates**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall safeguarding training figures for the whole trust.

**Queen’s Hospital Burton emergency department**

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all safeguarding training modules.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in the emergency department at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent awareness</td>
<td>91</td>
<td>93</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>90</td>
<td>93</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Basic safeguarding adults | 90 | 93 | 96.8% | 90% | Yes
---|---|---|---|---|---
Child protection 2 | 89 | 93 | 95.7% | 90% | Yes
Child protection 1 | 89 | 93 | 95.7% | 90% | Yes
Child protection 3 | 53 | 60 | 88.3% | 90% | No

The trust had an overall safeguarding training completion rate of 95.6% for qualified nursing staff in Queen’s Hospital Burton emergency department. The trust’s mandatory training targets were met for five of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in the emergency department at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 1</td>
<td>22</td>
<td>29</td>
<td>75.9%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Basic safeguarding adults</td>
<td>21</td>
<td>29</td>
<td>72.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>20</td>
<td>29</td>
<td>69.0%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Adult protection awareness</td>
<td>19</td>
<td>29</td>
<td>65.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>10</td>
<td>16</td>
<td>62.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>18</td>
<td>29</td>
<td>62.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 68.3% for qualified medical staff in Queen’s Hospital Burton emergency department. The trust’s mandatory training targets were not met for any of the six safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Clinical staff working with children, young people and/or their parents received training at level 3, in line with national guidance. This training included an awareness of Child Sexual Exploitation (CSE), modern day slavery and female genital mutilation (FGM) and outlined responsibilities for reporting and referring cases identified. The trust had an FGM guideline to support staff with this. However, the trust’s mandatory training targets were not met for any of the six safeguarding training modules for which medical staff were eligible. During our inspection safeguarding training for medical staff was added to the department risk register in order that this would be closely monitored until the senior team were satisfied with the completion rate.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The Care Quality Commission (CQC) uses national surveys to find out about the experiences of people who use NHS services. As part of the CQC emergency department survey (October 2017), questionnaires were sent to people who had used emergency department services Between October 2016 and March 2017. Responses were received from 277 patients at this trust. The trust scored ‘about the same’ as other trusts for describing the department as clean.

Standards of cleanliness and hygiene were monitored and maintained through local cleaning and hand hygiene audits, staff training and trust wide infection prevention and control policies and procedures.
Most areas of the emergency department and the emergency ambulatory care unit were well presented and visibly clean and tidy. This included clinical areas, corridors, toilet facilities, offices and storage areas. Housekeeping staff were seen in ED during the 24-hour period. Staff generally kept the equipment clean and cleaning schedules were present in each area and completed. However, we did identify some items of equipment that despite evidence of checking were still dusty. This was addressed in the department immediately it was raised.

Hand cleansing gel was available at points throughout the departments for use by staff, patients and relatives and staff were ‘bare below the elbow’ to allow effective hand washing. We observed staff washing their hands between patients in line with the five moments of hand hygiene. Sinks were equipped with liquid soap, paper towels and a pedal bin to reduce cross infection.

Hand hygiene audits were undertaken to measure compliance with the World Health Organisation’s (WHO) ‘5 Moments for Hand Hygiene’. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Information provided by the trust showed infection control audits including hand hygiene were between 95-100 %.

Personal protective equipment (PPE) for example gloves and aprons, were available and we observed staff using the equipment appropriately. We also observed infection prevention procedures were undertaken for patients requiring vascular access, for example to take blood samples or receive intravenous fluids.

We witnessed staff clean cubicles thoroughly between each patient to reduce cross infection.

There were effective systems and processes in place for the segregation and management of clinical and non-clinical waste. Sharps bins were readily available for staff to use. Sharps bins adhered to British standards, were dated appropriately, free from protruding needles and stored safely above floor level. Disposable curtains used in the department were clearly dated and changed routinely every six months.

Specific cubicles were available for patients who had been identified as having an infection or who required isolation for some other reason, for example patients admitted who were very susceptible to an infection for example receiving chemotherapy. During our inspection we observed a patient being nursed in isolation in one of the cubicles.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The department was remodelled in 2017/18 and mostly complied with Health Building Note 15-01: Accident & emergency departments 2013. For example, two entrances to an emergency department, CCTV was provided in accordance with current regulations, assessment/treatment rooms with all-round patient access were provided for the assessment and treatment of patients and there was unimpeded access to the resuscitation area from the ambulance entrance that avoided the main waiting area. However, neither entrance had a canopied drop-off zone to offer protection from adverse weather for patients being transferred from ambulances.

The ED had two triage rooms, 12 major cubicles, five minor cubicles, two ‘fit to sit’ rooms, a plaster cubicle, three resus bays, three rapid assessment and treatment (RAT) cubicles (pit stop), one waiting room and a quiet relatives room. The location of the ED was within a suitable distance of necessary supporting services for example, theatres, computed tomography (CT), and x-ray.

The adult and children’s emergency areas were located together, ensuring equal access to all services, but audio and visually separated from each other. Patients accessed the department through three potential routes. Self-presenting patients through the reception area, ambulance pre-alerts through the majors’ entrance and all other ambulance patients through the pit stop area.
The department had undergone a recent refurbishment to enable disabled access and implement clear signage. Patients and staff commented on what a great improvement it was.

Patients admitted through the reception area were booked in by reception staff. There was a notice which advised patients to allow others to book in and to await their turn. Reception staff told us they would always take patients to one side for a discussion if they did not want to disclose information at the reception desk.

Sufficient seating was available with open space for wheelchairs as required. During our inspection we did not see the area full to capacity, however a queue of patients waiting for booking in, did occur on five separate occasions due to availability of only one receptionist. Whilst there are two in the department one works in the patient reception and one in the ambulance pitstop reception. To facilitate staff meal breaks the pit stop receptionist covered the main reception this led to queues in reception as ambulance crews took priority for booking in their patients over the waiting self-presenting patients.

Once booked in patients were advised to sit and wait for the triage nurse to call them for further assessment. There were two triage rooms with access through from reception to minors. Patients were called through mostly on a first come first served basis. Staff told us they would review the patient list prior to calling patients in if there were more than two or three patients waiting. However, as there was no direct line of sight between the patients in the waiting room and the clinical staff we were concerned that a deteriorating patient could be missed. We raised this with the senior management team during our inspection. Immediate action was taken to source triage room doors that allowed clinical staff to see into the waiting room. Prior to the well led inspection we were informed the trust were still investigating this and in the interim, had reminded staff in triage that they should regularly observe patients in the waiting area.

Adult patients in the waiting area had access to a television to watch. However, there was no information board or screen indicating how long they may wait to be seen or who oversaw the department. Staff told us the screen had only worked for one week in six months. We raised this with the trust during our inspection and were informed it would be repaired.

The children's area of the waiting room was separated from the adult area by a wall and monitored by closed circuit television (CCTV). ED provided toys and a play area for younger children in the waiting area to keep them amused. A baby changing facility had also been provided. However, there were no games or distraction items for teenage or younger adults in the department. There was a television but this was for use by the whole waiting room so was unlikely to aid reduction in anxiety levels. The seating in all waiting areas was in good condition.

A bay in the minors' assessment area was separated and decorated specifically for children to be assessed away from the adults. This enabled timely triage and movement through the department into either resus for stabilisation or for review in the paediatric assessment unit within the children's department. Minimising further distress from waiting in a busy ED.

Majors contained 12 spaces including one room which could be used for patients requiring barrier nursing or a more peaceful environment. To make this space less clinical staff had recently arranged for it to be re-decorated.

The resus area contained four bays; three for adults and one specifically designed for children. The pit stop area was the smallest area and staff reported that on occasions it did become full. However, during our inspection it did not become overcrowded. Ambulance patients were accepted by clinical staff and taken into one of three cubicles for assessment and triage before streaming into one of the other areas.

Most treatment areas were spacious and there was a calm atmosphere. This had a positive impact on patients.

The ambulatory emergency care unit (AEC) had six clinic rooms available and a central seating area (four chairs), if required for patients awaiting blood test results or awaiting assessment in a room. All rooms were stocked with oxygen cylinders and consumables stored according to
national guidance. An office for staff and a patient toilet were also available. The area had its own resuscitation trolley which had been checked daily and was easily accessible to staff.

A dedicated room within the AEC for undertaking psychiatric assessments was safe. The push button alarm was located on the wall and was a strip alarm going around the room as per current guidance. A strip alarm allows staff to access it to summon assistance at any point in the room. Staff did not carry personal alarms but staff we spoke with were very aware of personal safety and would sit near the door. The two-way doors could not be barricaded and were fitted with frosted glass to ensure privacy and dignity. All other cubicles had access to an alarm for patients to summon staff if needed. The layout of this room complied with the standards set out in the College of Emergency Medicine’s (2013) ‘Mental health in emergency departments’.

The room was ligature free and the staff within the department had assessed other ligature risks. For example, toilets contained anti-ligature alarm cords and collapsible curtain rails were in all curtained areas. Ligature cutters were available on all four resuscitation trolleys. All staff we spoke with were aware they were kept in the top drawer of the trolley. Regular checks were made of cutters as part of daily environmental checks undertaken by the nurse in charge of the department.

Adjacent to the AEC area was also the acute assessment unit (AAC). This unit had beds made available to ED for patients whose stay was expected to be less than 24 hours. This area was medically covered by the ED consultant and nursed by the medicine nursing team.

For children or younger people admitted with a mental health illness, there were bays in the children’s ED where they could be observed initially before admission to the PAU.

Appropriate resuscitation equipment for adults and children was available in the resus area. In addition, a difficult airway trolley (DAT) was available in majors and a further adult resuscitation trolley. Whilst these were fully equipped and mostly checked regularly the bougies were not stored correctly. In three out of four cases they were misshapen and the sterile packaging was damaged. This was immediately highlighted with staff and rectified. Matron discussed sourcing a container to hang them on the side of the trolley to prevent future damage. (A bougie is a thin, flexible surgical instrument for exploring or dilating a passage of the body usually an airway).

Medical equipment in all areas was recorded on a database with maintenance schedules in line with manufacturer’s instructions. We looked at 25 items of equipment at random and found them all in date except the blood gas analyser which should have been serviced in August 2018. This was reported and action was taken during our inspection. Engineers were available to check and repair equipment where required.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Systems were in place for assessing all patients arriving in the emergency department to determine how quickly they should be reviewed. This included a clear streaming/triage process for both ambulance arrivals and walk-in patients.

The hospital had an emergency department risk assessment tool. This was an electronic tool that calculated the risk of the department and rated it as either red, amber or green. Staff inputted data hourly, and the tool calculated the level of risk. This gave an ‘at a glance’ look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where the risk was.

These risks were reviewed and discussed at bed meetings. These were held according to capacity within the hospital. During our inspection the trust were in the highest capacity plan which meant bed meetings were held two hourly from 8am until 8pm to facilitate staffing changes and movement of patients throughout the hospital. Ordinarily, bed meetings were held at 8.30am, 12 noon, 2pm, 4pm and 6pm.
During the meeting there was a discussion about an emergency department risk assessment tool used to determine how busy the hospital was. The live ED tracker stated the hospital was on ‘amber’ although it was known ED was on ‘red’. This difference was discussed at the meetings as the staff perception of the feel of the ED and what was happening at any one time was seen as the most accurate representation of how the department was running.

Clinical handovers were held separately for medical and nursing staff morning and evening. Safety ‘huddles’ for all staff were held at three hourly intervals throughout the 24-hour period. The meetings were to ensure medical and nursing staff were aware of the status of patients in their care, treatment plans and next steps to be taken to ensure continuity of safe care, thereby reducing risk.

A live electronic feed from the local ambulance trusts informed the emergency department on the arrival times of ambulances due into the department. If a seriously ill patient was being conveyed to the hospital, ED was advised prior to their arrival and could prepare in a timely way.

Sepsis Six Care Bundle posters were in all areas of the departments to remind staff of their responsibilities and what they should do. The Sepsis Six Care Bundle is an initial resuscitation bundle designed to ensure basic intervention is given within the first hour including administration of IV antibiotics. There is strong evidence that the prompt delivery of basic aspects of care detailed in the Sepsis Six Care Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions. Sepsis is a life-threatening condition that arises when the body’s response to infection injures its own tissues and organs and action is required quickly. In documents, (quality board minutes September 2018), received from the trust prior to or inspection in relation to the Sepsis Care Bundle it was stated that Queens Hospital Burton (QHB) was more aligned to the national standard than the Royal Derby Hospital.

The trust had a plan for maintaining audit of sepsis including audit, 10 patients/month for Sepsis Screening, 15 patients/month for antibiotic administration and 10 patients/month against the full Sepsis 6 care bundle. Training was also to continue with development of an online sepsis training package (e-learning) for medical staff and continuing education for the teicoplanin PGD and the use of the Co-Amoxiclav PGD. We received Emergency Admission Areas Sepsis Screening audit results for the trust from April 2018 - December 2018 which showed 100% compliance. This was in line with evidence we gathered on inspection.

On admission, adult patients were assessed using the NEWS2 scoring system which included a baseline assessment to determine and monitor the severity of the patient’s condition. The score determined the degree of illness of a patient and was based on a number of vital signs including respiratory rate, oxygen saturation level, blood pressure and heart rate. The score was highlighted on the initial assessment with a sticker according to the patients’ risk of sepsis. We reviewed eight charts three of which identified the patient as red flagged for sepsis by use of a red sticker. Each of these three patients were given a full sepsis screen and received antibiotics within the hour. This information was also cross referenced on the hospital electronic system.

Patients brought into the department by ambulance were brought into the ‘pit-stop’ area until 10pm. Our observations throughout the inspection showed the handover from ambulance staff to pit-stop staff was smooth and generally quick. ED staff did a full set of observations on all patients once handed over; they did not rely on ambulance staff observations for on-going care. They also documented which ambulance trust had conveyed the patient in case of any concerns or discrepancies later that they may need to review.

Ambulance staff from both local NHS trusts told us they felt supported and listened to by both medical and nursing staff on conveying a patient to ED especially in resus.

Patients brought in by ambulance were handed over to hospital staff either in the ‘pitstop’ area or in resuscitation, dependent upon how sick they were. We observed full handovers from ambulance
crews undertaken in a professional and timely manner. We did not witness any patients returning to ambulances because the department could not accommodate them.

We specifically followed five patients from ambulance to initial assessment and treatment. All patients had their observations recorded on the NEWS2 chart within 10 minutes of entry into the department. According to the score we witnessed them being appropriately triaged and moved to different areas of the department. Three were assessed and treated in pitstop all within 45 minutes of arrival. One patient with breathing difficulties was initially assessed and transferred into resus. The fifth patient was admitted at 11:53. The initial observation documented a NEWS of 8, by 12:38 the team had completed a full sepsis screen including first dose of antibiotics. This patient was transferred to a medical bed within 75 minutes of leaving the ambulance.

If a patient had deteriorated during their journey or was deteriorating as they arrived at ED this was communicated by the ambulance crews to the ED pit stop co-ordinator who would respond to the information appropriately and prioritise them for urgent attention.

During the week of our inspection (28 January 2019 to 3 February 2019) information received from one of the local NHS ambulance trusts showed average daily ambulance handover times from ambulance staff to ED staff ranged from 17 minutes 41 seconds to 27 minutes 29 seconds which was above the standard of 15 minutes. However, during our inspection we followed five handovers which all took place within 13 minutes.

The unit used the Manchester triage tool for assessing patients throughout the department. Experienced nurses were on duty on each shift to triage patients who self-presented in the department. All children were triaged by a children's nurse and pain levels were assessed during this process.

The minor injuries area mostly operated using a ‘see and treat’ system. This meant patients were seen directly by the emergency nurse practitioner treating them who completed the episode of care, without further triage or assessment.

This system required that safeguards were in place to ensure that patients who required immediate attention were not waiting for longer than one hour to be seen. If the wait is longer than this, the Royal College of Emergency Medicine standard requires that patients should have an assessment by a clinician (Initial assessment of Emergency Department patients, 2017).

Patients presenting at the minor injuries area were initially booked in by receptionists without clinical training. The receptionists had a first contact protocol which listed circumstances when they must immediately alert nursing staff. Reception staff could quickly alert the triage nurses on duty if a patient deteriorated or was admitted with one of a list of higher risk complaints/illnesses. We observed this process as a patient was sent by a GP for review due to potential anaphylaxis. The receptionist used a buzzer located at the desk to summon assistance. The nurse arrived immediately and escorted the patient into the pitstop area and treated the patient appropriately. The receptionist we spoke with confirmed that the immediate response from the clinical team was “how it always was”.

The first contact protocol provided a list of 16 symptoms and conditions for receptionists to look out for. These included any breathing difficulties, chest pain, uncontrolled bleeding and severe pain. The protocol instructed reception staff to inform a member of staff for any patient that was a concern and not to be afraid to interrupt a nurse seeing another patient.

All children up to the age of 12 months old must be seen by a member of nursing staff within 15 minutes of arrival, regardless of the reason they were attending. During our inspection we reviewed medical notes of eight children specifically in relation to arrival time and all eight children were seen within 15 minutes.
The Royal College of Emergency Medicine (RCEM) ‘Initial assessment of emergency department patients’ suggests a detailed triage assessment should be made within 15 minutes of the patient’s arrival. We reviewed the ED records for 15 patients (13 adults and two children) admitted by the front door of the department. Time from arrival to triage varied between 0 and 60 minutes. Our review of records showed four patients waited 15 minutes or less, four patients waited between 15 and 30 minutes and seven patients waited between 30 and 60 minutes. All patient records had a triage time recorded.

Staff knew the assessment and streaming/triage processes and the whole department, although at times very busy, appeared calm with staff in control. Staff were trained and assessed prior to being on triaging duties. During our inspection one triage room was being run by an emergency nurse practitioner and one by a registered nurse with triage competencies. This meant that the registered nurse was not able to complete the full patient pathway to discharge. As a result, patients seen by a registered non ENP nurse could expect to spend longer in the department as after triage they had to wait to have treatment and medications prescribed by an ENP or doctor. The senior team were aware of this and were working towards using ENP’s in each triage room. This would increase the see and treat patients and improve timely discharge if appropriate. We witnessed four patients streamed through the ENP treated within an hour and one patient with the registered nurse have an initial triage and then an hour wait to see an ENP for treatment.

In the paediatric emergency area, the nurse in charge was paediatric trained all other nurses in the ED were adult nurses who had undertaken in-house additional training to care for children. Children were assessed using the PEWS (paediatric early warning score). Discussions were in place to align this assessment with the Royal Derby Hospital as they use a paediatric observation priority score (POPS). POPS was a bespoke emergency and urgent care checklist which quickly scores (between 0 and 16) acutely ill children on a combination of physiological, behavioural and risk identifiers using easy to collect data with an assessment of pain being experienced by the child. This enables staff to assess, prioritise and treat acutely ill children and manage risk in busy clinical areas.

Paediatric early warning scores were also used to identify children whose condition was deteriorating. We observed staff who assessed children listen to the child’s version of events and not just their parents when this was appropriate. Staff told us any child or adult who scored highly would require screening for sepsis.

Clearly labelled sepsis trolleys, containing amongst other items, syringes, blood bottles, intravenous (IV) fluids and antibiotics, were available in both adult and paediatric areas so treatment could be instigated quickly. However, during our inspection there was no evidence that the sepsis trolley was checked daily, so we were not assured it was always ready for use. We discussed this with the senior team who planned to implement a checking process immediately.

Processes were in place for staff to follow in the event of a sudden unexpected death of a baby or child in the department. Support was available when required. At the end of each shift a debriefing period was included in the handover in order that each member of staff had the opportunity to come to terms with anything that had concerned them during the day. This could include an aggressive, violent or traumatic incident that occurred in the department or something that was particularly upsetting for a single member of staff.

Two psychiatric liaison teams staffed by mental health trained nurses were available to the emergency department 24 hours a day to support patients admitted with mental health problems and the staff caring for them. One covered the hours from 8am to 2pm and the crisis mental health team covered 2pm to 8am. We reviewed one patient requiring intervention by the team who received care in a timely manner. Staff informed us the teams were very approachable. However, as referrals were not accepted until the patient was medically fit this could lead to long delays in patients receiving a mental health review.
The emergency department took responsibility for venous thromboembolism risk assessments of patients with lower limb fractures or injuries and patients admitted to the short stay unit. Venous thromboembolism or VTE is a condition in which a blood clot forms, most often in the deep veins of the leg, it can travel in the circulation, lodging in the lungs (known as pulmonary embolism or PE). A VTE clinic was also run in the AEC. Staff described this as a great service allowing for same day assessment and treatment of patients.

Staff who arranged for a patient’s transfer to a ward from ED were required to complete a patient transfer form which clearly identified the patient and the receiving ward. In addition, information regarding their situation, background and assessment were documented with recent observations taken. The form was completed/signed by a nurse or doctor and a nurse on the receiving ward. This ensured that risks to the safety of the patient were minimised on transfer.

Doctors across the emergency department held board rounds at 8am, 2pm and 10pm which was when junior medical staff commenced a shift. This meant all medical staff were aware of the status of patients in their care, treatment plans and next steps to be taken to ensure continuity of safe care.

At the time of our inspection the ED had arrangements in place to provide a place of safety. The term ‘place of safety’ is used in the Mental Health Act 1983. Section 136 of the Act gives police officers the power to remove an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a ‘place of safety’ where they may be assessed by a doctor. However, plans submitted by the trust to refurbish the relative’s room were in place and awaiting commissioner approval. In addition, the ED was fully compliant with the pathway requirements for Section 136 as a result of the Policing and Crime Act (2017).

Local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures were in place and had been assessed against all invasive procedures carried out in the department.

**Emergency Department Survey 2016**

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

In the CQC Emergency Department Survey, the trust scored about the same as other trusts for all five questions in the Emergency Department Survey 2016 relevant to assessing and responding to patient risk.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the</td>
<td>8.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?  9.7  About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Median time from arrival to initial assessment (emergency ambulance cases only)

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

The median time from arrival to initial assessment was consistently better than the overall England median from November 2017 to June 2018.

In June 2018 the trust’s median time to initial assessment was three minutes compared to the England average of seven minutes.

Ambulance – Time to initial assessment from November 2017 to October 2018 at Burton Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Queen’s Hospital Burton

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

From December 2017 to November 2018 there was an overall stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Queen’s Hospital Burton.

In November 2018, 46.4% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - Queen’s Hospital Burton
Information received following our inspection showed ambulance handover times had not significantly improved since November 2018. Percentage of journeys with turnaround times over 30 minutes were 58% in December 2018, 56% in January 2019 and 47% in February 2019.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

**Queen’s Hospital Burton**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

From November 2017 to October 2018, the hospital reported 93 “black breaches”. The majority of these, 76, occurred during the winter of 2017/18, from November 2017 to February 2018.
All breaches were described by the trust as being due to “access and capacity” issues.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

During our inspection there were no black breaches reported.

**Nurse staffing**

**Planned vs actual**

The trust reported their staffing numbers for qualified nursing staff working in urgent and emergency care as below as of March 2018 and October 2018.

There was a small increase in the number of qualified nursing staff in post at Royal Derby Hospital in October 2018 compared to the number in post in March 2018. The number of qualified nursing staff in post at Queen’s Hospital Burton was similar in March 2018 and October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>139.5</td>
<td>147.2</td>
</tr>
<tr>
<td>Queen's Hospital Burton</td>
<td>89.6</td>
<td>99.4</td>
</tr>
<tr>
<td>Total staff</td>
<td>229.1</td>
<td>246.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 10.7% for qualified nursing staff working in urgent and emergency care. The trust had a target vacancy rate of 6%. The breakdown by site was as follows:

- Royal Derby Hospital: 8.5%
- Queen’s Hospital Burton: 14.1%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 10.6% for qualified nursing staff working in urgent and emergency care. This was within the trust’s turnover target of between 8% and 12%.

The breakdown by site was as follows:

- Royal Derby Hospital: 9.9%
- Queen’s Hospital Burton: 11.8%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 4.7% for qualified nursing staff working in urgent and emergency care. This was higher than the trust’s target of 3.8%.

The breakdown by site was as follows:

- Royal Derby Hospital: 4.7%
- Queen’s Hospital Burton: 4.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in urgent and emergency care.

From November 2017 to October 2018, the trust reported that 9.3% of qualified nursing staff hours in its urgent and emergency care services were filled by bank staff, while 6.8% were filled by agency staff. In addition, 3.3% of qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th></th>
<th>Agency</th>
<th></th>
<th>Unfilled</th>
<th></th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>22,132</td>
<td>8.2%</td>
<td>375</td>
<td>0.1%</td>
<td>9,848</td>
<td>3.7%</td>
<td>268,695</td>
</tr>
<tr>
<td>Queens Hospital</td>
<td>20,716</td>
<td>10.7%</td>
<td>31,198</td>
<td>16.2%</td>
<td>5,195</td>
<td>2.7%</td>
<td>193,056</td>
</tr>
<tr>
<td>Total</td>
<td>42,847</td>
<td>9.3%</td>
<td>31,572</td>
<td>6.8%</td>
<td>15,042</td>
<td>3.3%</td>
<td>461,751</td>
</tr>
</tbody>
</table>

Over the same period, the trust reported that 17.2% of unqualified nursing staff hours in its urgent and emergency care services were filled by bank staff, while 0.6% were filled by agency staff. In addition, 4.5% of qualified nursing staff hours were not filled by either bank or agency staff to cover staff absence.
The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

At the time of our inspection, we were informed the emergency department (ED) was fully recruited with nursing staff and had started to collate a list of nurses wishing to join the team. There were no nurse vacancies. During our visit we saw all nursing staff including emergency nurse practitioners (ENPs) able to manage their case load efficiently and effectively in all areas even when busy and meet patient’s needs. A team of nine emergency nurse practitioners (ENPs) worked in the department to support nursing and medical staff. ENPs are clinical professionals who have developed their skills and theoretical knowledge to a very high standard and are able to carry out tasks similar to that of a junior doctor.

In the major’s area of adult ED nursing staff were allocated a maximum of four patients. Staffing for each shift was based on knowledge of when peak demand for the department occurred. Staff reported that agency staff used were usually regular staff and bank staff were used to cover annual leave or sickness. Bank staff are those health care workers who do not have a permanent contract to work in a specific area but can be utilised to fill gaps in the workforce due to for example sickness or annual leave cover. The department used specific bank staff who already worked in the trust and had worked in the department on a regular basis. They therefore knew the layout of the department as well as the routine.

The nurse staffing levels and skill mix were sufficient to meet the needs of patients. There was an allocated nurse for those patients being treated on corridors and we noted that one nurse was caring for up to four patients at any one time. During our inspection we found patients had their care and treatment mostly carried out in a timely manner.

The emergency department (ED) at Burton Hospital had a minimum of one children’s nurse present, or a nurse with up to date paediatric competencies, on each shift in line with the ‘Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings’ document titled, “Standards for Children and Young People in Emergency Care Settings” (2012) which recommends that ‘all clinical staff should have minimum competencies including recognition of the sick or injured child, basic life support skills, the ability to initiate appropriate treatment in accordance with locally agreed protocols’. Registered nurses (adult) had received additional competencies above and beyond paediatric resuscitation training, to provide them with the skills required to recognise a child whose condition may be deteriorating.

During our inspection we asked the trust for assurance around the number of staff who were competent to care for children. Information received from the trust stated, “All band 6 and 7 nurses in the department have Emergency Paediatric Advanced life support and there is at least one of these on every shift, we are assured that this training is sufficient for department needs”. (‘The course is intended to provide training for multi-disciplinary healthcare professionals in the early recognition of the child in respiratory or circulatory failure and the development of the knowledge and core skills required to prevent further deterioration towards respiratory or cardiorespiratory arrest’). The ED education lead had also developed a package of paediatric learning for all registered general nurses. A competency package and triage training for all paediatric nurses in the care of adults was also in place. We witnessed all the current competency sign off documents and were assured all staff had completed them and been assessed as competent. All children requiring admission were triaged and admitted directly to the paediatric assessment unit either from minors or resus if stabilisation was required.
The ‘pit stop’ area of three bays was staffed by three qualified nurses (RNs) and three health care assistants (HCAs). At times during each afternoon of our visit we saw all cubicles filled with additional patients waiting in the area to be assessed. One nurse on each shift oversaw the area and had oversight of the reasons for patient's admission and the on-going movement of patients to other areas.

The AEC was staffed by two qualified nurses and one health care assistant (HCA) on each shift caring for up to six patients. This had changed recently as the unit was now managed by a senior nurse with specific oversight of this area and was managed by the ED matron and senior team. Staff we spoke with told us that staffing was much better since this new management structure had been in place. They said they “felt more part of the ED team”. Staff we spoke with told us they felt it was a much safer place to work. If required, staff could request a further staff member for 1:1 supervision of a patient. When asked, a member of staff informed us they were nearly always able to obtain a further member of staff for supervision duties. This could include caring for a patient who was at end of life, had alcohol intoxication or had taken a drug overdose.

The AEC was staffed between 10am and 8pm involving two shifts. A GP was always on duty between these hours with one junior doctor (senior house officer level) between 8am and 4pm.

Agency and bank staff were inducted into the department with the process following set criteria. This included orientation to the department, admission documentation, use of the sepsis screening tool and the cardiac arrest procedure.

**Medical staffing**

**Planned vs actual**

The trust reported their medical staffing numbers for urgent and emergency care for March and October 2018 as below.

There was a modest increase in the number of medical staff in post at Queen’s Hospital Burton, from 24.6 WTEs in March 2018 to 28.4 WTEs in October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>October 2018</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>74.8</td>
<td>100.9</td>
<td>74.1%</td>
<td>82.6</td>
<td>103.9</td>
<td>79.5%</td>
</tr>
<tr>
<td>Queen's Hospital Burton</td>
<td>24.6</td>
<td>42.0</td>
<td>58.5%</td>
<td>28.4</td>
<td>43.2</td>
<td>65.7%</td>
</tr>
<tr>
<td>Total staff</td>
<td>99.3</td>
<td>142.9</td>
<td>69.5%</td>
<td>111.0</td>
<td>147.1</td>
<td>75.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 26.4% for medical staff in urgent and emergency care. The trust had a target vacancy rate of 6%.

The breakdown by site was as follows:

- Royal Derby Hospital: 25.1%
- Queen’s Hospital Burton: 29.5%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**
From November 2017 to October 2018, the trust reported a turnover rate of 28.0% for medical staff in urgent and emergency care. This was higher than the trust’s target of having a turnover rate of between 8% and 12%.

The breakdown by site was as follows:

- Royal Derby Hospital: 25.0%
- Queen’s Hospital Burton: 37.5%

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 3.6% for medical staff in urgent and emergency care. This was lower than the trust's target of 3.8%.

The breakdown by site was as follows:

- Royal Derby Hospital: 4.2%
- Queen’s Hospital Burton: 1.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

From November 2017 to October 2018, the trust reported that 0.2% of medical staff hours in its urgent and emergency care services were filled by bank staff. Over the same period 5.3% of medical staff hours were filled by locum staff. In addition, 2.6% of medical staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Locum Hours</th>
<th>Locum %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>847</td>
<td>0.2%</td>
<td>8,668</td>
<td>2.4%</td>
<td>9,152</td>
<td>2.6%</td>
<td>356,329</td>
</tr>
<tr>
<td>Queen's Hospital Burton</td>
<td>0</td>
<td>0.0%</td>
<td>13,133</td>
<td>24.2%</td>
<td>1,577</td>
<td>2.9%</td>
<td>54,210</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>847</strong></td>
<td><strong>0.2%</strong></td>
<td><strong>21,800</strong></td>
<td><strong>5.3%</strong></td>
<td><strong>10,729</strong></td>
<td><strong>2.6%</strong></td>
<td><strong>410,539</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

**Staffing skill mix**

As of September 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was lower than the England average.

**Staffing skill mix for the 96 whole time equivalent staff working in urgent and emergency care at University Hospitals of Derby and Burton NHS Foundation Trust.**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>34%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>31%</td>
<td>34%</td>
</tr>
</tbody>
</table>
Consultant presence in the emergency department (ED) was 8am to 10pm daily. This was in line with the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours per day. An on-call consultant covered the out of hours period seven days a week. There was also an allocated consultant for the ED patients admitted to the acute assessment centre (AAC) and a GP allocated to the AEC from 10am - 6pm.

Middle grade (9 WTE) and junior doctors (12 WTE) were present 24 hours every day.

At the time of our inspection there was eight substantive consultants in ED and one who was also the head of service for the department. A further five locum consultants supported the ED team.

The trust human resources department was responsible for undertaking the appropriate checks for all NHS locum staff. Within the ED, locum doctors received an induction to the department which was fully documented.

A combined medical and nursing handover took place in the ED three times daily. We observed one handover and saw detailed discussions take place regarding patients in the department.

Burton ED did not have a consultant with sub-specialist training in paediatric emergency medicine as the number of paediatric patients seen in the department did not meet the necessary criteria. However, we witnessed excellent communication and partnership working during a case of a medical emergency where staff had access to appropriate medical paediatric support. There was a consultant paediatrician and a middle grade on call and available 24/7.

**Records**

Records of patient’s care and treatment were in electronic and paper format and included an ‘accident and emergency record’, which included an ‘adult inpatient risk assessment booklet’ and an emergency department (ED) care chart’. We saw records were available for each patient who had been booked into the department.

In the ED, paper records were stored in racks behind the nurses’ station, so were easily accessible for staff. Staff never left this area unattended, so records remained secure.

The digital system being used in adult ED at the time of our inspection had not been upgraded to meet the reporting requirements for the 2018 emergency care data set (ECDS). ECDS is a national data set for urgent and emergency care, which is used to collect information from emergency departments across England. By implementing ECDS across all emergency departments, data will be able to be used to provide a more accurate, detailed and comprehensive picture of all
emergency attendances. The introduction of the ECDS introduced a requirement for providers to increase submission of their emergency department data from monthly/weekly to daily in line with a national move to have access data in a timelier manner.

Records we reviewed were up to date. For example, we reviewed the ED records for 14 patients (12 adults and two children) admitted through the front door of the department. Of these, all patient records had a triage time recorded.

Risk assessments for pressure areas were mostly undertaken and acted on appropriately in line with trust policy. Trust policy stated an initial assessment was to be completed on admission followed by a further, more detailed assessment when a patient had been in the department for four or more hours. Both were completed using nationally recognised assessment tools.

We reviewed the ED records for 10 patients on day one and eight patients on day two, specifically looking at nursing care interventions. Of those on day one, all patients had a pressure area risk assessment on admission and a review as required. On day two, four patients had not had a pressure area risk assessment. As we were not assured by the lack of consistency from one day to the next we discussed this finding with senior nurses and matron. Matron was aware that senior monitoring of completed care charts was on some days inconsistent. As a result of this an action plan had already been put into place. This was due to commence the following week and involved a daily senior co-ordinator for each shift to ensure these consistency issues did not continue.

Emergency department safety checklists were in place or fully completed. Of the records reviewed (as above over two days), all records contained a checklist completed appropriately.

Patient records prompted staff to record patient’s mental health needs or vulnerability. This meant staff were confident patient records would tell them if a patient had an underlying mental health diagnosis or were vulnerable for other reasons. For those patients with pre-existing mental health conditions staff could contact the specialist mental health team if required.

The mental health liaison team documented their review of a patient in the ED patient record. This meant the patient’s mental health assessment, care plan and risk assessment were accessible to staff in the ED.

Staff told us they had a very good working relationship with the mental health teams and could approach them at any time for advice if for example; a patient attempted to discharge themselves or refused treatment.

Records in the emergency ambulatory care unit were in both electronic and paper format. A full assessment of care was undertaken as soon after admission as possible and placed in the booklet produced for this purpose. A plan of care for each assessment was then completed. It included, but was not limited to assessments for falls, personal handling, pain, oral hygiene and pressure ulcers.

**Medicines**

Medicines and medicines related stationery were managed appropriately. The ordering, storage and administration of controlled drugs (CDs) were in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Records indicated where CDs had been checked daily in line with trust policy.

Medicines requiring refrigerated storage were stored appropriately and within recommended temperature ranges. Records indicated where fridge temperature checks had mostly been completed daily by staff and that staff knew the process to follow should the temperature not be within the required range.

Emergency medicines were stored on resuscitation trolleys, trolleys were secure, sealed with tamper evident fastenings and checked daily.

We reviewed 12 medicine administration records. Our review showed patients getting their medicines in a timely manner and when they needed them.
The Care Quality Commission (CQC) emergency department survey (2016) asked patients if the purpose of new medication was explained to them in a way they could understand and if they were told about possible side effects of new medication. Results showed the trust scored ‘about the same’ as other trusts for both questions.

Patients were prescribed antibiotics in accordance with local antibiotic formularies. Local microbiology protocols for the administration of antibiotics were available in the ED and we saw prescribers were using them appropriately. This included a review of treatment following a microbiological sample result becoming available.

Where patients were prescribed an antimicrobial, we saw the clinical indication, dose and duration of treatment had been documented in their ED record appropriately and in line with National Institute for Health and Care Excellence (NICE) guidance.

Where a patient dependent on alcohol or illegal drugs was admitted, they were offered medicines to assist their withdrawal and associated side-effects in addition to a referral to an alcohol clinical nurse specialist if required.

**Incidents**

**Never events**

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

From January to December 2018, the trust reported no incidents that were classified as never events for urgent and emergency care.

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

**University Hospitals of Derby and Burton NHS Foundation Trust**

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Diagnostic incident including delay (including failure to act on test results): five
- Treatment delay: five
- Medication incident: one
- Sub-optimal care of the deteriorating patient: one

The time taken by the trust to report these 12 SI’s to STEIS was variable:
• Two took between 15 and 30 days to report
• Two took between 61 and 90 days to report
• Eight took more than 90 days to report

(Source: Strategic Executive Information System (STEIS))

An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust’s electronic reporting system.

We spoke with 15 nursing staff and four medical staff specifically about incident reporting. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate. Staff we spoke with could give us examples of recent incidents they had reported.

Senior staff told us incidents and shared learning from incidents was discussed at handover, safety briefings, newsletters and emails. Staff we spoke with said they had received feedback from incidents they had raised. Several staff gave us the same example of changes made to the pit stop area in the refurbishment as a result of a previous incident. The changes implemented had improved movement through the area and reduced the risk of a recurrence of the original incident.

We were assured all incidents were raised appropriately.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with were familiar with the duty of candour and the concepts of openness and transparency. Senior staff were able to give examples of how they had applied the duty of candour when an incident required it.

Mortality and morbidity reviews were reported to be held monthly. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Medical staff told us all Emergency Department (ED) deaths for the previous month would be discussed as well as, any Coroner reports. However, we were told the meetings were often cancelled. During and after our inspection we requested the minutes of three mortality and morbidity meetings held between October 2018 and December 2018. However, we were provided with mortality meeting minutes from one meeting in June 2018. As a result, we cannot be assured that mortality meetings were a regular occurrence within the department. The meeting minutes identify three members of medical staff attending with no representation from across the multidisciplinary team. The minutes did not identify consistent processes were in place to review and discuss individual cases in any depth and identify any learning from these. Documentation did not follow a trust recognised template and did not identify an agenda or any sign off discussion about previous cases. The meeting minutes or cases discussed did not follow any criteria identified in National Quality Board (NQB) first edition of the National Guidance on Learning from Deaths for Trusts.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.
Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported one new pressure ulcer in its urgent and emergency care services. This occurred in January 2018. Over these 12 months the trust reported no falls with harm or urinary tract infections in patients with a catheter in urgent and emergency care.  

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The Emergency Department (ED) mostly provided care and treatment based on national guidance including National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards. Departmental compliance in for example, sepsis, asthma and consultant sign-off was measured through local and national audits and monitored through quality governance meetings and the patient safety committee.

The ED had participated in one RCEM audit ‘Vital signs in children’. Abnormal vital signs acted upon in the Emergency Department had improved to 75% cases from 70% the previous year. This took the Trust above the national average. However, we were not provided with evidence of any other audits within the department. Senior leaders told us this was because of the low numbers of substantively employed medical staff within the ED.

Care pathways were available for staff to use. These provided details of the care that was required in line with recognised guidance and provided a proforma to document the care staff had given. Examples of care bundles included; fractured neck of femur, sepsis and venous thromboembolism (VTE). During our inspection we saw good examples where the fractured neck of femur and sepsis pathways had been used appropriately. New care bundles were being introduced and changes made to pathways of care now that Queens Hospital Burton had been acquired by Royal Derby Hospital.

Older people who were frail or vulnerable received (or got referred for) a comprehensive assessment of their physical, mental and social needs through the hospital frailty service. We reviewed the medical notes of four patients being cared for in the AAC who were also under the care of the frailty team.

All patients were assessed for skin vulnerability and if appropriate placed on a trolley with a red mattress, to reduce deterioration in their skin whilst in the emergency department. However, we were told that x-rays could not be taken on the red mattresses. This had the potential to cause discomfort for patients being transferred on and off red mattresses with for example a fractured neck of femur. As they would have a risk of skin breakdown but would also require an x-ray. Staff told us that they would admit the patient onto a non-pressure relieving mattress to undertake the x-ray and then transfer them onto a red mattress post x-ray. We were not able to corroborate this action during our inspection.

We observed one team handover during our inspection. The handover referred to the psychological and emotional needs of patients, as well as their relatives / carers.

Patients physical health needs were assessed on admission to the ED. Records also prompted staff to record a patient’s mental health or vulnerability needs. Staff told us they would seek advice through the liaison team to ensure they were following best practice for assessing and monitoring the physical health of people with severe mental illness.
The department participated in audits that were related to (or referred) to mental health and emotional wellbeing. Senior leads demonstrated to us a good awareness of the risks and issues related to mental health and emotional wellbeing. We observed as a result of these audits new assessment documentation had been introduced to support patients whilst in the department. Information received from the trust, following this inspection, showed where further actions were also planned to increase provision for vulnerable patients.

Patients who were suspected to be experiencing depression were assessed using an 'Emergency Department Adult Mental Health Triage Form'. This assessment prompted staff to consider a referral to mental health services depending on the level of patient risk.

Staff told us they were able to deal with any violence and aggression in an appropriate way and gave us examples of actions they would take including where they would go for additional support.

New policies and procedures reviewed and developed following the acquisition of Queen’s Hospital Burton was available on the trust’s intranet based on Royal College of Emergency Medicine (RCEM) for staff to use although both old and new guidance documents were available which staff could find confusing. Some staff we spoke to looked at both. We raised this with the trust on day one of our inspection and access to the old policies was immediately removed. Staff were directed to the new guidance on the intranet home page.

The paediatric emergency department used 'Standards of Children and Young People in Emergency Care Settings'. The guidance provides healthcare professionals, providers and service planners with measurable and auditable standards of care for children which are applicable to all urgent and emergency care settings in the UK. It is published by the Royal College of Paediatric and Child Health.

**Nutrition and hydration**

**Emergency Department Survey 2016**

**Queen’s Hospital Burton**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Arrangements were in place in terms of food and drink for patients (and accompanying friends and family) who were in the department for any length of time. The Emergency Department (ED) had a small drinks area where staff could make refreshments for patients (and accompanying friends and family) and where able, patients were encouraged to help themselves.

The emergency department safety checklist prompted staff at regular intervals to offer patients refreshments. Of the 10 records we reviewed, 10 had been completed appropriately on day one of our inspection. However, on day two we reviewed a further six records which identified four not completed accurately. We raised this with matron during our inspection who was aware that consistency was on occasion a concern. The senior team already had a plan in place to address this with use of a lead coordinator for the day to monitor and support consistency of care across each shift. We saw evidence from meeting records that this was due to start the following week.
During our inspection we did not find patients who had not been offered food and drink for significant amounts of time.

During our inspection we found four patients where it had been requested by the medical team that the patient’s fluid input and output was to be monitored through a fluid balance chart. We found fluid balance charts were complete in all cases.

Patient’s nutrition and hydration needs were routinely assessed in the ED. Patient records prompted staff to record nutrition and hydration needs.

**Pain relief**

**Emergency Department Survey 2016**

**Royal Derby Hospital**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was better than other trusts.

The trust scored 8.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

**Queen’s Hospital Burton**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 4.5 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was worse than other trusts.

The trust scored 7.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patients in the Emergency Department (ED) had their pain assessed and managed in line with the Core Standards for Pain Management Services in the UK (2015). Where patients had acute pain, we saw an individualised analgesic plan appropriate to their clinical condition.

Staff in the department used a ‘Score Modify Analgesia Re-assess Titrate’ (SMART) pain management plan devised by one of the emergency nurse practitioners. This plan advised an appropriate pathway for assessing and treating pain. Patients were also given a card stating what time they had been administered pain relief and advising them the time they should request a further pain assessment if it had not been automatically completed. We saw two patients using these cards during our inspection. They both liked the idea as they felt they were able to gain some control over their pain management. The pathway directed staff on which analgesia to use according to the patient’s pain score and advised on a reassessment time frame.

Pain scores were assessed using the SMART tool and documented on the emergency department safety checklist (NEWS2). We reviewed 12 pain checklists during the inspection all were
completed satisfactorily. Children were offered pain relief within 20 minutes of arrival and those in severe pain were reassessed every hour at least.

The SMART Pain Management Plan had been introduced to improve management of pain within the department. An audit of the plan was due in April 2019.

We spoke with 8 patients (six adults and two children) and asked them if they had needed pain killers whilst in the ED and if so, how long they had to wait for them. Where applicable, all the patients told us they got pain killers almost immediately after they had asked for them.

Registered nurses (RNs) were able to administer simple pain relief using patient group direction (PGDs). Patient group directions provide a legal framework to allow registered health professionals to supply and/or administer specified medicines, to a predefined group of patients without them having to see a doctor. This meant that patient would receive their medication quicker.

Nursing staff had easy and timely access to a senior doctor for prescribing analgesia for severe pain.

**Patient outcomes**

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Queen’s Hospital Burton**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Queen’s Hospital Burton emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for two standards:

- **Standard 1a (fundamental):** O₂ should be given on arrival to maintain saturations of 94-98%. This department: 11.5%; UK: 19%.

- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 6.3%; UK: 26%.

The department’s results for the remaining five standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

During our inspection we discussed these standards and questioned the reported results. We also requested an update from the trust after our inspection. However, no further information or explanation for these results was received so we could not be assured these standards were improving.

**Queen’s Hospital Burton**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.
In the 2016/17 Consultant sign-off audit, Queen’s Hospital Burton emergency department reported data for only one of the four national standards. The department was in the lower UK quartile for this standard:

Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 0.0%; UK: 11%.

It should be noted that the department submitted only two sets of patients records to the audit.

No data were reported for the remaining three standards.

(Source: Royal College of Emergency Medicine)

Queen’s Hospital Burton

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

In the 2016/17 Severe sepsis and septic shock audit, Queen’s Hospital Burton emergency department performed better than the UK average for two standards, similar to for four standards and worse than for two standards.

The department was in the upper UK quartile for two standards:

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 65.4%; UK: 44.9%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 59.6%; UK: 44.4%.

The department was in the lower UK quartile for two standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 37.7%; UK: 69.1%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 29.4%; UK: 60.0%.

The department’s results for the remaining four standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

During our inspection we were shown evidence from more recent sepsis audit which identified improvements in standard one and four.

Unplanned re-attendance rate within seven days

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.
From November 2017 to October 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. However, the trust’s performance for this metric was better than the England average.

Over these 12 months there was overall a modest improvement in the trust's performance against this metric.

In November 2017, the trust’s performance was 6.9% compared to the England average of 7.6%.

In October 2018, the trust’s performance was 6.0% compared to the England average of 8.0%.

Unplanned re-attendance rate within seven days - University Hospitals of Derby and Burton NHS Foundation Trust

![Graph showing the trend of unplanned re-attendance rate](image)

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

From November 2017 to June 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% in seven out of eight months. However, the trust's performance for this metric was better than the England average in six out of eight months.

There was a substantial improvement in the trust’s performance in January 2018 compared to the previous month.

In December 2017, the trust’s performance was 11.4% compared to the England average of 7.9%.

In January 2018, the trust’s performance was 5.6% compared to the England average of 7.7%.

In June 2018, the trust’s performance was 6.0% compared to the England average of 7.9%.

Unplanned re-attendance rate within seven days - Burton Hospitals NHS Foundation Trust
Information about the outcomes of patient’s care and treatment was routinely collected and monitored, we were assured all relevant staff were using the information collected and/or results to improve patient outcomes. Senior staff within the Emergency Department (ED) demonstrated knowledge of RCEM audits and as such were able to tell us where improvements had been made. For example, with the introduction of the sepsis identification stickers attached to each admission booklet to correspond with the patients NEWS2 score on initial admission.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

From November 2017 to October 2018, 88.9% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were not met for medical staff or additional clinical services staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
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<td>Additional professional, scientific and technical</td>
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<td>100.0%</td>
<td>90%</td>
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<tr>
<td>Allied health professionals</td>
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</tr>
<tr>
<td>Qualified nurses</td>
<td>201</td>
<td>221</td>
<td>91.0%</td>
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<tr>
<td>Additional clinical services</td>
<td>62</td>
<td>75</td>
<td>82.7%</td>
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</tr>
<tr>
<td>Medical staff</td>
<td>13</td>
<td>22</td>
<td>59.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>338</td>
<td>380</td>
<td>88.9%</td>
<td>90%</td>
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</tr>
</tbody>
</table>
Over the same period, 89.8% of staff within urgent and emergency care services at Royal Derby Hospital received an appraisal. The trust’s training targets were not met for medical staff or additional clinical services staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
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</thead>
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<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
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<td>15</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
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<tr>
<td>Qualified nurses</td>
<td>126</td>
<td>136</td>
<td>92.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>51</td>
<td>58</td>
<td>87.9%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Medical staff</td>
<td>11</td>
<td>20</td>
<td>55.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>230</td>
<td>256</td>
<td>89.8%</td>
<td>90%</td>
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</tr>
</tbody>
</table>

Over the same period, 87.1% of staff within urgent and emergency care services at Queen’s Hospital Burton received an appraisal. Training targets were not met for qualified nurses or additional clinical services staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and clerical</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>Estates and ancillary</td>
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<tr>
<td>Qualified nurses</td>
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<td>Additional clinical services</td>
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<tr>
<td>Total</td>
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<td>124</td>
<td>87.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The clinical head of division ensured all consultants received an appraisal and were revalidated as appropriate. During our inspection the service provided information that showed all consultants had received an appraisal in the last 12 months in line with NHS England guidance.

The department education coordinator ensured the learning needs of staff were identified and staff received appropriate training. Their remit also included coordinating the link nurse groups within the service, training and initiatives such as pressure sore prevention.

They monitored appraisal compliance rates and the quality of appraisals and gave feedback to the appraiser. The education coordinator conducted an annual training needs analysis which identified statutory and mandatory training required by staff. It also identified the induction requirements, training required to meet national standards, continuing professional development needs, leadership development and role specific training for nursing staff across the service.

Staff we spoke with told us there were excellent training opportunities available and they were supported to attend them. Staff told us they felt the skills they had developed either in this role or from previous employment was highly valued by senior managers within the department.
Medical staff told us they had good access to teaching within the department. Locum staff told us they attended ‘junior’ or ‘middle grade’ teaching sessions weekly and felt they had good access to clinical guidance necessary to inform their practice.

We were assured there was a team within the Emergency Department (ED) responsible for antimicrobial stewardship. We saw data was monitored and fed back on prescribing practice at prescriber and/or team level. This met National Institute for Health and Care Excellence (NICE) guidance.

During our inspection we observed good nursing interventions and staff demonstrated to us they had the skills, knowledge and experience to identify and manage issues arising from patients' living with for example, mental health conditions, a learning disability, autism and dementia.

Staff demonstrated they had the skills to sensitively manage any difficult behaviour that patients might display. The trust employed a vulnerable person lead who managed a team of virtual staff with extra training and skills in de-escalation and challenging behaviour. These staff were used in ED to support patients that may need increased care prior to further assessment. The matron was also in the process of arranging extra training for the ED team in the extra skills provided by this team. This would enable patients to be more effectively ‘managed and treated at the front door’, potentially reducing the need for admission.

Poor or variable staff performance was identified and managed appropriately. We saw actions in place to support staff to improve and/or undertake an alternative role within the department. For example, plans were in place to train staff, who had six months or more ED experience, in triage.

**Multidisciplinary working**

We received positive feedback regarding working relationships amongst the multidisciplinary team. Staff told us they felt there was consistency in working practices. For example, practices were generally the same on a daily basis. To ensure regular consistency a shift lead was identified and there was a plan in place to have one senior manager responsible for each shift to ensure all decisions were made by one person rather than staff asking all three managers.

Nursing, medical and day to day leadership of the department was effective. The department appeared calm on all three days of our inspection and there was oversight of patient care. There were regularly assessed actions to address patient and staffing numbers in the ED, increased waits and high acuity in the department. Attendance at the two hourly capacity bed meetings was compulsory and well managed.

During our inspection we attended two of the bed meetings. Personnel in attendance included senior matrons from all areas of the hospital, the on-call manager, operations manager and director of operations. The focus was on any additional staffing required and moving those medical patients that needed to be admitted from the emergency department. We saw senior staff working together with good evidence of problems being shared, multidisciplinary working in place and the process being a trust wide response and not solely an ED problem.

Arrangements were in place for the care of patients requiring other services within the hospital or healthcare services external to the trust for example, psychiatric liaison services.

A frailty service was in place for the assessment and treatment of patients who were frail.

Specialist nurses were available to support and review patients. For example, respiratory assessment nurses and the vulnerable adult team.

When patients were discharged, reception staff generated letters from the department’s electronic system; these were printed off and posted to the patient’s GP.

**Seven-day services**

The emergency department (ED) was open 24 hours a day, every day for anyone who attended.
The ambulatory emergency care Unit (AECU) was open Monday to Friday, 10:00am to 10:30pm. The ED met the NHS England’s seven-day services priority standard; Time to First Consultant Review. In all the records we reviewed patients had been seen and assessed by a suitable consultant within 14 hours of admission.

The department had access to all other specialities if required to treat patients appropriately. For example, a stroke, heart attack, abdominal pain or a fractured bone. For services not available at this department pathways were in place for patients to be transferred to other NHS providers in the area. In addition, access to diagnostic services was also readily available all day for example x-rays, Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scanning and pathology. Emergency nurse practitioners were able to request limb x-rays rather than having to wait for a doctor to do so which reduced the amount of time patients had to wait. A psychiatric liaison service was available 24 hours a day seven days a week to support patients with a mental health illness, or drug and alcohol dependency and the staff caring for them in the department. Staff did report to us that delays occurred in patients being seen as a referral was not accepted prior to the patients being medically fit for referral. Once this referral had been accepted by the crisis mental health team they then had four hours to respond. Leading to unnecessary delays in the ED. Data we were provided with during our inspection identified that 11%, (5 out of 46), of patients in one 24-hour period were in the ED waiting for a mental health assessment with breach times of between 6 and 20 hours.

A children and adolescent mental health services nurse (CAMHS) was provided for inpatients only. This meant that all children requiring a CAHMS assessment had to admitted to one of the children’s wards. The paediatric specialist nurse we spoke with was in discussion with CAHMS teams during our inspection to review this process. As it was not always appropriate/necessary to admit all children if their need was specific to CAHMS only.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance for Gastrointestinal Haemorrhage: Time to Get Control (2015) states there must be a gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night, either on-site or as part of an agreement within a network of providers. A full and effective GI bleed rota was in place.

**Health promotion**

National priorities to improve the population’s health were supported through the admission process in the Emergency Department (ED). For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer. Questions within the ED documentation prompted staff to explore the patient’s current lifestyle.

Patients who might need extra support were identified through the admission process and medical review. This included, patients in the last 12 months of their lives and patients at risk of developing a long-term condition.

Health and condition specific advice was provided through leaflets on the trust’s website.

Specialist nurses were available in the hospital and attended the ED following a patient referral. Specialist nurses encouraged patients with monitoring their health, including health assessments and checks, where appropriate and necessary.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.

Queen’s Hospital Burton
Staff at Queen’s Hospital Burton were eligible for two levels of combined MCA and Deprivation of Liberty Safeguards training. The completion target for both levels was 90%. This requirement was inherited from the predecessor trust.

A breakdown of compliance for MCA and Deprivation of Liberty Safeguards training for qualified nursing staff in the emergency department at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>46</td>
<td>54</td>
<td>85.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 1</td>
<td>34</td>
<td>39</td>
<td>87.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for qualified nursing staff in the emergency department at Queen’s Hospital Burton for either module.

A breakdown of compliance for the trust’s Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training from November 2017 to October 2018 for medical staff in the emergency department at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>9</td>
<td>24</td>
<td>37.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 1</td>
<td>1</td>
<td>5</td>
<td>20.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for medical staff in the emergency department at Queen’s Hospital Burton for either module. In particular, only one of the five eligible medical staff had completed the level 1 training. Information received after our inspection showed only minimal improvements with 29% at level one and 39% at level two.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

At the time of our inspection there were no patients detained under the Mental Health Act. However, staff demonstrated to us an awareness of the additional steps to consider if the patient did not consent to treatment. Staff told us they would get advice on this, if required, from the mental health liaison team.

Staff demonstrated understanding of the issues around consent, and without exception, we saw staff obtaining consent prior to all interventions.

We spoke with 15 patients (13 adults and two children). Without exception, we were told staff asked for consent before any intervention.

Medical staff referred to Fraser guidelines when seeking consent from a child or young person. Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
ED staff followed advice contained within Royal College of Emergency Medicine (RCEM): ‘The Mental Capacity Act in Emergency Medicine Practice’. Medical and nursing staff understood the Mental Capacity Act (MCA) and were trained to assess a patient’s capacity.

There had been no Deprivation of Liberty Safeguard applications made by the Emergency Department (ED) during the year preceding our inspection. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Is the service caring?

Compassionate care

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average in 11 out of 12 months from November 2017 to October 2018.

Over these 12 months there was an improvement in the trust’s performance against this metric.

In November 2017 the trust’s performance was 79.9% compared to the England average of 86.9%.

In October 2018 the trust’s performance was 86.4% compared to the England average of 87.1%.

A&E Friends and Family Test performance - University Hospitals of Derby and Burton NHS Foundation Trust
Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average in seven out of eight months from November 2017 to October 2018.

Over these 12 months there was an overall modest improvement in the trust’s performance against this metric.

In November 2017 the trust’s performance was 85.9% compared to the England average of 86.9%.

In June 2018 the trust’s performance was 87.7% compared to the England average of 87.4%.

A&E Friends and Family Test performance - Burton Hospitals NHS Foundation Trust
Throughout our inspection we observed compassionate care being delivered by all members of staff towards patients. Feedback from patients and relatives confirmed that staff had treated them well and were gentle and kind. Staff spoke to patients politely and with a smile, always listening to what they had to say. Staff informed patients, both adults and children, what they were doing and why which put people at ease. Relatives were also treated with kindness and compassion.

Observations evidenced that staff showed an understanding of patients with particular needs, for example those living with dementia and did not display judgemental behaviour towards them.

Reception staff tried to ensure patients did not crowd the desk, so information could be given confidentially. If someone wished to talk more privately the staff moved them away so they could do so.

Curtains were closed when patients were giving details to medical staff or being examined but at other times they were left open to aid observation. However, if a patient requested it, the curtains were closed and we observed staff asking if they could enter a cubicle if that were so.

All the patients we spoke with told us their privacy and dignity had been respected during their stay and staff had been thoughtful in their approach. Comments such as for example, “wonderful, nothing was too much trouble”, and “It’s been a rollercoaster but the staff have supported us really well”, “They’re incredible.” were heard throughout our inspection.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

We saw staff provide support to a patient as they were being told some bad news. The patient and relative were understandably distressed. The nurse in charge stopped what she was doing and immediately took the family aside to reassure and support them.

Staff supported patients and families accessing spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for patients, friends and families to access.
Understanding and involvement of patients and those close to them

Emergency Department Survey 2016

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

The trust scored about the same as other trusts for all 24 Emergency Department Survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
| Q23. Were you involved as much as you wanted to                          | 7.9        | About the
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>be in decisions about your care and treatment?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.0</td>
<td>About the same as</td>
</tr>
</tbody>
</table>
We spoke with 15 patients (13 adults two children) and eight relatives during our inspection of the ED and all patients told us they had been given enough information about their condition and/or treatment in a way that they could understand.

Patients also told us, they were told and understood what was going to happen to them during their patient journey. Where possible staff involved patients and their relatives in all decisions about their care and treatment.

We saw and heard staff communicate well with patients and relatives where appropriate. Staff always introduced themselves and gave thorough explanations of care and treatment, ensuring patients understood what was being said. In all areas we observed staff engaging with patients in a meaningful way and spent time explaining their treatment options to them. When patients had questions for staff they explained in simple non-medical terms what they meant.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The Emergency Department (ED) had worked closely with commissioners and external stakeholders to implement an integrated streaming service. This was to ensure patients were directed to the correct location or service and to the correct person to manage their clinical needs.

We observed all processes to be effective in meeting the needs of local people. We found there were minimal handover delays for patients arriving by ambulance and whilst waiting to be handed over to staff there was oversight by department staff of the patients presenting condition and any deterioration. During our inspection we witnessed no overcrowding in the emergency department. Nurse staffing levels and skill mix were sufficient to meet the needs of patients and there was a clear streaming and/or triage process in place for patients arriving at the front door of the department.

The layout of ED was generally suitable for the number of admissions the service received. Staff told us they would still like the “pitstop” to be bigger but noted the improvement in the department since the 2017/18 refit. Once during our inspection, we saw patients being cared for on trolleys in the corridor within the ED as there were no free cubicles to use. However, at all times a ‘corridor’ nurse was present. We noted that these patients were moved to this area only prior to ward transfer or discharge. This freed up the cubicle for patients still requiring assessment. Disabled toilet facilities were available in the main ED and in the reception area. We saw where the environment was considerate to the needs of vulnerable patients for example, patients living with dementia. Some of the cubicles were fitted with boards to orientate patients to the date, time, place and the nurses name caring for them.

During our inspection, we were made aware of, and observed, systems and staff members in place to aid the delivery of care to patients in need of additional support. For example, dementia champions the use of dementia symbols, learning disability link nurses and alert flags on patient records.

Signage to the department was clear and displayed in several different languages. However, there was a no visual display in the waiting area advising patients of the length of time they could expect to wait to be seen. Staff in the department told us it had not worked consistently for more than two weeks in the last six months. We told the trust during this inspection and they planned to have the display replaced to inform patients of current waiting times.
The department team had also enquired about boards/posters to inform patients about different uniforms and job roles in the ED. However, this had proved cost prohibitive. This may have been useful to patients and their waiting relatives as during an observation of the triage system whilst sitting in the waiting room, patients were unsure why those triaged by an ANP were seen and treated quicker than those triaged by a nurse with less training. We observed a patient triaged by a nurse wait an hour and 10 minutes when triaged by a nurse as they had to return to the waiting room to await a further assessment and treatment decision by the ANP before care could continue.

It had been recognised the use of the ambulatory emergency care unit (AEC) had not been utilised effectively by ED. From 30 April 2018 a new way of working was being implemented and more space would be available in AEC. ED would utilise the space to benefit patients and which would also free up trolley space. For example, patients waiting for results of cardiac enzymes would be transferred to AEC to await their results.

During our inspection we saw sufficient seating was available in all areas for patients and relatives. In the reception area there were two notices in different languages to assist non-English-speaking patients.

Some staff in urgent and emergency care spoke languages other than English and could help patients and relatives when required. However, the hospital had access to a telephone interpreting service and we were informed by the reception staff in ED they took advantage of the service on a regular basis.

**Meeting people’s individual needs**

**Queen’s Hospital Burton**

**Emergency Department Survey 2016**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the acquisition. These data are provided for contextual purposes do not form part of our judgement.

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**The service took account of patients’ individual needs.**

The Emergency Department (ED) had acted to address the accessible information standard. From 31 July 2016, all organisations that provide NHS care or adult social care were legally required to follow the accessible information standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support, so they can communicate effectively with health and social care services.

At this inspection we saw there appeared to have been action taken to address this standard. There was a hearing loop available at the reception desk, disabled toilet facilities were available in the waiting area and the main ED and we saw leaflets and written information, available in written
format, across the department. There was also ramped access to the ED to aid entry and exit for patients with mobility issues.

The ED had taken account of the individual needs of patients living with dementia. With the orientation boards and ‘twiddle muffs’. There was also access to a communication box used to aid communication with patients unable to articulate their needs. The vulnerable adults team were also utilised in the department to provide 1-1 care for any patient with the potential for vulnerability.

As extra support or supervision for vulnerable or agitated patients was provided by a specialist team, this meant 1:1 supervision was always provided. During our inspection we observed, on a number of occasions, where vulnerable patients were not left alone, this reduced anxiety and the need for frequently calling for assistance.

Arrangements were in place for patients who needed interpreting services. Staff had access to an external interpreting service, 24 hours a day, seven days a week. During our observation in reception staff were communicating with patients through mobile phone translation applications that belonged to the patients. We discussed this with matron and she planned to access funds to provide the reception team with a hand-held device so that they could initiate this with patients immediately.

The department had a quiet room for family members to spend time with their loved ones following a death. The hospital provided a worship area and the chaplaincy team were based there, providing a 24 hour on-call service for relatives and friends of any or no faith should they require religious or spiritual support. The chaplaincy team were able to access leaders of all religious faiths and ask them to attend. Staff could and did contact the chaplaincy team at any time they were required. Queens Hospital Burton had a chapel which was available at all times. Prayer room facilities were provided either in the chapel or elsewhere in the hospital.

Patients with particular needs for example a learning disability were ‘flagged’ on the electronic system used for booking patients in for treatment. This was used from attendance at ED to admission to a ward. This ensured staff followed the learning disability (LD) pathway for that patient. The specialist LD nurse was notified by email and telephone if a patient was admitted with a learning disability and would respond and support staff if required with communication and care plans. Their role was also to liaise with the community LD team about future care needs of the patient. A telephone referral system was in place for staff to access the learning disability specialist nurse employed by the trust.

Six beds in the acute admissions centre (AAC) were available for patients leaving the department who required a short period of observation, investigation or treatment prior to discharge. More beds could be allocated to patients to improve the flow from the ED if required.

Staff worked with the appropriate agencies and health care professionals to ensure patients with complex health and social care needs were discharged safely. The psychiatric liaison team acted as a conduit between the emergency department and community teams supporting adults and children with mental health needs and those with a learning disability. This ensured patients discharged from the department received the on-going care they required.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice.

Median time from arrival to treatment (all patients)

University Hospitals of Derby and Burton NHS Foundation Trust
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard and outperformed the England average in 11 months over the 12-month period from November 2017 to October 2018.

From March to October 2018 performance against this standard showed a trend of improvement.

In March 2018 the trust’s median time to treatment was 64 minutes compared to the England average of 64 minutes.

In October 2018 the trust’s median time to treatment was 46 minutes compared to the England average of 58 minutes.

**Median time from arrival to treatment from November 2017 to October 2018 at University Hospitals of Derby and Burton NHS Foundation Trust**

![Graph](graph.png)

*Source: NHS Digital - A&E quality indicators*

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

The trust consistently met the standard and outperformed the England average from November 2017 to June 2018.

Over these eight months there was a deteriorating trend in performance. However, the RCEM standard of one hour was met.

In November 2017 the trust’s median time to treatment was 41 minutes compared to the England average of 60 minutes.

In June 2018 the trust’s median time to treatment was 50 minutes compared to the England average of 62 minutes.

**Median time from arrival to treatment from November 2017 to October 2018 at Burton Hospitals NHS Foundation Trust**
Information received following our inspection showed the median time from arrival to treatment from at Queens Hospital Burton improved slightly since July 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>Median time from arrival to treatment (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2018</td>
<td>95</td>
</tr>
<tr>
<td>August 2018</td>
<td>70</td>
</tr>
<tr>
<td>September 2018</td>
<td>74</td>
</tr>
<tr>
<td>October 2018</td>
<td>66</td>
</tr>
<tr>
<td>November 2018</td>
<td>72</td>
</tr>
<tr>
<td>December 2018</td>
<td>66</td>
</tr>
<tr>
<td>January 2019</td>
<td>70</td>
</tr>
<tr>
<td>February 2019</td>
<td>80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From December 2017 to November 2018 the trust consistently failed to meet the standard. The trust performed worse than the England average in eight out of 12 months.

From December 2017 to November 2018 performance against this metric showed a modest trend of improvement.

<table>
<thead>
<tr>
<th>Month and year</th>
<th>Trust rate</th>
<th>England rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>January 2018</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>February 2018</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>March 2018</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>April 2018</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>May 2018</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>June 2018</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>July 2018</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>August 2018</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>September 2018</td>
<td>86%</td>
<td>89%</td>
</tr>
<tr>
<td>October 2018</td>
<td>89%</td>
<td>89%</td>
</tr>
</tbody>
</table>
Four hour target performance - University Hospitals of Derby and Burton NHS Foundation Trust

<table>
<thead>
<tr>
<th>Month and year</th>
<th>Trust rate</th>
<th>England rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>89%</td>
<td>85%</td>
</tr>
<tr>
<td>January 2018</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>February 2018</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>March 2018</td>
<td>94%</td>
<td>85%</td>
</tr>
<tr>
<td>April 2018</td>
<td>95%</td>
<td>89%</td>
</tr>
<tr>
<td>May 2018</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>June 2018</td>
<td>93%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Burton Hospitals NHS Foundation Trust

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From December 2017 to November 2018 the trust met the standard in two out of seven months. With the exception of January 2018, the trust outperformed the England average.

Over these seven months the trust’s performance against this metric showed a modest trend of improvement.
Information received following our inspection showed, the Department of Health’s standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department had not been met in any month between July 2018 and February 2019. The percentage of patients admitted, transferred or discharged within four hours is shown in the table below:

<table>
<thead>
<tr>
<th>Month and year</th>
<th>Trust rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>85.2%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>84.2%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>82.4%</td>
</tr>
<tr>
<td>Oct-18</td>
<td>85.3%</td>
</tr>
<tr>
<td>Nov-18</td>
<td>78.0%</td>
</tr>
<tr>
<td>Dec-18</td>
<td>82.9%</td>
</tr>
<tr>
<td>Jan-19</td>
<td>77.1%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>73.7%</td>
</tr>
<tr>
<td>Total</td>
<td>81.1%</td>
</tr>
</tbody>
</table>

Percentage of patients waiting more than four hours from the decision to admit until being admitted

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From December 2017 to November 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average.

From December 2017 to June 2018 the trust’s performance against this metric showed a trend of improvement. Then from June to November 2018 the trust performance showed a deteriorating trend.

(Source: NHS England - A&E Waiting times)
The table below shows the number of patients waiting more than four hours from the decision to admit to being admitted:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>269</td>
</tr>
<tr>
<td>January 2018</td>
<td>214</td>
</tr>
<tr>
<td>February 2018</td>
<td>105</td>
</tr>
<tr>
<td>March 2018</td>
<td>138</td>
</tr>
<tr>
<td>April 2018</td>
<td>87</td>
</tr>
<tr>
<td>May 2018</td>
<td>45</td>
</tr>
<tr>
<td>June 2018</td>
<td>37</td>
</tr>
<tr>
<td>July 2018</td>
<td>139</td>
</tr>
<tr>
<td>August 2018</td>
<td>171</td>
</tr>
<tr>
<td>September 2018</td>
<td>293</td>
</tr>
<tr>
<td>October 2018</td>
<td>166</td>
</tr>
<tr>
<td>November 2018</td>
<td>349</td>
</tr>
</tbody>
</table>

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

From December 2017 to June 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was consistently better than the England average.

From January to June 2018 the trust’s performance against this metric showed a trend of improvement.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Burton Hospitals NHS Foundation Trust**
The table below shows the number of patients waiting more than four hours from the decision to admit to being admitted:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>195</td>
</tr>
<tr>
<td>January 2018</td>
<td>385</td>
</tr>
<tr>
<td>February 2018</td>
<td>275</td>
</tr>
<tr>
<td>March 2018</td>
<td>74</td>
</tr>
<tr>
<td>April 2018</td>
<td>72</td>
</tr>
<tr>
<td>May 2018</td>
<td>50</td>
</tr>
<tr>
<td>June 2018</td>
<td>72</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps).

Information received following our inspection for the percentage of patients waiting more than four hours from the decision to admit until being admitted at Queens Hospital Burton is shown in the table below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage of patients waiting more than four hours from the decision to admit to being admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>14.8%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>15.8%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>17.6%</td>
</tr>
<tr>
<td>Oct-18</td>
<td>14.7%</td>
</tr>
<tr>
<td>Nov-18</td>
<td>22.0%</td>
</tr>
<tr>
<td>Dec-18</td>
<td>17.1%</td>
</tr>
<tr>
<td>Jan-19</td>
<td>22.9%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>26.3%</td>
</tr>
<tr>
<td>Total</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

(Number of patients waiting more than 12 hours from the decision to admit until being admitted)
admitted
University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Over the 12 months from December 2017 to November 2018, 25 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in May and October 2018 (five each).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017</td>
<td>0</td>
</tr>
<tr>
<td>January 2018</td>
<td>0</td>
</tr>
<tr>
<td>February 2018</td>
<td>0</td>
</tr>
<tr>
<td>March 2018</td>
<td>2</td>
</tr>
<tr>
<td>April 2018</td>
<td>3</td>
</tr>
<tr>
<td>May 2018</td>
<td>5</td>
</tr>
<tr>
<td>June 2018</td>
<td>3</td>
</tr>
<tr>
<td>July 2018</td>
<td>1</td>
</tr>
<tr>
<td>August 2018</td>
<td>2</td>
</tr>
<tr>
<td>September 2018</td>
<td>2</td>
</tr>
<tr>
<td>October 2018</td>
<td>5</td>
</tr>
<tr>
<td>November 2018</td>
<td>2</td>
</tr>
</tbody>
</table>

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

Over the 12 months from December 2017 to November 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

(Source: NHS England - A&E Waiting times)

Information received following our inspection showed from July 2018 to February 2019, three patients (in February 2019) waited more than 12 hours from the decision to admit until being admitted.

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

University Hospitals of Derby and Burton NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently better than the England average.
Over these 12 months the trust reported consistent performance against this standard. In October 2018 the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 1.0%, compared to the England average which was 1.7%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospitals of Derby and Burton NHS Foundation Trust

![Graph showing percentage of patients leaving urgent and emergency care services before being seen](image)

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

From November 2017 to April 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was consistently better than the England average.

Over these six months the trust’s performance against this standard was quite consistent.

In April 2018 the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0.3%, compared to the England average which was 2.6%.

No data were available for the trust for this metric for May or June 2018. In both months there were fewer than six patients that left the trust’s urgent and emergency care services before being seen for treatment. The numbers and associated percentages were therefore suppressed in the published data to protect patient confidentiality.
Information received following our inspection for the percentage of patients that left urgent and emergency care services, at Queens Hospital Burton, without being seen is shown in the table below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage of patient that left ED without being seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>2.3%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>2.1%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>1.5%</td>
</tr>
<tr>
<td>Oct-18</td>
<td>1.7%</td>
</tr>
<tr>
<td>Nov-18</td>
<td>1.6%</td>
</tr>
<tr>
<td>Dec-18</td>
<td>1.1%</td>
</tr>
<tr>
<td>Jan-19</td>
<td>1.4%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Median total time in A&E per patient (all patients)

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From December 2017 to November 2018 the trust’s monthly median total time in A&E for all patients was higher than the England average in eight out of 12 months.

Over these 12 months the trust’s performance against this metric showed a trend of improvement.

In November 2017 the trust’s monthly median total time in A&E for all patients was 177 minutes compared to the England average of 152 minutes.
In October 2018 the trust’s monthly median total time in A&E for all patients was 150 minutes compared to the England average of 151 minutes.

**Median total time in A&E per patient - University Hospitals of Derby and Burton NHS Foundation Trust**

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**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition are included in this analysis. These data are provided for contextual purposes are not used to form part of our judgement.

From December 2017 to June 2018 the trust’s monthly median total time in A&E for all patients was consistently lower than the England average.

Over these 12 months the trust’s performance against this metric showed a deteriorating trend.

In November 2017 the trust’s monthly median total time in A&E for all patients was 88 minutes compared to the England average of 152 minutes.

In June 2018 the trust’s monthly median total time in A&E for all patients was 97 minutes compared to the England average of 148 minutes.

---

**Median total time in A&E per patient - Burton Hospitals NHS Foundation Trust**
Information received following our inspection showed, between July 2018 and February 2019, the median total time in A&E per patient at Queens Hospital Burton had declined:

<table>
<thead>
<tr>
<th>Month</th>
<th>Median total time in A&amp;E per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-18</td>
<td>188</td>
</tr>
<tr>
<td>Aug-18</td>
<td>177</td>
</tr>
<tr>
<td>Sep-18</td>
<td>178</td>
</tr>
<tr>
<td>Oct-18</td>
<td>166</td>
</tr>
<tr>
<td>Nov-18</td>
<td>180</td>
</tr>
<tr>
<td>Dec-18</td>
<td>171</td>
</tr>
<tr>
<td>Jan-19</td>
<td>183</td>
</tr>
<tr>
<td>Feb-19</td>
<td>194</td>
</tr>
<tr>
<td>Total</td>
<td>179</td>
</tr>
</tbody>
</table>

Operational pressures in the ED for example, increases in demand, were communicated using the Operational Pressures Escalation Levels (OPEL) framework. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels ran from OPEL 1; The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. During our inspection the ED was consistently at OPEL 3.

An operational escalation policy was in place to support the ED in meeting variations within patient flow. At times where demand exceeded capacity a full capacity protocol was in place. Senior staff within the department were aware of both the policy and protocol and we saw actions taken that aligned to both.

An ED risk tool gave an “at a glance” look at the number of patients in the department, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building. The ED risk tool was updated appropriately during our inspection.
A trust wide winter plan set out the trust’s arrangements for the winter period. Winter had been recognised as a period of increased pressure due to demand both in the clinical acuity of the patients and the capacity demands on resources within the trust. The winter plan prepared the trust, with support from health and care providers in the local area, to focus on admission avoidance schemes and ambulatory care pathways, creating the capacity to meet increased demand.

Operational flow (patient flow) through the hospital was managed by an operations centre. The operations centre acted as the hub for information regarding the daily management of patient flow. Bed meetings were held at 9am, 12pm, 4pm and 6pm daily, further bed meetings were held if the hospital site was under extreme pressure (OPEL 4). Attendance at bed meetings followed the standard operating procedure for bed meetings but typically included; the site duty manager, bed manager, flow managers, representatives from ED and MAU, and escalation managers from other areas. At times of extreme pressure additional staff were required to attend for example, the emergency physician in charge of ED.

Members at the meeting had live access to the current situation in the emergency department via a computer monitor. An overview of patients in ED was discussed with potential admissions highlighted. The meeting focus was to improve the outward flow of patients and free up bed spaces for those requiring admission. However, ED patients were still being delayed in the department as a result of awaiting speciality beds. Data received for one 24-hour period during our inspection showed 43% (20 out of 46) of patients were delayed leaving the department due to “bed not available”. Patients waited between four and twenty hours. This increased pressure on the department and had a negative impact on the patient journey. We spoke with senior staff in the ED who were actively encouraging movement of patients during the full 24-hour period.

Within the ED, three-hourly huddles took place between the nurse in charge and the emergency physician in charge to review all patients in the department. We attended the huddle and saw where a discussion took place of all patients in the ED as well as any safety issues within the department.

Three rapid assessment and treatment (RAT) cubicles were available for the early assessment of "majors" patients arriving by ambulance. The RAT process was carried out by a consultant, registered nurse and health care assistant. We saw the RAT process was effective at reducing ambulance handover times. Patients we observed were seen within 15 minutes of arrival in the department.

Patient referrals to specialty teams, such as surgery and orthopaedics within the hospital were mostly timely. The clinical lead for ED had produced a simple well laid out protocol (Emergency Care Standards) for other specialties to follow and expected them to follow it. If there was a delay in the referral or admission process they approached the specialty head of service or the department matron to resolve the situation.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

None of the patients we spoke with had needed to complain about the ED. However, all of the patients said they would speak to one of the staff or the nurse in charge if they had any concerns.

**Trust level**

From November 2017 to October 2018 the trust received 107 complaints about urgent and emergency care. For the 95 complaints that had been closed at the time of data submission, the trust took an average of 44.0 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.
The 12 complaints that had not yet been closed had been open for an average of 65 days (mean) at the time of data submission. This was also not in line with the policy statement above. The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>68</td>
</tr>
<tr>
<td>Communication</td>
<td>11</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>10</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>6</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Trust admin/policies/procedures including patient record management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>

**Queens Hospital Burton**

From November 2017 to October 2018 the hospital received 22 complaints about urgent and emergency care. For the 15 complaints that had been closed at the time of data submission, the trust took an average of 47.4 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The seven complaints that had not yet been closed had been open for an average of 71.4 days at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>16</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The emergency department listened to people’s concerns and complaints, responded to them and used them to improve services.

We saw posters and leaflets in the emergency department (ED) outlining the process for patients, relatives or friends to make a complaint. Burton Hospital had a Patient Advice and Liaison Service (PALS) located in the main entrance to the hospital. The PALS team provided a confidential advice and information service dedicated to listening to patients, their carers and relatives. The team supported people to make a complaint, compliment or resolve an issue someone may be concerned about.
All concerns raised in the department were logged on the hospital’s electronic system. If complaints could not be resolved locally the PALS team would raise these as formal complaints which would be investigated appropriately.

The senior nurse for ED told us that if anybody raised concerns with staff in ED they tried to resolve them immediately without the need to take them to the PALS team.

ED had received 22 complaints between November 2017 to October 2018. One of those investigations had been led by a clinical commissioning group (CCG). Seven had been responded to and closed. Five were still on-going.

Although the senior nurse had oversight of all complaints, Band 5 and 6 nurses were supported to undertake investigations of complaints to gain management experience. The investigations involved medical input where this was required. Patients were always asked if they wanted to meet with the senior nurse to discuss their concerns.

All complaint investigations went to the divisional leadership team and onto the chief executive for sign off. No complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO) which considers complaints made and which the NHS has not been able to resolve.

Complaints were seen by senior clinicians as a way to learn and improve their service. For example, as a result of one complaint, a system had been introduced where patients/relatives/carers were given a SMART pain card if they were on analgesia. If the patient had increased pain or was due more medication, they could hand the card to a nurse who ensured their pain was reviewed and addressed in a timely manner. This had been in place for 12 months and the ENP who had introduced it was planning on completing the first audit.

Information about complaints with any learning was conveyed immediately to all staff through email and discussed at department meetings.

**Number of compliments made to the trust**

*Queen’s Hospital Burton*

From October 2017 to September 2018 the hospital received 85 compliments about its urgent and emergency care services. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

*Leadership*

Managers at all levels in the ED had the right skills and abilities to run a service providing high-quality sustainable care.

The Emergency Department (ED) was part of the medicine division. Triumvirate leadership was provided at divisional level by a divisional medical director, divisional director and divisional nurse director. Business unit triumvirate leadership consisted of a general manager, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by ward/department managers.

Leaders in the emergency department (ED) demonstrated they had the experience, knowledge and skills to provide a well-led service. All senior staff in ED spoke of their desire to deliver an outstanding service to their patients.
Every member of staff we spoke with felt senior managers were approachable and felt well supported in their role.

Nurse leaders worked clinically in the department at least one day a week. This ensured they kept their clinical skills up to date and allowed them time to work with other members of all grades of staff to monitor they were working safely and in line with current clinical practice. In addition, if the department was busy they were able to help ease pressure in the department and support more junior staff.

The senior nurse leads used specific closed groups on a phone application to ensure any vacant shifts that required covering and any important information was conveyed to staff immediately. During our inspection we became aware a shift required filling at short notice. A message was sent to all members of staff requesting volunteers and was filled within minutes.

All senior leaders had an awareness of Royal College of Emergency Medicine (RCEM) guidelines. RCEM guidelines are fundamental for professionals working in emergency medicine. Results and feedback from RCEM audits were widely shared across the leadership team.

At the time of our inspection senior leaders were highly visible, and working clinically, within the department and front-line staff described them as approachable. Staff told us, they received feedback following incidents or complaints raised, support following times of extreme pressure or an adverse event was described as excellent by several members of staff. The morale of the unit seemed high with staff expressing how much they loved working in the department.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust’s overall purpose was to deliver ‘Exceptional care together’. Staff we spoke with knew what the trust’s vision was and that it was underpinned by its five “PRIDE” values; putting patients first, right first time, investing our resources wisely, developing our people and ensuring value through partnership.

The vision and values had been included as part of a communications campaign that included engagement events, new brand identification for the trust and live social media events with staff.

UHDB was in the process of building a long-term overarching strategy by March 2019. This would set out ambitions to improve patient care, secure important services at QHB, develop tertiary services based at RDH and make best use of community hospitals. This was “being informed through a comprehensive staff, patient and stakeholder engagement process”. The Trust’s five Strategy described the scale of the operational and financial challenge facing the organisation (and the wider health local health economy) and how through significant system wide transformation, they sought to work collaboratively with commissioners and other health and social care providers to deliver a sustainable health and social care system.

The 5 Strategy had been supported by five annual plans. These plans (known as plan on a page) were broken down into the five values. Abbreviated to PRIDE, the plan on a page had 30 annual objectives per year which outlined the contribution to the overall aims of the strategy.

Staff in the department were especially focussed on delivering personalised care to patients and constantly improving. All staff we spoke with were aware of the development of a new vision and strategy building on the strengths of the previously individual trusts.

Senior staff in the department were aware that outward flow from the department needed to improve. There were concerns about improving access to mental health beds, especially for younger people. However, this issue was acknowledged as being a national issue and not exclusive to this trust.

From October 2018 staff were being rotated between the various departments in ED and the ambulatory emergency care unit (AEC). This meant staff would be able to extend their knowledge
base and it would also benefit ED patients. For example, patients waiting for blood test results for cardiac enzymes would be moved to AEC instead of waiting in ED which may prevent another patient being treated.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a strong culture of teamwork within the emergency department (ED) and providing good quality care for patients. Every member of staff we spoke with told us they would not want to work anywhere else because of the team they worked with.

We observed staff working well together and helping each other in an open, friendly but professional manner. Different disciplines worked alongside each other and showed respect for each other's opinions.

Staff felt valued for their contribution to the department and because of the training they received. Because senior leaders and managers were visible in ED and available, staff felt able to raise any concerns they had quickly before they had time to escalate further.

Two new members of nursing staff had been appointed to commence in ED recently. They had been given details of their training dates and been encouraged to contact each other prior to their start date. This meant they would have the opportunity to get to know each other before they started working at the trust which may prevent loneliness or isolation. We spoke with several members of staff that had previously worked in the department who after only a short time (in one case a matter of weeks), had decided that they had made a mistake and had returned to roles within the department.

A strong culture of safety and well-being of staff was evident in the department. Senior staff were available 24 hours a day by telephone for any member of staff who needed support or encouragement. The daily debrief at the end of each shift supported staff to feel they could ask for help if they needed it without recrimination. It had become “just something we do”.

If staff failed to perform in their job role, processes were in place to support them although staff were placed on performance management if this was necessary. Development opportunities were open to all staff and Band six and seven nurses were supported to undertake a leadership course.

Senior managers within the Emergency Department (ED) told us they were proud of their staff and the teamwork they all demonstrated.

Consideration was given to patients’ mental health and emotional wellbeing needs in day to day activity within the service, for example, record keeping and care and treatment plans. We also observed patients’ mental health and emotional wellbeing considered as part of the handover process.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with were familiar with the duty of candour and the concepts of openness and transparency.

Incidents requiring investigation/ moderate or above harm triggered a duty of candour section within the reporting form. Staff working within the incident area, offered the initial verbal apology to patients and their next of kin/ family.

Mechanisms were in place for providing all staff at every level with the development they needed, including appraisals and career development conversations. We saw where recent developments included some band five nursing staff progressing to band six leadership roles and trainee nursing associate staff were working in the ED. The nursing associate role is a support role that sits alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients.
There were appropriate security arrangements in place to keep staff and others safe and protected from violence, including at weekends and out of hours. Staff told us the hospital security team were very responsive and described a good working relationship with the local police.

**Governance**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish

There were effective structures, processes and systems of accountability in place to support the delivery of the trust’s strategy and good quality sustainable services. Department leaders met weekly to discuss issues at the clinical governance meeting. Our review of action logs for these meetings demonstrated priorities had been given to key issues, for example, serious incidents, mandatory training, sepsis audits, coroner’s inquests, compliments and complaints (with any themes identified).

We reviewed meeting minutes from the Mental Health Operational Group Monday, 21st May 2018, and the first joint meeting since acquisition in October 2018. The items discussed were a CAMHS Update, Health & Safety and Security Update, Section 136, Mental Health Patient Data and a patient story. These provided assurance that the new trust was considering all locations and now coming together for joint reviews.

Leadership within the Emergency Department (ED) was effective. At the time of our inspection there were six band seven nursing sisters in post. There was always a band seven taking the lead or, assuming accountability for the day to day running of the department. Band sevens worked as part of the team and provided a consistent leadership approach for the ED staff. Band six staff were also encouraged to take charge of the department whilst the band seven managed direct patient care. This allowed for team development and supported organisational talent mapping and succession planning, by recognising and developing individuals with the potential to fill the key roles in the department.

Individual staff we spoke with were aware of their role and responsibility, what they were accountable for and to whom.

Relationships with third party providers was reported as being good, for example with the local mental health trust and the ambulance trusts. Meetings were held regularly and any issues resolved

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The management of risks, issues and performance in the Emergency Department (ED) appeared robust. Concerns identified by the inspection team such as, criteria for carrying out observations on patients with a wound, visibility of the fit to sit areas and of patients in waiting areas were managed appropriately and immediately steps were taken to rectify the concerns or implement actions that would mitigate risks.

Quality, safety and performance was discussed at a weekly speciality governance meeting which reported to monthly clinical directorate governance meetings. These meetings upwardly reported to the quality performance improvement committee which was chaired by the chief executive. Staff we spoke with on the frontline were aware of the departments worry areas and had witnessed the changes to address them during the department refurbishment and the creation of ‘pit stop’.

Daily risks were conveyed to staff during handover and board rounds. Staff informed us they were aware of any on-going issues and concerns within the department.

We saw effective structures in place to ensure staff received appropriate and timely feedback from for example, incidents, complaints and performance data. Without exception staff repeatedly told
us they received feedback and that departmental staff meetings were well attended and a “useful way of keeping in touch with what was going on”. Senior managers told us anyone unable to attend meetings would always be updated via email or the staff notice boards.

Senior leaders were aware of national guidance and performance outcomes relevant to the department.

Audit participation was good. For example, the ED had participated in many RCEM audits including for example; ‘Vital signs in children’ and ‘Procedural sedation in adults’, we also saw evidence of prescribing and triage audits within the department.

The ED risk register dated October 2018 identified nine risks; medical staffing levels, patient safety/infrastructure and the inappropriate storage of controlled and standard drugs. nursing vacancies, provision of a secure physical environment and risk to safety. Causes of the risk and impact on patients were identified in each case and controls were in place to manage the risk. The day before our inspection commenced the medicines storage areas had been replaced and discussion to remove this from the risk register was had at the local governance meeting we attended.

The department participated in audits that were related to (or referred) to mental health and emotional wellbeing. Senior leads demonstrated to us a good awareness of the risks and issues related to mental health and emotional wellbeing. We observed as a result of these audits new assessment documentation had been introduced to support patients whilst in the department. Information received from the trust, following this inspection, showed where further actions were also planned to increase provision for vulnerable patients.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. During our inspection, staff we spoke with told us about a recent major incident exercise. Staff told us these usually took place six monthly. The last one included setting up the biohazard and decontamination area outside the hospital and staff practising preparing injections and taking blood in biohazard suits.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Senior leaders in the department demonstrated they had a good understanding of performance across the department and gave examples of how clinical audit, performance and patient and staff feedback were used to drive improvements across the service.

Staff had access to information they needed to carry out their roles effectively, with policies and procedures available on the trust’s intranet. However, during our inspection, we reported to the trust that staff were showing us various policies on the intranet that had not been reviewed in a number of years. It was quickly identified that since the acquisition the system still contained both Derby and Burton policies in different areas and the current up to date policies for the new joint trust. The trust immediately set about to rectify this and by the next day had produced an urgent bulletin to inform staff of the actual location for up to date information on policies and procedures.

Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all polices were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

The department used both paper and electronic records for reviewing and documenting patient care. GP records of a patient could be reviewed on line as access to the system was available. Staff were able to access information on patient’s care and treatment on electronic systems using password protection systems.
During our inspection we did not see any occasion when patient records with confidential information were left unattended. Patient records were kept securely at all times.

Effective systems and processes were in place to ensure data and notifications were submitted to external bodies as required. For example, serious incidents to both the Care Quality Commission and the commissioners for the trust.

**Engagement**

**The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**

The Emergency Department (ED) gathered patient feedback through the A&E Friends and Family Test (FFT). FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely they are to recommend the service to their friends and family if they needed similar care or treatment.

Due to the nature of emergency departments (EDs) it is not always easy for staff to obtain feedback from patients and their relatives on the services it provides. However, results from the friends and family test (FFT) for October 2018 provided by the trust prior to our inspection identified that of that number 79% would recommend the service.

In ED staff felt both engaged and empowered to suggest new ways of working within their areas as well as raise concerns. We spoke with one member of staff who has suggested modifications to the mental health assessment pro-forma and one that had implemented a new pain tool. The staff members concerned informed us they had felt able to speak with the lead nurse for ED and had been given the authority to go ahead with their idea and present them for trial within the department. They had both been received very favourably and implemented in the department. We saw the processes were now embedded.

All the staff we spoke with were aware of the role of the ‘freedom to speak up guardian’. Senior managers felt they were engaging with staff and gave us an example of where they had met with staff to discuss their concerns.

The PALS team provided a confidential advice and information service dedicated to listening to patients, their carers and relatives. The team supported people to make a complaint, compliment or resolve an issue someone may be concerned about. As well as dealing with concerns and complaints, the team signposted to other services both within and outside of the trust. They collated comments and suggestions through questionnaires, face to face discussions, comment cards, the trust web site, email or telephone. In addition, they were able to find independent help and support to involve and engage people in trust work through membership, volunteering and attending specific groups.

The ED worked collaboratively with external partners to build a shared understanding of challenges within the system. This included; NHS Improvement (NHSI), commissioners, local NHS acute and community trusts and the local NHS ambulance trust.

**Learning, continuous improvement and innovation**

**The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**

All staff were committed to on-going improvement in patient care, treatment and experience. Senior leaders in the emergency department (ED) wanted to continue to learn and improve systems and the department for improved patient experience and outcomes. They identified and used examples by learning when things went well and when they did not and being innovative with new ways of working.
The clinical lead for ED knew that to achieve the 95% performance target on a regular basis, more effort was required by all specialties across the hospital working with ED in order to improve the timeliness of patient admission to an appropriate ward. They told us it was a ‘systems issue’ and not just ED.

Staff in the department used a ‘Score Modify Analgesia Re-assess Titrate’ (SMART) pain management plan devised by one of the emergency nurse practitioners. This plan advised an appropriate pathway for assessing and treating pain. Patients were also given a card stating what time they had been administered pain relief and advising them the time they should request a further pain assessment if it had not been automatically completed. We saw two patients using these cards during our inspection. They both liked the idea as they felt they were able to gain some control over their pain management. The pathway directed staff on which analgesia to use according to the patient’s pain score and advised on a reassessment time frame.

The ED team had completed a major transformation project that had engaged staff and patients in development and reconfiguration. This resulted in an expanded and safer environment for patients and staff.

The senior ED team had significantly improved nurse recruitment and retention through a programme of support and facilitating the department as a supportive, rewarding place to work. This had resulted in the return of staff who had undertaken programmes outside of the department and the return of other staff who had previously left.

The education lead had transformed the departments nursing development and training figures in the 12 months they had been in post.
Medical care (including older people’s care)

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1st July 2018 following the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust. The latter acquired the former under its existing registration with the CQC. Our legal position is that the acquired trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data relate to the same legal entity as the acquired trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, while some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust has 788 medical beds located across two acute hospitals; Royal Derby Hospital and Queens Hospital Burton.

Queens Hospital Burton (QHB) has 212 beds across 14 wards and units.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary care unit (ward 6)</td>
<td>Cardiology</td>
<td>10</td>
</tr>
<tr>
<td>Diabetes centre</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Endoscopy unit</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Endoscopy unit - day case</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Haematology - day case</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Medical day case</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Oncology unit - day case</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Ward 3</td>
<td>Short stay unit</td>
<td>32</td>
</tr>
<tr>
<td>Ward 4</td>
<td>Care of the elderly</td>
<td>27</td>
</tr>
<tr>
<td>Ward 5</td>
<td>Respiratory medicine</td>
<td>31</td>
</tr>
<tr>
<td>Ward 6</td>
<td>General medicine</td>
<td>20</td>
</tr>
<tr>
<td>Ward 7</td>
<td>Acute medicine/ haematology</td>
<td>18</td>
</tr>
<tr>
<td>Ward 8</td>
<td>Stroke rehabilitation</td>
<td>27</td>
</tr>
<tr>
<td>Ward 16</td>
<td>Care of the elderly</td>
<td>27</td>
</tr>
</tbody>
</table>

Medical specialties provided at the Queens Hospital include acute medicine for older people, cardiology, haematology, respiratory and stroke medicine and these services are managed as a single division.

The hospital has a consultant-led frailty service, consisting of advanced clinical practitioners, physiotherapists and occupational therapists, predominantly working at the front door and using the Edmonton frailty stratification tool. The frailty team can expedite discharge from the emergency pathway and follow the patient within the community.
The service had a consultant-led frailty service, consisting of advanced clinical practitioners, physiotherapists and occupational therapists who identify suitable patients in the Emergency Department and Acute Assessment Centre. Use was made of the Edmonton frailty stratification tool to together with additional inclusion and exclusion criteria. The frailty team could expedite discharge from the emergency pathway and follow up the patient within the community; the provider’s frailty and discharge policies were linked. Staff from the team could evidence their impact in reducing admissions and length of stay.

The acute medicine for older people wards focus on the care of patients with complex needs secondary to cognitive impairment. This specialty works collaboratively with external partners to resolve issues and facilitate safe discharge.

(Source: Routine Provider Information Request AC1 - Acute context)

**Admissions figures - University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018.

The trust had 76,679 medical admissions from August 2017 to July 2018. Emergency admissions accounted for 33,736 (44.0%), 1,616 (2.1%) were elective, and the remaining 41,327 (53.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 29,731
- Gastroenterology: 12,716
- Medical oncology: 10,436

**Admissions figures – Queens Hospital Burton**

The Queens Hospital Burton, as the pre-acquisition Burton Hospitals NHS Foundation Trust had 26,681 medical admissions from August 2017 to June 2018. Emergency admissions accounted for 12,046 (45.1%), 264 (1.0%) were elective, and the remaining 14,371 (53.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 9,439
- Gastroenterology: 5,124
- Medical oncology: 4,598

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff groups completed it. However, completion rates for medical staff were much lower than required.

All staff at the Queens Hospital were required to complete mandatory training in key skills dependent on their roles. Staff told us that they could access training including on-line modules that were available from any computer including outside of the hospital.

We saw training matrices that clearly identified who had been trained and who had not and senior nurses were able to talk confidently about why some staff had outstanding training for reasons such as absence. When we spoke to staff they confirmed this with most saying they were up to date with their mandatory training.

Completion rates for medical staff in some modules were significantly below the target although some doctors told us they were achieving very nearly 100% completion themselves.

Infection control was not included in the mandatory training programme, so the service could not provide a compliance figure.

As of October 2018, staff from the two predecessor trusts continued to complete different sets of legacy mandatory training modules. Because of this, it is not possible to produce trust level data.

Mandatory training completion rates

Queen’s Hospital Burton

Staff at Queen’s Hospital Burton had a mandatory training completion target of 90% for all mandatory training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in medical care at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food safety</td>
<td>210</td>
<td>210</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>210</td>
<td>210</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>206</td>
<td>210</td>
<td>98.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>203</td>
<td>210</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>199</td>
<td>210</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>198</td>
<td>210</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>186</td>
<td>201</td>
<td>92.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training module</td>
<td>Number trained</td>
<td>Number eligible</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met Yes / No</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>Trust induction</td>
<td>61</td>
<td>61</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>60</td>
<td>61</td>
<td>98.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>53</td>
<td>61</td>
<td>86.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>51</td>
<td>61</td>
<td>83.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>49</td>
<td>61</td>
<td>80.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Doctors manual handling awareness</td>
<td>49</td>
<td>61</td>
<td>80.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>43</td>
<td>61</td>
<td>70.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion theory (doctors)</td>
<td>34</td>
<td>50</td>
<td>68.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance - 1 year</td>
<td>40</td>
<td>61</td>
<td>65.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 91.1% for qualified nursing staff in medical care at Queen’s Hospital Burton. The trust’s mandatory training targets were met for nine of the 21 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in medical care at Queen’s Hospital Burton is shown below:
The trust had an overall training compliance rate of 76.4% for medical staff in medical care at Queen’s Hospital Burton. The trust’s mandatory training targets were met for two of the 16 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

### Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it although training rates for medical staff were well below trust targets.

The service had systems in place to protect patients from abuse, neglect, harassment, breaches of their dignity and discrimination. This included those abuses addressed by recent national initiatives such as female genital mutilation and modern-day slavery. Safeguarding processes and polices were communicated to all staff and we saw them being used. Staff were updated through the trust’s mandatory training programme.

We saw references to safeguarding on noticeboards on the wards and departments we visited.

Staff of different grades knew what abuse was and acted to protect patients from abuse. When we asked about instances of safeguarding they could give examples and talk about what actions had been taken. When we identified patients for whom there were safeguarding concerns, we saw from notes and through conversations that they or other people had been protected from harm they might cause, through the use of the trust’s policies and working with other agencies.

The service had an enhanced nursing policy in place for patients needing additional supervision as well as restraint or tranquilisation. This policy was linked to other relevant policies including safeguarding and deprivation of liberty and provided for escalation and de-escalation of observation and support. At higher levels of supervision there was an expectation that the provider’s enhanced care team be involved. On one ward we saw them supporting a patient to keep themselves and the ward safe with a great deal of skill and compassion.

### Safeguarding training completion rates

As of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it is not possible to produce trust level data.

**Queen’s Hospital Burton**

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all safeguarding training modules.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in medical care at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Actual</th>
<th>Compliance Rate</th>
<th>Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse incident reporting</td>
<td>40</td>
<td>61</td>
<td>65.6%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>38</td>
<td>61</td>
<td>62.3%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>16</td>
<td>26</td>
<td>61.5%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>35</td>
<td>61</td>
<td>57.4%</td>
<td>No</td>
</tr>
</tbody>
</table>
### Training module completion rates

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 4</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>760</td>
<td>777</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>741</td>
<td>763</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>753</td>
<td>779</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>751</td>
<td>778</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>731</td>
<td>774</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>199</td>
<td>224</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 96.1% for qualified nursing staff in medical care at Queen's Hospital Burton. The trust's mandatory training targets were met for six of the seven safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in medical care at Queen's Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent awareness</td>
<td>52</td>
<td>61</td>
<td>85.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>44</td>
<td>61</td>
<td>72.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>42</td>
<td>61</td>
<td>68.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>42</td>
<td>61</td>
<td>68.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>38</td>
<td>61</td>
<td>62.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 71.5% for medical staff in medical care at Queen's Hospital Burton. The trust’s mandatory training targets were not met for any of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

### Cleanliness, infection control and hygiene

The service controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All the areas we inspected were visibly clean and both domestic and clinical waste including sharps was stored properly and when necessary in specialist containers. Toilets were clean, hand gel dispensers were available on all entrances to wards and departments and we saw hand washing prompts and posters in many places. Ward managers told us they were happy with the standards of cleaning provided by the domestic teams.

When we observed staff giving care and treatment we noted that in all cases they followed correct practice in the washing of hands, use of protective personal equipment such as gloves and aprons and adopted the ‘bare below the elbow’ rule.

Hand hygiene audits for the Queens Hospital site were requested but not provided.
When we observed staff giving care we saw that they were using the proper aseptic techniques. Aseptic technique is a standard healthcare practice that helps prevent the transfer of germs to or from an open wound and other susceptible areas on a patient's body.

The service had incorporated the Royal Marsden Online Clinical Nursing Procedure as recommended by the Evidence Based Practice Council into its guidelines for urinary catheterisation and vascular access devices to reduce the risk of infection and irritation.

Staff used a scoring method to access vascular access sites and the service had also setup an “IV midline team” promoting the use of this method for long term vascular access.

There were sufficient numbers of side rooms available on the wards to manage the care of infected patients properly. However, staff told us, there was pressure on these side rooms to support the privacy needs of dying patients and their families. Where these room were in use for the purposes of isolation we saw they were identified as such with warning notices and staff took the appropriate measures.

We saw that equipment had “I’m clean” stickers to indicate they had been cleaned between patients and were ready for use and we saw staff were diligent about cleaning equipment such as commodes after use.

There was an infection prevention and control standard in use for the prevention of meticillin resistant staphylococcus aureus (MRSA). In line with current Department of Health Guidelines only specific patient groups were screened.

There was an infection prevention and control standard in use for the prevention of clostridium difficile and we saw notices reminding staff that alcohol gel did not kill the spores that carry the infection and that handwashing was necessary.

Standards of cleanliness and hygiene were maintained in Endoscopy. Endoscopy equipment was decontaminated in line with the relevant Department of Health Technical Memorandum.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

The hospital was a relatively new estate and the wards and departments were suitable for purpose. However, because of the number of patients being cared for there appeared to be pressure on space and we saw that the use of some rooms had been changed. For example, on Ward 4 a store room had been converted to a side room. While that room was suitable a large wet room which was suitable for wheelchair use was being used as a storeroom meaning it was not available for those who needed it. Similarly, we were told that a purpose built “mental health room” on the Acute Assessment Centre was being used as a storeroom. When we visited on 5 February this was not the case but a subsequent visit on 20 February found it was being used to store two wheelchairs.

The areas we inspected were largely tidy. Some equipment such as beds was stored in corridors but that which was stored did not present a substantial fire risk. We noted that fire exits were not blocked and fire doors were not wedged open except in one case at the Sir Robert Peel Hospital where a recent fault, awaiting repair, made this necessary. Fire-fighting equipment was appropriate to the area and when we checked, extinguishers had not exceeded their expiry dates.

Pressure relieving mattresses were available when needed as were hoists and their slings in suitable sizes. Staff told us they had enough equipment to care for patients although concern was expressed that there was only one MRI scanner.
We checked a sample of resuscitation trolleys and saw they were tamper proofed, checked daily with records held on the trolley and equipped in line with Resuscitation Council (UK) guidelines. Equipment had asset numbers and a use by date. All the equipment we sampled was within their service date except one vital signs monitor which was out of date by more than eight months. When we drew this to the attention of the ward staff they removed it from service but did not consider it was the responsibility of staff to check for this date before using equipment.

When we asked about the responsiveness of maintenance teams to requests we were told that there was usually a wait but that urgent matters would get attended to promptly. However, on the Acute Assessment Centre we were told that some monitoring equipment was unserviceable and unable to be repaired because it was no longer supported by the manufacturer.

Waste, including clinical waste, was managed properly. When we looked at sluices and waste storage areas we saw the waste was properly stored and secured. Sharps bins were sealed and stored when full and we did not see any that were overflowing.

We were told that at the Sir Robert Peel Hospital endoscopy suite there was no problem with scope availability but at the Queens Hospital suite it was a weekly occurrence that a patient would need to wait for a scope to be decontaminated. We were told that this was being addressed through considering the purchase of additional equipment and by considering the ways patients were scheduled.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary**

On admission Staff completed risk assessments for each patient which were stored on the service’s Electronic Patient Record (EPR) system.

Risk assessments on the EPR system were triggered either as bundles or individually although these were often quite generic and not fully completed or personalised. Staff were generally happy with the system although we were told that sometimes unnecessary assessments were triggered early in the patient’s pathway and that some assessments such as pain and bedrails were not automatically displayed as part of the initial care plan meaning that these assessments could be missed. We saw in some patient records that this was the case. It was also noted that there was no tailored care plan for patients with specific illnesses for example, Parkinson’s disease. However, we noted that patients on the frailty pathway had a specific template which in the records we saw was completed every time.

Many of the patients stayed on the medical wards for some time and we were told it was the practice on most wards to update risk assessments on a Sunday as well as in response to events. The patient records we saw reflected this.

Patients were scored against an early warning scoring system (NEWS2) during routine observations. NEWS2 is a track-and-trigger early warning score system that is used to identify and respond to patients at risk of deteriorating. There were observation and clinical responses to each NEWS2 score which assessments by senior staff and when necessary access to a critical care outreach team and transfer to higher levels of care.

The service followed sepsis guidelines which involved screening using the early warning scoring system as well as other factors. This screening tool was available in both paper form and on the EPR system and we noted both methods in use. Patients identified as being at risk were placed on
the “Sepsis 6” pathway. There were separate guidelines for neutropenic sepsis in use for cancer and haematology patients.

We reviewed four sets of patient records in detail and we noted that observations were taken on time, calculated correctly and NEWS2 scoring had taken place in line with the trust policy and none of the patients had triggered further assessment including sepsis. The service carried out monthly audits of staff’s adherence to the trust policy. On Ward 6 we saw that a NEWS2 audit had taken place that identified some examples of poor completion. An action plan had been created and communicated through ward briefings and staff appraisals. As a result, the safety culture on the ward had improved. However, we did not see that this learning had been disseminated throughout the rest of the division.

All four patients had assessment of pressure areas completed and we noted that there was proactive repositioning of patients taking place to best prevent sores developing. Where this repositioning had been refused by patients it was clearly documented in the notes.

Similarly, patients had falls and nutritional risk assessments carried out and care plans were appropriately updated.

To aid the identification of patients at risk, pictures or icons were displayed at the patient’s bedside. However, we saw these were used inconsistently.

Liaison Psychiatric Nurses (LPN) from a neighbouring mental health trust were based on site and we saw them involved in multidisciplinary conversations with hospital staff about patients. Staff also told us that this service responded promptly out of hours and that they had the support they needed to manage patients whose mental health was deteriorating. We were also told that because the LPNs had access to blood results they were able to take this aspect of the patient’s pathology into consideration. This service was available from Monday to Saturday, 08:30-16:30 and covered by the Crisis Team out of these times.

National safety standards for invasive procedures (NatSSIPS) are national standards which cover all invasive procedures including those performed outside of the operating department and should be used as a basis for the development of Local Standards for Invasive Procedures (LocSSIPS) by organisations providing NHS-funded care. Within Endoscopy, local processes for invasive procedures had been reviewed in line with national standards and LocSSIPS had been developed for a wide range of endoscopic procedures. For example, colonoscopy and gastric varices.

The endoscopy suite at the Robert Peel hospital provided diagnostic procedures only to low risk patients. We saw that the NEWS2 system was used there to monitor patients and that there were always staff available with intermediate life support and intravenous cannulation skills to support a deteriorating patient. There was a transfer protocol and a perforation policy that required patients to be transferred to Burton by emergency ambulance. Staff were confident about what to do when transferring a patient and described how they had successfully transferred a patient the previous year.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, agency staff new to the hospital were not given a formal induction to fully understand the service’s procedures and to make use of the electronic patient record system.

Ward managers told us that they had sufficient staff, but this was usually achieved by making use
of both bank staff and agency staff as the vacancy rate for qualified staff was 20%. The number of shifts not filled across the medical wards was 1.7%.

Senior managers considered the skill mix available on a shift by shift basis and where necessary they would redeploy staff across the wards to make sure that patients were cared for by appropriately skilled and experienced staff. This was stressful for nurses, but we were told that matrons and managers were supportive and that staff were able to do this. During our visit we discussed a staffing challenge that had been brought to our attention on Ward 19 with senior nurses and they were able to describe in detail how they were dealing with upcoming shifts by splitting nurses shifts across wards when necessary. This ward which had temporarily changed from elective orthopaedic to predominantly medical beds was sometimes staffed during the day with only two or three registered nurses when the establishment template was five.

On one ward that currently had a group of patients with particularly complex needs we saw that this had been assessed and resulted in an increased staffing ratio.

Staff were often moved between wards at short notice because agency staff could sometimes not setup intravenous administration and sometimes they did not have access to the hospital’s electronic patient record system. One member of staff told us that they would sometimes choose to staff a shift vacancy with a healthcare support worker who could use the computer system than an agency nurse who could not.

Agency staff did not always receive an effective induction to the trust or the ward on which they worked. We spoke to an agency nurse who told us it was their first day at the trust and that they had been welcomed, told where they were going and shown round by staff and knew who to go to if they had any questions. However, they also told us they had had no formal induction and that they had not been given access to the trust’s electronic patient record system. Another member of permanent staff told us that there was no specific protocol to use for new agency staff, that they “always show agency staff around but no checklist”.

Agency staff told us there were not paid to come in and learn the online patient records system and that they were expected to come in on their day off to do that.

When we spoke to a student nurse who was in her second day at the hospital we were also told that they had been welcomed but also that they had received an “induction tour”, had been introduced to polices through intranet training and allocated a ward mentor to deal with all questions.

When we visited wards, we noted that handovers took place when shifts changed. We observed one and we noted it was detailed and appropriate with a typed sheet used as an aid memoir. There was dedicated time for “board rounds” when individual patients were discussed amongst the multi-disciplinary team. These took place first thing in the morning and there was a review in the early afternoon to confirm that care plans had progressed

Planned vs actual

The trust reported their staffing numbers for qualified nursing staff working in medical care as below as of March 2018 and October 2018.

At both sites the number of qualified nursing staff in post in medical care increased in October 2018 in comparison to March 2018.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
<th>Actual staff (WTEs)</th>
<th>Planned staff (WTEs)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital Burton</td>
<td>188.5</td>
<td>236.8</td>
<td>79.6%</td>
<td>192.5</td>
<td>231.7</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From November 2017 to October 2018, the trust reported a vacancy rate of 15.6% for qualified nursing staff working in medical care. The trust had a target vacancy rate of 6%.

The vacancy rate for Queen’s Hospital Burton was 20.2% This was identified as an issue in the risk register for the acute medicine service with actions in place although it was noted recruitment remained difficult.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 9.1% for qualified nursing staff working in medical care. This was within the trust’s turnover target of between 8% and 12%.

The turnover rate for Queen’s Hospital Burton was 9.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 4.3% for qualified nursing staff working in medical care. This was higher than the trust’s target of 3.8%.

The sickness rate for Queen’s Hospital Burton was 4.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in medical care.

From November 2017 to October 2018, the trust reported that 12.6% of qualified nursing staff hours in its medical care services were filled by bank staff, while 1.4% were filled by agency staff. In addition, 1.8% of qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Agency</th>
<th>Unfilled</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
</tr>
<tr>
<td>Queens Hospital</td>
<td>63,909</td>
<td>15.5%</td>
<td>20,473</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Over the same period, the trust reported that 21.2% of unqualified nursing staff hours in its medical care services were filled by bank staff, while 0.6% were filled by agency staff. In addition, 4.0% of qualified nursing staff hours were not filled by either bank or agency staff to
cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens Hospital</td>
<td>51,208</td>
<td>16.8%</td>
<td>7,315</td>
<td>2.4%</td>
<td>8,261</td>
<td>2.7%</td>
<td>304,455</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The vacancy rate for medical staff was 10% but use of locum staff ensured that the number of unfilled shifts was virtually nil. However turnover rates were very high at 44% and when we asked about this we were told it was difficult to attract junior staff and there was not always the mix of grades that would be wished for. This was identified as an issue in the risk register for the acute medicine service with actions in place to maintain the fill rate.

For example, the Acute Assessment Centre was staffed during the week by one locum registrar and five other doctors, a mix of trust grade staff, clinical fellows and GP trainees whereas the preferred staffing would be two registrars, three doctors in foundation year 2 and three doctors in foundation year 1.

Senior medical staff commented that they believed that the “merger” would improve their ability to attract staff.

We observed handovers taking place and they were effective. Handovers were at planned times on each ward and we saw sheets were used to record and prompt discussions.

Consultants or other senior medical staff were available in the hospital or on call and able to respond within 30 minutes. However, staff often told us there were delays in junior doctors responding to the wards because of their workloads.

Planned vs actual

The trust reported their medical staffing numbers for medical care for March and October 2018 as below.

There was a decrease in the number of medical staff in post in medical care at Queen’s Hospital Burton, from 69.1 WTEs in March 2018 to 59.4 WTEs in October 2018. As a result, the fill rate decreased from 90.6% to 80.5%.
Vacancy rates

From November 2017 to October 2018, the trust reported a vacancy rate of 13.4% for medical staff in medical care. The trust had a target vacancy rate of 6%.

The vacancy rate for the Queen’s Hospital Burton was 10.7%

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 30.5% for medical staff in medical care. This was higher than the trust’s target of having a turnover rate of between 8% and 12%.

The turnover rate for the Queen’s Hospital Burton was 44.4%

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 1.0% for medical staff in medical care. This was lower than the trust’s target of 3.8%.

The sickness rate for the Queen’s Hospital Burton was 1.1%

Bank and locum staff usage

From November 2017 to October 2018, the trust reported that 0.9% of medical staff hours in its medical care services were filled by bank staff. Over the same period 5.4% of medical staff hours were filled by locum staff. In addition, 0.1% of medical staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Locum Hours</th>
<th>Locum %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen's Hospital Burton</td>
<td>0</td>
<td>0.0%</td>
<td>18,175</td>
<td>7.7%</td>
<td>298</td>
<td>0.1%</td>
<td>235,350</td>
</tr>
</tbody>
</table>

Staffing skill mix

As of September 2018, the proportion of consultant staff reported to be working at the trust was the same as to the England average. The proportion of junior (foundation year 1-2) staff was similar to the England average.
Staffing skill mix for the 371 Whole Time Equivalent staff working in medicine at University Hospitals of Derby and Burton NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The trust used an electronic patient record system. This was used alongside paper records and different wards adopted different uses of paper to suit their individual needs.

We noted that the system was in use across the Queens Hospital in Burton, the Sir Robert Peel Hospital in Tamworth and the Samuel Johnson Hospital in Litchfield. When we asked staff if it was an issue that a different system was in use at Derby they did not consider it a problem.

Most staff spoke positively about the system and while some staff considered that the risk assessment bundles were sometimes inappropriate no-one raised any safety concerns with the inspection team about the system.

On the wards we visited we noted that notes were kept in trolleys which were locked and we did not see unattended paper records. We also saw that electronic patient record systems were password protected and were not secured when left unattended.

Access to electronic records was through computers on the different wards and units and we saw wireless laptops being used by staff to access and change records during handovers and ward rounds.

Access to the system was by a username and password which was provided following training. All substantive and bank staff had access to the system as did most agency staff. We saw lists of named agency staff who did have access to the system and staff tried to ensure they were the ones supplied but some agency staff were working without access to the systems and relied on colleagues, usually healthcare support workers to help them. However, it was noted that there was not a culture of sharing passwords to overcome this.

Agency staff told us they were required to attend IT training in their own time to get access to the EPR system.
We reviewed four sets of notes in detail and they were up to date and when on paper legible. Admission processes triggered assessments of any disabilities a patient might have including problems with communication. There were also assessments of mental capacity, self-harm and frailty which triggered the use of relevant assessment bundles when needed.

Discharge planning was initiated on the EPR system on admission as required by the service’s policy. The records that we saw had discharge plans in place and when we discussed complex discharges with the discharge facilitators the plans they described for individual patients corresponded to those on the system.

We did note that some risk assessments were not always fully completed and some were not completed at all. When we asked about the latter we were told that some risk assessments were part of a bundle and were not relevant to the patient and that in some instances risk assessments had been manually triggered earlier in the patient’s pathway but were not needed.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

The service had a medicines management policy which was used in conjunction with other policies covering antibiotics, unlicensed medicines, patient group directives and the use of intravenous therapy. These polices ensured that the Department of Health Guidelines for the Safe and Secure Handling of Medicines and the Nursing and Midwifery Council advice on Administration of Medicines and Codes of Professional Conduct would be followed.

Storage of medicines, including controlled drugs was seen to be correct with unlocked trollies never left unattended and when not in use trollies were secured in line with the services policies. Drugs fridges were at the correct temperatures and we saw evidence that they were regularly checked although there were occasional gaps in the recording of the temperatures.

An electronic prescribing system was in use in the trust and was used for all inpatients. The system recorded drug allergies and this was a mandatory field. Where paper prescribing was necessary the medicines management policy how this must be done. Any introduction of paper records for medicines including supplemental sheets was required to be signed off by the service’s Drug and Therapeutics Group.

Staff were observed administering medicines and they followed the required policies and procedures.

We reviewed five electronic medicines records and found them to be very clear with good instructions. For two patients out of the five a medicine had been administered at the wrong time in one case an hour early and in the other case an hour and a half late. We made the ward sister aware of this and it did not have an adverse effect on the patients.

On wards controlled drugs were checked daily and pharmacists carried out audits.

Pharmacy technicians visited wards each morning to check on the medicines for newly admitted patients and to carry out medicine’s reconciliation. They were available throughout the day by pager to advise including liaison with pharmacists as necessary. This system also worked well to support the supply of medicines for patients to take home with them as staff told us there were very few delays.
Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

There were systems in place to direct staff what to do when incidents occurred. The trust recorded and managed incidents using an electronic incident management system.

We spoke to staff about recognising patient safety incidents and what they would do. They gave answers appropriate to their role but in all cases, they told us the incidents would be entered onto the system by them or by the person who they informed.

We asked staff for examples of recent incidents and they were able to describe the incident, how it was resolved and how preventative measures were put in place. We looked at two incidents of our choosing in detail and we saw that in both cases the incident procedure had been followed and that an investigation had taken place and recommendations for changes made. We saw that the changes had been put in place and that this was communicated in an appropriate way, for example in handovers, through posters and using briefing sessions.

On one ward we noted that details of a drug administration incident was on the wall of a clinical room and that it was written very carefully as learning material for the staff not as a criticism of what had happened.

Staff to whom we spoke were familiar with the concept of the duty of candour and while they were not always able to describe it in detail were clear about the importance of telling patients when something had gone wrong and we were assured that they would report untoward incidents. The service told us that formalised duty of candour training sessions had not taken place and training had been ad hoc. However, there was now a duty of candour project manager in place who was rolling out face to face training and working towards developing an e learning training pack. The trust was aiming to have 90% of staff trained within 12 months of the e learning pack being available.

Never events

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust we have used this to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, the trust reported three incidents classified as never events for medical care.

The first occurred in July 2018 at Royal Derby Hospital and was of never event type “Unintentional connection of a patient requiring oxygen to an air flowmeter”.


The other two never events both occurred in November 2018. One was an incidence of wrong site surgery (the hospital location was not specified); the other was an incidence of administration of medication by the wrong route at Royal Derby Hospital.

**Burton Hospitals NHS Foundation Trust**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From January to December 2018, the trust reported no incidents that were classified as never events for medical care.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 50 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Slips/trips/falls: 21
- Pressure ulcer: 16
- Medication incident: three
- Diagnostic incident including delay (including failure to act on test results): two
- Venous thrombo-embolism: two
- Sub-optimal care of the deteriorating patient: two
- Confidential information leak/information governance breach: one
- Surgical/invasive procedure incident: one
- Treatment delay: one
- Abuse/alleged abuse of adult patient by staff: one

The time taken by the trust to report these 50 SI’s to STEIS varied:

- 33 were reported within 14 days
- Four took between 15 and 30 days to report
- Two took between 31 and 60 days to report
- Five took between 61 and 90 days to report
- Six took more than 90 days to report

**Burton Hospitals NHS Foundation Trust**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents
(SIs) in medical care which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Pressure ulcer: 13
- Slips/trips/falls: two
- Sub-optimal care of the deteriorating patient: two
- Medication incident: one
- Treatment delay: one

The time taken by the trust to report these 19 SI’s to STEIS was variable:

- Two took between 15 and 30 days to report
- Eight took between 61 and 90 days to report
- Nine took more than 90 days to report

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff patients and visitors through. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data relate to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported 41 new pressure ulcers, nine falls with harm and 15 urinary tract infections in patients with a catheter in its medical care services.

Prevalence rate (number of patients per 100 surveyed) of patient harms at University Hospitals of Derby and Burton NHS Foundation Trust
1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

**Source: NHS Digital - Safety Thermometer**

**Burton Hospitals NHS Foundation Trust**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported 34 new pressure ulcers, three falls with harm and five urinary tract infections in patients with a catheter in its medical care services.

**Prevalence rate (number of patients per 100 surveyed) of patient harms at Burton Hospitals NHS Foundation Trust**
Total Falls (3)

Total CUTIs (5)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

When we looked at polices and clinical guidance we noted that these, and therefore the treatment delivered was in line with guidance from the National Institute for Health and Care Excellence (NICE). This ensured that patients were assessed taking into account their mental and social factors and not just their medical conditions.

The medicine division’s audit plan identified audit topics including national audits, local audits and audits against NICE guidelines. We also saw a record of completed audits at the Queen’s Hospital Burton only which covered the same areas.

The trust had not submitted anything to the NICE Shared Learning database, however the clinical audit manager had registered to attend the next NICE annual conference to understand how best to engage and start to share best practice.

The service followed sepsis guidelines which made use of the “Sepsis 6” pathway. There were separate guidelines for neutropenic sepsis in use for cancer and haematology patients. We saw audits had taken place covering “Sepsis: Time to treat, review and step down”, “Recognition and management of sepsis” and “Neutropenic sepsis Assessment Tool” at the Queen’s Hospital Burton site.

Consultant medical staff were present on the Acute Assessment Centre from 8am to 5pm meaning that acutely ill patients were reviewed twice each day. This was also the case on the coronary care ward where cover was from 9am until half past six in the evening. On other wards consultant cover was not always in place at the weekends.

Endoscopic procedures at both the Queens Hospital Burton and the Sir Robert Peel Hospital Tamworth were carried out in line with the policies and procedures of the British Society of
Gastroenterology guidance. Both endoscopy units were accredited with the Joint Advisory Group on gastrointestinal endoscopy (JAG) standards.

The service used an electronic prescribing system which provided on-line guidance for medicines including antimicrobial guidelines.

The management of violence and aggression is supported by mandatory training in de-escalation and there was an enhanced nursing team to provide support.

Older patients always had their mental and social needs assessed as part of frailty pathway and referred as necessary. There was a frailty team and access to Liaison Psychiatric Nurses from the local mental health trust.

There was a policy for management of vascular catheters that used a standard method of scoring the risk of developing and infection. We looked at patients’ records and noted that while there was good initial documentation these were not always updated each day.

Door to needle times for the Queen’s Hospital Burton were only provided for December 2018 but they were 100% within the nice guideline of less than four and a half hours.

**Nutrition and hydration**

*Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.*

Patients had their nutritional needs assessed on admission using a screening tool as part of the risk assessment bundles on the electronic patient record system. Patients were referred to specialist support dependent on their needs including dieticians and their care plans were updated.

When we spoke to patients we asked about the food and drink that they were offered and almost all were complimentary about the quality and choice of the menus. Patients told us they were regularly offered drinks and this corresponded with our observations of staff asking and where appropriate prompting and encouraging patients to drink.

We also saw, on more than one occasion, staff spending time helping patients choose food from the hospital’s menus. We were also told by staff that a new menu and food ordering system meant food could be ordered in a timelier fashion. On Ward 6 we saw that there was a fruit bowl available to patients, relatives and staff.

On the stroke wards we noted that nursing staff could carry out assessments of whether patients were able to swallow food and drink safely and this meant that when the Speech and Language Therapy (SALT) service was unavailable at the weekend most patients who were assessed as safe to do so were able to eat and drink. However, on other wards nurses did not have these skills and so patients admitted over the weekend with swallowing problems could not eat until they had been assessed. For a patient admitted on a Friday night this would mean waiting until Monday morning.

We were also told that it could be difficult to get timely SALT assessments during the week due to the workload on the service.

*Where thickeners were prescribed we saw that this was reinforced by the thickness to be made up being written on boards above the patient’s bed.*

When we looked at patients records we noted comprehensive and complete recording of food
intake and fluid balance, but we rarely saw fluid targets identified.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.*

The service had implemented the Faculty of Pain Medicine’s Core Standards for Pain Management (2015)

Pain assessments were included in patients’ records on the service’s electronic patient record system. Staff checked whether patients were in pain through intentional rounding and we saw them using charts to support this. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

We asked the patients to whom we spoke about their pain and we were told that staff regularly asked about their pain and that pain relief was offered when it was needed.

Activity coordinators from the enhanced care team also supported the management of pain through, for example distraction and in one case we noted using massage. We were also told by the learning disability lead that following an incident where a patient’s distress had been mistakenly attributed to their behaviour rather than the pain that measures had been put in place to support staff to recognise how some patients express pain differently.

**Patient outcomes**

*Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. However, some outcomes for patients were worse than the England average.*

We saw from information submitted that following the acquisition of the Queen’s Hospital Burton the audit program had been subsumed into that of the trust as a whole.

There was a clinical audit plan which was aligned with the board assurance framework, approved by the audit committee and signed off by the Trust Board. The different business units within the medicine division each submitted a clinical audit report to the medicine governance meeting once a quarter. The report contained information about the progress of audit topics, results of audit and any learning identified from audit.

We saw audits had taken place covering “Sepsis: Time to treat, review and step down”, “Recognition and management of sepsis” and “Neutropenic sepsis Assessment Tool” at the Queen’s Hospital Burton site.

Endoscopic procedures at both the Queens Hospital Burton and the Sir Robert Peel Hospital Tamworth were accredited with the Joint Advisory Group on gastrointestinal endoscopy (JAG) standards. Neither unit had outstanding actions from the last audit.

**Relative risk of readmission**

*Trust level – elective admissions*

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition
in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From June 2017 to May 2018, patients at the trust had a similar to expected risk of readmission for elective medical admissions compared to the England average.

- Risk of readmission for medical oncology was higher than expected.
- Risk of readmission for clinical haematology was similar to expected.
- Risk of readmission for gastroenterology was lower than expected.

**Elective Admissions – Trust level**

![Graph showing readmission rates for various specialties]  

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.*

**Trust level – non-elective admissions**

From June 2017 to May 2018, patients at the trust had a similar to expected risk of readmission for elective medical admissions compared to the England average.

- Risk of readmission for general medicine was similar to expected.
- Risk of readmission for medical oncology was lower than expected.
- Risk of readmission for nephrology was higher than expected.

**Non-Elective Admissions - Trust level**

![Graph showing readmission rates for various specialties]  

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.*

**Queen’s Hospital Burton – elective admissions**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis.
These data are provided for contextual purposes and are not used to form part of our judgement.

From June 2017 to May 2018, patients at Queen’s Hospital Burton had a similar to expected risk of readmission for elective medical admissions compared to the England average.

- Risk of readmission for medical oncology was higher than expected.
- Risks of readmission for gastroenterology and clinical haematology were lower than expected.

**Elective Admissions – Queen’s Hospital Burton**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Queen’s Hospital Burton – non-elective admissions**

From June 2017 to May 2018, patients at Queen’s Hospital Burton had a similar to expected risk of readmission for elective medical admissions compared to the England average.

- Risks of readmission for general medicine and geriatric medicine were similar to expected.
- Risk of readmission for stroke medicine was higher than expected.

**Non-Elective Admissions - Queen’s Hospital Burton**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.
(Source: Hospital Episode Statistics)

Sentinel Stroke National Audit Programme (SSNAP)

Queen's Hospital Burton

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

Queen's Hospital Burton takes part in the Sentinel Stroke National Audit programme.

The hospital's performance is shown in the tables below.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A↑</td>
<td>A</td>
<td>B↓</td>
<td>A↑</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A↑↑</td>
<td>B↓</td>
<td>B</td>
<td>C↓</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
</tr>
</tbody>
</table>

On a scale of A-E, where A is best, the hospital’s overall SSNAP level deteriorated from grade C for the two audit periods from December 2016 to July 2017 to grade D for the subsequent two audit periods from August 2017 to March 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>E</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A↑↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
<td>E↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A↑</td>
<td>B↓</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Patient-centred total key indicator level</td>
<td>C↑</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
</tr>
</tbody>
</table>

The hospital’s patient-centred stroke unit indicator was consistently grade D for the four most recent audit periods, covering the 16 months from December 2016 to March 2018.

The hospital's patient-centred total key indicator level deteriorated from grade C for the two audit periods from December 2016 to July 2017 to grade D for the subsequent two audit periods from August 2017 to March 2018.
The hospital's performance for team-centred stroke unit indicator was consistently grade D for the four most recent audit periods, covering the 16 months from December 2016 to March 2018.

The hospital's patient-centred total key indicator level deteriorated from grade C for the three audit periods from December 2016 to November 2017 to grade D for the most recent audit period from December 2017 to March 2018.

(Source: Royal College of Physicians London, SSNAP audit)

The SSNAP rating of D reflected the following characteristics of the stroke service. There was no consultant review or specialist nursing input at weekends meaning initial swallowing assessment by a nurse is not always within four hours. As continuous consultant cover was not provided, consultant review within fourteen hours was not always possible and less than 50% of stroke patients are admitted to the stroke unit within four hours. Physiotherapy and occupational therapy services are limited at the weekend and there was no speech and language therapy service available at the weekend.

### Lung Cancer Audit

**Burton Hospitals NHS Foundation Trust**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

The trust participated in the 2017 Lung Cancer Audit.

The crude proportion of patients seen by a cancer nurse specialist was 85.7%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 83.0%.

The case-mix adjusted proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 19.9%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was significantly better than the national level.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 51.8%. This was within the expected range compared to other trusts. The trust’s performance in
the equivalent measure from the 2016 audit was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer receiving chemotherapy was 74.7%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was not significantly different from the national level.

The case-mix adjusted one year relative survival rate for the trust in 2017 was 61.8%. This was within the expected range compared to other trusts. In 2016 the trust’s performance for this metric was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Queen’s Hospital Burton

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

The trust participated in the National Audit of Inpatient Falls 2017.

At Queen’s Hospital Burton the crude proportion of patients who had a vision assessment (if applicable) was 89.7%. This did not meet the national aspirational standard of 100%. Results of more than 80% for this metric are rated as good.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 53.6%. This did not meet the national aspirational standard of 100%. Results of between 50% and 79% for this metric are rated as fair.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 7.1%. This did not meet the national aspirational standard of 100%. Results of less than 50% for this metric are rated as poor.

The crude proportion of patients with a call bell in reach (if applicable) was 82.1%. This did not meet the national aspirational standard of 100%. Results of more than 80% for this metric are rated as good.

(Source: Royal College of Physicians)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

We saw wards and departments were staffed by employees with a variety of levels of expertise, skills and knowledge. Aside from staff based in each department or ward there were specialist nurses, doctors and healthcare professionals who could be called on to provide care and advice. This meant that patients had their needs, preferences and choices met by staff with the right skills and knowledge.

There were clinical nurse specialist and link/champion roles identified on ward areas and throughout the hospital. Examples roles we saw included learning disability, tissue viability, dementia, diabetes, manual handling, suction and end of life care. Most staff we spoke with could name an individual from their ward or knew how to contact the service or individual across the
hospital site.

There were also staff from other organisations available, for example Liaison Psychiatric Nurses from the local mental health trust had their own offices on the hospital estate and worked alongside hospital staff.

All staff at the Queens Hospital were required to complete mandatory training in key skills dependent on their roles. Mandatory training was programmed by ward managers to fit into the staffing need of the ward and that time protected for staff to be off the ward on training. Staff told us that they could access training including on-line modules that were available from any computer including outside of the hospital.

Staff new to the trust were given a formal induction which included their initial mandatory training as well as training specific to their role. The services completion figures were 100%. Newly qualified staff were given extra support including a twelve-month long preceptorship programme.

Most staff told us that their appraisals were up to date. Some staff and managers went on to tell us that some appraisals were late because the appraisal information was being transferred from the electronic system at Burton to the system used at Derby. This was to align all appraisals into one system to better manage data across the trust. Appraisals took place throughout the year; however, there had been some delays for some staff during the transition from one system to another. Staff told us they saw both advantages and disadvantages to the realignment but had no overall concerns. All professional staff were given the necessary support and access to training to maintain their professional registrations as well as opportunities for personal development.

Regular appraisals were in place for medical staff and all doctors were revalidated every five years based on their engagement with medical appraisal processes. Annual appraisals were undertaken with fully trained, accredited medical appraisers. The responsible officer was responsible for making a recommendation to the GMC for a doctor to be revalidated.

**Appraisal rates – trust level**

From November 2017 to October 2018, 87.4% of staff in medical care at the trust received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were met for estates and ancillary staff and allied health professionals but were not met for any other staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>33</td>
<td>34</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>205</td>
<td>223</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>54</td>
<td>61</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>38</td>
<td>43</td>
<td>88.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>838</td>
<td>950</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>381</td>
<td>432</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>529</td>
<td>628</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>88</td>
<td>108</td>
<td>81.5%</td>
<td>100%</td>
<td>No</td>
</tr>
</tbody>
</table>
Total & 2,166 & 2,479 & 87.4% \\

**Appraisal rates – Queen’s Hospital Burton**

From November 2017 to October 2018, 90.2% of staff in medical care at Queen’s Hospital Burton received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were met for medical staff and three other staff groups but were not met for the remaining three staff groups, including qualified nurses.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>80</td>
<td>86</td>
<td>93.0%</td>
<td>90%</td>
<td>Yes</td>
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<tr>
<td>Allied health professionals</td>
<td>58</td>
<td>64</td>
<td>90.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>190</td>
<td>213</td>
<td>89.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>123</td>
<td>139</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>479</strong></td>
<td><strong>531</strong></td>
<td><strong>90.2%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Each patient had a named consultant and a named nurse who was the primary point of contact for that patient during that nurse’s shift.

There was significant input from allied health professionals to the wards and we observed good multidisciplinary working at both handovers and ward rounds and staff working together on the wards. Staff of different professions were respectful and complimentary of other professional roles and often took the opportunity to praise the contributions of their colleagues.

We also saw how most wards had daily multidisciplinary board rounds to share information which might involve the consultant, physiotherapists, occupational therapists and discharge coordinators. It was not always possible to have all staff groups at every meeting but both physiotherapists and occupational therapists who worked closely with one another told us that they coordinated their attendance to make sure at least one of them was there.

Those wards caring for elderly patients had a discharge facilitator who worked five days a week. Their role was to work with teams both in and out of the hospital to ensure that patients left the hospital for a suitable place as soon as possible after they were medically fit for discharge. They told us that their approach was to plan for discharge on admission and an important part of this was to involve the patient, relatives, carers and all the professionals who could contribute to the patient’s discharge. When we spoke to these facilitators it was clear that being based on a single
ward they knew the individual patients very well. They were clear about each patient’s stage on their pathway, the prospective plan for their discharge and barriers there might be to that.

The service’s discharge and transfer policies were based around the principal that these were multi-disciplinary and multi-agency decisions and we saw standard operating procedures, guidance and protocols that supported this.

We looked at patient records and saw that there was good evidence of multi-disciplinary input and when the ward based discharge facilitators were involved the information and planning was particularly good.

Seven-day services

All in-patient medical wards were open 24 hours a day, seven days a week. Diagnostic services including plain radiography, computerised tomography and pathology were available 24 hours a day. However, diagnostic ultrasound and magnetic resonance imaging were not.

On the stroke wards we noted that nursing staff were able to carry out assessments of whether patients were able to swallow food and drink safely and this meant that when the Speech and Language Therapy (SALT) service was unavailable at the weekend most patients who were safe to do so were able to eat and drink. However, on other wards nurses did not have these skills and so patients admitted over the weekend with swallowing problems could not be fed until they had been assessed. For a patient admitted on a Friday night this would mean waiting until Monday.

Liaison Psychiatric Nurses (LPN) from a neighbouring mental health trust were based on site and this service was available from Monday to Saturday, 08.30-16.30 and covered by the Crisis Team out of these times.

The Acute Assessment Centre was open continuously covered seven days a week by acute physicians from 8am to 5pm when general physicians took over on call.

In coronary care there was continuous cardiology consultant cover 7 days a week. A consultant was on the ward 9am to 6.30pm and was then available by phone. Out of hours there were no dedicated junior staff put in practice the staff rang the consultants directly.

On the stroke ward there was no consultant review or specialist nursing input at weekends. As continuous consultant cover was not provided, consultant review within fourteen hours was not always possible and less than 50% of stroke patients are admitted to the stroke unit within four hours. Physiotherapy and occupational therapy services are limited at the weekend and there was no speech and language therapy service available at the weekend.

Health promotion

We saw health promotion literature in public areas and on wards throughout the hospital. These comprised for the most part posters with, or without associated leaflets that signposted patients to other more detailed resources. These included smoking cessation services, mental health support, bereavement support and other initiatives around diet and wellbeing.

Patients were screened for smoking, alcohol dependence and their mental health on admission and when necessary referred into appropriate services including an alcohol specialist nurse and Alcohol Care Team.

Wards and departments all had information leaflets relevant to the services provided and the patient group that they served. There was a facility to download key documents in other languages from the trust’s intranet.
There was a good deal of literature to encourage patients to get up from bed, to dress in daytime clothes and to get moving as an aid to their better recovery and to shorten their time in hospital.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The service had a consent policy in place which addressed in detail the principles and processes for obtaining informed consent including consideration of the Mental Capacity Act.

Consent was not included in the trust’s mandatory training but staff we spoke to were aware of the policy and how to obtain consent.

Throughout the inspection we noted staff talking to patients about their care and obtaining their consent to do so in a conversational manner.

Most of the patients to whom we spoke knew about their treatment and told us staff had discussed decisions and options with them.

We asked about relatives acting as translators and the staff said that it was useful but that the trust policy was they were not to be used to obtain consent and this was strictly adhered to. We asked other staff about this on several wards and they told us the same thing.

**Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Most knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**

The service had polices covering the Mental Capacity Act (MCA) and the Deprivation of Liberty Standards (DoLS) and these were referenced when necessary in other policies.

Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory for both medical and nursing staff. However, completion rates were slightly lower than the trust’s targets but for level 1 training for medical staff they were only 20%.

Patients were assessed for their mental capacity on admission and if necessary during their stay and we saw completed records.

On one ward we visited there was a patient who was subject to an urgent deprivation of liberty. We looked at the relevant records and found them to have been completed properly and lawfully. All staff on the ward were aware of the patient and were able to talk about what they should do to prevent them leaving. The ward was also receiving support from the Enhanced Care Team who were providing techniques to restrain the patient using the least restrictive methods possible which were largely distraction and conversation.

**Mental Capacity Act and Deprivation of Liberty training completion**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it is not possible to produce trust level data.

**Queen’s Hospital Burton**

Staff at Queen’s Hospital Burton were eligible for two levels of combined MCA and Deprivation of
Liberty Safeguards training. The completion target for both levels was 90%. This requirement was inherited from the predecessor trust.

A breakdown of compliance for MCA and Deprivation of Liberty Safeguards training for the period from November 2017 to October 2018 level for qualified nursing staff in medical care at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 1</td>
<td>114</td>
<td>140</td>
<td>81.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>57</td>
<td>69</td>
<td>82.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for either module for qualified nursing staff in medical care at Queen’s Hospital Burton.

A breakdown of compliance for these modules for the same period for medical staff in medical care at Royal Derby Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>25</td>
<td>31</td>
<td>80.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 1</td>
<td>6</td>
<td>30</td>
<td>20.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for either module for medical staff in medical care at Royal Derby Hospital. Only six of the 30 eligible medical staff had completed the level 1 training.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff always acting in a kind and compassionate manner, checking on patient’s needs, taking time to speak to them and responding promptly to call bells despite the wards being very busy. However, some patients told us because of this they did not like to call the staff when they needed something.

Feedback from patients confirmed that staff treated them well and with kindness. We spoke with fifteen patients and their feedback was positive including specific comments about the caring approach of the staff including “very well cared for”, “marvellous staff”, “nice manner” & “brilliant care”.
Staff drew curtains when appropriate and on some wards which used older style fabric curtains they used red pegs to ensure the curtains remained closed.

We saw that those patients who struggled to manage their own care were given the help they needed to attend to their appearance and manner of dress so as to maintain their dignity. We also noted that greatly distressed patients had their dignity protected by the staff using curtains.

We observed mealtimes and saw that patients were given the necessary support to eat their meals and we also saw staff being very patient in helping a confused patient make a menu choice. Staff were familiar with the patients so their needs were being met but we saw that they were not always using systems intended to assist with this such as icons on bedheads or information boards.

Staff checked patients were comfortable through intentional rounding and we saw them using charts to support this. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

**Friends and Family test performance**

From October 2017 to September 2018 (excluding July 2018) the Friends and Family Test (FFT) response rate for medical care at Queen’s Hospital Burton was 15.0%. This was based on 1,725 responses. This was lower than the England average of 25%.

A breakdown of FFT performance by ward for medical wards at this hospital over the same period is shown below.

All three wards scored 98% for these 11 months overall.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 3</td>
<td>604</td>
<td>31%</td>
<td>Oct-17: 95% Nov-17: 93% Dec-17: 100% Jan-18: 97% Feb-18: 94% Mar-18: 98% Apr-18: 95% May-18: 96% Jun-18: 97% Jul-18: 96% Aug-18: 95% Sep-18: 96%</td>
<td>97% 97% 90%</td>
</tr>
<tr>
<td>Ward 5</td>
<td>275</td>
<td>42%</td>
<td>Oct-17: 94% Nov-17: 94% Dec-17: 95% Jan-18: 100% Feb-18: 95% Mar-18: 100% Apr-18: 95% May-18: 100% Jun-18: 100% Jul-18: 100% Aug-18: 93% Sep-18: 100%</td>
<td>100% 93% 97%</td>
</tr>
<tr>
<td>Ward 8</td>
<td>150</td>
<td>21%</td>
<td>Oct-17: 95% Nov-17: 100% Dec-17: 100% Jan-18: 100% Feb-18: 100% Mar-18: 100% Apr-18: 100% May-18: 100% Jun-18: 93% Jul-18: 100% Aug-18: 96% Sep-18: 100%</td>
<td>93% 100% 97%</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>145</td>
<td>14%</td>
<td>Oct-17: 98% Nov-17: 100% Dec-17: 100% Jan-18: 100% Feb-18: 100% Mar-18: 100% Apr-18: 100% May-18: 100% Jun-18: 100% Jul-18: 100% Aug-18: 95% Sep-18: 100%</td>
<td>100% 95% 99%</td>
</tr>
<tr>
<td>Ward 7</td>
<td>125</td>
<td>8%</td>
<td>Oct-17: 95% Nov-17: 92% Dec-17: 67% Jan-18: 93% Feb-18: 100% Mar-18: 100% Apr-18: 95% May-18: 100% Jun-18: 100% Jul-18: 100% Aug-18: 96% Sep-18: 85%</td>
<td>96% 85% 85%</td>
</tr>
<tr>
<td>Ward 15</td>
<td>707</td>
<td>42%</td>
<td>Oct-17: 85% Nov-17: 100% Dec-17: 100% Jan-18: 93% Feb-18: 100% Mar-18: 100% Apr-18: 95% May-18: 100% Jun-18: 100% Jul-18: 93% Aug-18: 93% Sep-18: 100%</td>
<td>96% 89% 100%</td>
</tr>
</tbody>
</table>

Key: 100% 50% 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

The hospital had a chaplaincy service which provided support for patients and relatives of any or no faith and provided an on-call service with chaplains available at any time of the day or night.

The wards could also call on an Enhanced Care Team who had the skills and resources to
support, entertain and when necessary distract patients. We were told this often prevented or reduced distress and in some instances, we saw ourselves, keeping people contented. We also saw ward staff acting in a kind and compassionate manner to distressed patients and using dementia aids such as twiddle muffs which are textured hand muffs with ribbons and buttons that keep a person’s hands “busy”.

Many patients told us that they had been provided with sufficient information about their illness, care and treatment. One patient told us that this had not been the case but when they complained the issue was quickly resolved.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment**

Staff spoke with patients in a manner that they understood and used language that was relevant and not overly medical. Many patients told us they had been kept informed and updated and this had been done well and was not rushed. One patient told us this had not been their experience but when they complained the issue was addressed and is was now “much better”.

We saw staff were welcoming to visitors and that there were flexible arrangements for accommodating the visiting needs of individual patients. We also observed a staff nurse realising that two relatives had been comforting an elderly patient for some time and suggesting that she took over, so they might get a meal.

When we spoke to patients several told us that they had been involved in the planning of their care and two told us that they were surprised by how much they were expected to do for themselves.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**The service planned and provided services in a way that met the needs of local people.**

The trust planned its services to meet the needs of local people through engagement with local Sustainability and Transformation Plans (STP). STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities. The trust crossed the boundary of the Staffordshire and Stoke-on-Trent STP and the Derbyshire STP with the Queens Hospital Burton, located at the edge of the former and the Royal Derby Hospital at the heart of the latter. The trust was therefore engaged with working with both STPs to address the recent acquisition.

The service encouraged feedback from patients and those close to them and as well as trust level surveys we saw that these took place at ward and service level within medicine and that the results were noted and acted on.

We saw on Ward 5 how they had uncovered themes in complaints and comments resulting in changes being made to the configuration of the ward so that it was easier for patients and relatives to approach the correct staff.

The Hospital estate was largely modern and made for a pleasant environment. There were some barriers to movement for disabled people to peripheral areas of the site. However, the main building had sufficient lifts and service had installed suitable ramps and walkways for wheelchair
users within the constraints of the site. Some wards were crowded and difficult to navigate around, car parking was crowded and full at some times of the day.

**Meeting people’s individual needs**

**The service took account of most patient’s individual needs**

The service’s mandatory training included equality and diversity training and the EPR system had the facility to record relevant information against the patient’s care record. It also flagged these as icons on the screen so that staff were prompted that a patient had a particular need. This use of the electronic patient record system was consistently applied.

The hospital was wheelchair friendly with suitable lifts, ramps, walkways and a newly introduced “Changing Places” washroom for disabled patients and visitors in a public area.

On wards we noted posters entitled “How do you communicate?”. This suggested that methods such as pictograms, large print text, sign language, braille, email or SMS text might be used. We also saw a communication action pack that offered pictograms and common British Sign Language and Makaton signs as well as advice on helping people with sight loss.

The trust’s complaints procedure encouraged complaints to be made in a variety of ways and instructed staff to help with this so as to encourage complaints from people who might struggle with complaining in writing. This policy also prompted the use of interpreters, advocates and required staff to consider what other reasonable adjustments might be offered.

On the stroke ward we asked about support that was available for patients or relatives who did not speak English to a level needed to communicate with the staff. We were told by staff that the hospital had translators available for local languages including Polish and Urdu and that the language line facility was also available. We asked about relatives acting as translators and the staff said that it was useful but that the trust policy was they were not to be used to obtain consent.

Many patient information leaflets were available pre-printed in Polish and Urdu and more were available to be printed on demand from the service’s intranet. Other leaflets could be translated on demand as needed.

The hospital had a chaplaincy service which provided support for patients and relatives of any or no faith and provided an on-call service with chaplains available at any time of the day or night.

The wards could also call on an Enhanced Care Team who had the skills and resources to support, entertain and when necessary distract patients. We were told this often prevented or reduced distress and in some instances, we saw ourselves, keeping people contented. We also saw ward staff acting in a kind and compassionate manner to distressed patients and using dementia aids such as twiddle muffs which are textured hand muffs with ribbons and buttons that keep a person’s hands “busy”.

Some wards had systems in place to identify patients who had particular requirements such as help with eating, support for their dementia or were at risk of falling. These often took the form of icons displayed adjacent to the patient’s bed space to prompt staff of the need. However, systems differed between wards and were often inconsistently used between staff or in some cases had fallen into disuse. Those needs however, were always recorded in the patient’s notes and care plans.

The trust had an Enhanced Care Team which worked in a multi-disciplinary manner across the trust. This joint working involved mental health, community, social care and safeguarding teams outside of the trust as well as internal wards and departments and they were co-located with the
vulnerable person lead who was employed by the local mental health trust. We discussed examples with the team and one was a patient with learning disabilities who had been admitted numerous times to the trust. After reviewing and working with the patient, working with other agencies and developing a plan for when the patient came into hospital the patient received the treatment they needed and the number of admissions to hospital and calls too other services fell. arrangements for their partner to stay in a side room with them following their surgery.

There was a dementia steering group which meets alternately across the Derby and Burton sites and as well as trust staff such as nurses, medics, and allied health professionals also includes representatives from clinical commissioning groups, nursing homes and carers.

Patients with complex needs had their discharge arranges made with other agencies through multi-disciplinary teams and the ward based discharge facilitators contributed greatly to this process through good record keeping and pro-active pursuit of discharge objectives.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Acutely ill medical patients were admitted through the service’s Acute Assessment Centre (AAC) 80% of the patients came through the service’s Emergency Department (ED) and 20% were admitted directly following discussion with a GP or other referrer thus avoiding the ED. Patients stayed for a maximum of 48 hours on the AAC and most patients stayed less than 24 hours.

Apart from lack of beds deeper in the hospital barriers to flow from the AAC were identified as lack of ultrasound and access to magnetic resonance imaging which was used for elective scans in the week and not available at the weekend.

Work in the AAC was scheduled using a “Medical Tracker” where the status of each patient was noted, where they were and how long they had been at the current point in the pathway and who was next to be clerked by a junior or reviewed by a senior doctor.

Patients expected to stay for a short period in the hospital who did not have need of a specialist ward were admitted to Ward 101 usually from AAC put 10% directly from the ED. Ward 101 had a ward based discharge facilitator, a pharmacy technician and an HCA dedicated to helping patients get home by doing things such as helping pack belongings. As well as access to the main discharge lounge Ward 101 had its own mini discharge lounge.

Patients suspected of having a stroke where identified in the emergency department and usually scanned and thrombolysed before admission. On admission to the Stroke Ward they followed a full stroke pathway that we were told would be integrated across the Derby and Burton sites by April 2019.

Clinical pathways for patients in this early part of their journey through the hospital were judged as being good.

The trust had two flow coordinators responsible for the emergency pathway who worked alongside bed managers for medicine and surgery. Each day they carried out a full wards round to identify empty beds, definite and potential discharges and barriers to discharge such as waits for investigations which could be escalated as needed. The flow coordinator told us liaised with the discharge team and community services and were aware of patients coming through the emergency pathway who would need, for example, a stroke or coronary care bed to be made available. This involved a good working relationship with the emergency department, the Acute
Assessment Centre and the Short Stay Ward.

The trust held bed management meetings several times a day and the number and timing of these depended on the escalation level that had been triggered. We attended two of these meetings on days when the trust had implemented their Full Capacity Protocol (FCP) as a response to the hospital being full. We saw that these were managed effectively and efficiently with input from the flow coordinators, senior staff responsible for the wards and departments and also staff representing the patient transport service. Staff not only discussed the situation in terms of bed capacity and flow, but we saw that they were familiar with the specific clinical and social needs of patients and adjusted their approach accordingly.

As part of the FCP the endoscopy unit was being used to provide overnight beds to patients who were medically fit for discharge but who would be discharged early the next day. This reduced out of hours discharge without taking up beds for other patients. The facility used proper beds, had sufficient space, was properly equipped and staffed and met the requirements for same sex accommodation. Endoscopy staff told us that when they arrived each day to open their unit everything was tidy and clean and they had experienced no impact other than some staff were being asked to contribute to the overnight staffing.

Those wards caring for patients with complex discharge needs had a discharge facilitator who worked five days a week. Their role was to work with teams both in and out of the hospital to ensure that patients left the hospital for a suitable place as soon as possible after they were medically fit for discharge. They told us that their approach was to plan for discharge on admission and an important part of this was to involve the patient, relatives, carers and all the professionals who could contribute to the patient’s discharge. When we spoke to these facilitators it was clear that through being based on a single ward they knew the individual patients very well and that they were clear about each patient’s stage on their pathway through the hospital, the prospective plan for their discharge and what barriers there might be to that.

Average length of stay

Trust Level

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust was 5.2 days, which was similar to the England average of six days.

Average lengths of stay for elective specialties:

- Average length of stay for elective patients in hepatology was shorter than the England average.
- Average length of stay for elective patients in clinical haematology was similar to the England average.

Elective Average Length of Stay – Trust Level
For medical non-elective patients, the average length of stay was 6.5 days, which was similar to the England average of 6.3 days.

Average lengths of stay for non-elective specialties:

- Average lengths of stay for elective patients in general medicine and cardiology were similar to the England averages.
- Average length of stay for elective patients in stroke medicine was longer than the England average.

Non-Elective Average Length of Stay – Trust Level

Queen’s Hospital Burton

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From July 2017 to June 2018 the average length of stay for medical elective patients at Queen’s Hospital Burton was 5.5 days, which was similar to the England average of six days.

Average lengths of stay for elective specialties:

- Average length of stay for elective patients in clinical haematology was shorter than the England average.
- Average lengths of stay for elective patients in gastroenterology and medical oncology were longer than the England averages.

Elective Average Length of Stay - Queen’s Hospital Burton
For medical non-elective patients, the average length of stay was seven days, which was similar to the England average of 6.3 days.

Average lengths of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was longer than the England average.
- Average lengths of stay for non-elective patients in geriatric medicine and stroke medicine were shorter than the England averages.

Non-Elective Average Length of Stay - Queen’s Hospital Burton

Referral to treatment (percentage within 18 weeks) - admitted performance

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was better than the England average in 11 out of 12 months.
Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From November 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was worse than the England average in six out of eight months.

(Source: NHS England)

**Burton Hospitals NHS Foundation Trust**

From November 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was worse than the England average in six out of eight months.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the trust performed better than the England average for admitted RTT (percentage within 18 weeks) for six out of eight medical specialties.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>96.2%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.8%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>92.6%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>91.3%</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

Over the same period there were two specialties where the trust performed worse than the England average for admitted RTT:
### Specialty grouping

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>90.4%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>87.8%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

### Burton Hospitals NHS Foundation Trust

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From November 2017 to June 2018 the trust performed better than the England average for admitted RTT (percentage within 18 weeks) for three out of six medical specialties.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>97.5%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.6%</td>
<td>81.7%</td>
</tr>
</tbody>
</table>

Over the same period there were three specialties where the trust performed worse than the England average for admitted RTT:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>92.9%</td>
<td>94.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>85.7%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>83.4%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

### Patient moving wards per admission

From November 2017 to October 2018, 39.1% of patients on the trust’s medical wards did not move wards during their admission, and 60.9% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

### Patient moving wards at night

From November 2017 to October 2018, there were 8,959 patient moves at night on medical wards. The highest numbers of ward moves were reported in January 2018 (804), December 2017 (801) and May 2018 (789).

The majority of ward moves at night over this period involved the medical assessment unit at Royal Derby Hospital (7,922, 88.4%). Otherwise the highest numbers of ward moves at night were reported for the Coronary Care Unit (118) and Ward 408 (cardiology, 67) at Royal Derby Hospital, and Ward 8 at Queen’s Hospital Burton (61).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

### Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

There was a trust level “Trust Policy and Procedures on Handlings Complaints” policy which referred to the aims of the NHS Constitution and set out principles that complaints should be encouraged and that complainants should be supported to make complaints.
On all wards that we visited we saw that there was information about how to complain and this mentioned contact with ward staff or the PALS service to get issues resolved quickly. We also noted that PALS information was available in both Urdu and Polish, the most commonly spoken languages other than English amongst the hospital’s patients.

The material made it clear that complaints could be made in a variety of ways and that staff would always support patients in making a complaint.

We asked staff about the complaints process and they always knew what they should do. On Ward 5 this prompted a discussion as to how complaints and comments had uncovered themes resulting in changes being made to the configuration of the ward so that it was easier for patients and relatives to approach the correct staff.

There was also clear easy to follow information on the hospital website about how to make a complaint with downloadable complaints forms and information about NHS Complaints Advocacy. NHS Complaint Advocacy can provide an advocate, independent of the NHS to help with a complaint at any stage of the process.

There was detailed learning and improvements through the complaints investigation process. The quarterly complaints and concerns reports provided details of actions from individual complaints, along with examples of learning from business units and divisions. These reports were reviewed at the Trust Quality Committee and fed up to the Trust Board.

**Trust level**

From October 2017 to September 2018 the trust received 194 complaints about medical care. For the 175 complaints that had been closed at the time of data submission the trust took an average of 47.2 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The 19 complaints that had not yet been closed had been open for an average of 78.8 days at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Treatment</td>
<td>61</td>
</tr>
<tr>
<td>Patient Care</td>
<td>45</td>
</tr>
<tr>
<td>Communication</td>
<td>32</td>
</tr>
<tr>
<td>Values and Behaviours (Staff)</td>
<td>19</td>
</tr>
<tr>
<td>Admissions and Discharges</td>
<td>16</td>
</tr>
<tr>
<td>Waiting Times</td>
<td>6</td>
</tr>
<tr>
<td>Access to Treatment or Drugs</td>
<td>4</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
</tr>
<tr>
<td>Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, Dignity &amp; Well-Being (Pdw)</td>
<td>1</td>
</tr>
<tr>
<td>Trust Admin/Policies/Procedures</td>
<td>1</td>
</tr>
</tbody>
</table>
Queens Hospital Burton

From October 2017 to September 2018 Queens Hospital Burton received seven complaints about medical care. For the four complaints that had been closed at the time of data submission, the trust took an average of 39.5 working days to investigate and close these complaints. This was in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The three complaints that had not yet been closed had been open for an average of 51.0 days at the time of data submission. This was not in line with the policy statement above.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>5</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

Trust level

From October 2017 to September 2018 the trust received 389 compliments about medical care. The trust did not provide a breakdown by subject for compliments received.

Queen’s Hospital Burton

From October 2017 to September 2018 the hospital received 254 compliments about its medical care services at Queens Hospital Burton. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Triumvirate leadership was provided at divisional level by a divisional medical director, divisional director and divisional nurse director. Business unit triumvirate leadership consisted of a general
manager, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by ward/department managers. When we spoke to senior staff in the medical core service they showed they had the skills and knowledge to understand the challenges that the service faced, to identify the risks and to plan both responses and for improvement.

Staff were very familiar with the local leadership and senior nursing staff were visible on the wards and were seen to be proactive.

A flow coordinator told us that since the acquisition they “see more of managers”. A staff nurse also told us that they saw matrons from Derby on the medical wards at Burton and that they were aware of their own senior managers being present in Derby as cross-site working developed.

Staff were less familiar with board members although the Chief Executive was always recognised and nursing staff were familiar with the Director of Nursing.

Leadership development was addressed at several levels, the LEAD programme for aspiring leaders, leadership masterclasses for existing leaders and a leadership community forum for more senior leaders to network and exchange information.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust had revisited its strategy as part of the acquisition work integrate the trusts.

We saw this articulated throughout the service both in staff and public areas using the overarching phrase “Exceptional Care Together” and the word PRIDE to articulate both values and objectives

**Values**

- **Passion** – high energy, pace, articulate, compelling, motivating, positive, dedicated
- **Respect** – compassionate, reflective, learning, relational, strengths-based
- **Innovation** – forward thinking, creative, disruptive, outward facing, curious, empowered
- **Determination** – driven, relentless, fostering boldness, fast paced, decisive, ambition
- **Excellence** – quality (and safety), aspirational, productive

**Objectives Take PRIDE**

- **Putting patients First**
- **Right care, first time**
- **Invest our resources wisely**
- **Develop our people**
- **Ensuring value through partners**

We saw this present throughout the service and staff were often keen to draw our attention to it.

Staff also talked about their involvement in workshops for integration of services and that many of them had attended roadshows and engagement sessions.
While some staff expressed understandable concerns about the situation offered opportunity. In medicine staff were enthused by the prospect of the establishment of a hyper-acute stroke service at Derby. We were told medical staff felt this “reasonable” and would expect to play their fair part in a collaboration.

In the endoscopy unit at the Samuel Johnson Hospital staff were excited about the potential to expand the range of services they offered and, in their view, saw the creation of the larger trust as an opportunity to grow the community hospitals.

A staff nurse at the Queens Hospital felt she would have enhanced career opportunities following the acquisition and was hoping there would be opportunities to rotate across the hospital sites.

**Culture**

**Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

Staff with whom we spoke said that they felt valued and respected for their work at the service. They were proud of the wards and departments in which they worked and often spoke highly of colleagues who worked on other wards or provided them with specialised services.

However, a member of staff from the service’s medical engineering department told us that they were being moved from their current offices to a location next to the mortuary and the first time that they knew this was to happen was when someone came to survey the offices for the new occupant.

We saw staff working together as teams and it was particularly noteworthy that multi-disciplinary teams were supportive of one another. Wards were an agreeable place to be with staff exchanging pleasantries as they went about their work.

Action was taken to address poor behaviour and performance through the trust wide capability policy.

While proud of the work they did staff were honest about failings and were particularly open when we talked about serious incidents that had required investigation and had resulted in improvements being keen to show us the relevant files and discuss them. Staff were clearly encouraged to be open and honest about raising concerns.

Formalised duty of candour training sessions had not taken place the trust told us training had been ad hoc. However, there was now a duty of candour project manager in place who was rolling out face to face training and working towards developing an e learning training pack. The trust was aiming to have 90% of staff trained within 12 months of the e-learning pack being available.

Appraisals were mandated for all staff and rates either met or narrowly fell short of the trust’s targets which we understood was because the appraisal timetables were being realigned to be consistent across the whole trust.

The health and wellbeing of its staff was a priority for the trust and we saw this reflected in one of the trusts five objectives. The trust aimed to develop a comprehensive range of interventions to treat, prevent and support optimum staff health. We saw evidence of this in the trusts plan on a page end of year report in the expansion of the occupational health team to include a clinical psychologist, specialist mental health nurse and physiotherapist and compliance with National Institute for Care Excellence (NICE) guidelines for the management of long term sickness and incapacity for work.
We saw material promoting equality and diversity within the organisation with interest groups. One that was of note was an Equality and diversity calendar which encouraged discussion and celebration of not only traditionally identified groups such as those of faith or from BME and LGBTQ communities but also groups identified with professions, associations with the armed forces and genres of music.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust had a governance structure in place with clear links from the board to committees covering key areas such as quality, finance and people. The medicine division also had a governance structure with links to the overall governance meetings.

Although most policies and procedures were still specific to Derby Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust, monthly meetings were taking place to review policies and procedure, prioritising those that were due for review and those where there were clear differences between the hospitals. Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all polices were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

There was a lead for medicines mortality who undertook a review of all deaths. If learning points were identified these were taken to the medical admissions unit senior team meeting and the medicines quality and risk meeting. However, since the acquisition of Burton Hospitals NHS Foundation Trust, senior managers told us that the mortality review process was developing into a more formal programme of mortality review meetings across the trust starting with the formation of a trust mortality committee.

The medicine division reviewed its performance regularly. We reviewed the latest quarterly scorecard consisting of 62 performance indicators ranging from complaint response times, waiting times and staffing levels. Performance was discussed at the trust performance management meeting where areas of concern or for improvement could be escalated to the trust operational group.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Comprehensive assurance systems were in place to escalate performance issues which were regularly reviewed. The board assurance framework had been redeveloped to reflect the trusts five objectives and allow the board to be aware of risks and mitigating actions for each of the objectives.

As part of the acquisition of Burton Hospital NHS Trust, risk management arrangements had been reviewed and strengthened with the production of a new policy and the establishment of a risk and compliance committee.

We reviewed the medicine division risk register and we recognised significant risks that had been discussed with us by managers and staff.

The medicine division had a programme of audit which meant that the service was measuring the quality of care and treatment against standards and looking for areas to improve and areas of concern.
We saw evidence in the trust board meeting minutes that sepsis management and performance was discussed at board level. Sepsis was subject to NHS England commissioning for quality and innovation scheme (CQUIN), ‘Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)’. The operational plan detailed further actions to take place over the next twelve months for the trust to receive the financial benefits of the CQUIN.

The medicine division considered seasonal fluctuations in demand and planned well in advance to reduce the risk to patients or staff. Planning for the two winter pressures wards had begun at least six months prior to them being opened.

We were supplied with a trust wide policy for incident planning and a separate major incident policy that applied to the Queens Hospital Burton, the Samuel Johnson Hospital Litchfield and the Sir Robert Peel Hospital Tamworth only. These documents demonstrated robust planning and covered both major incidents and business continuity.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Information from a variety of sources was used to make holistic decisions on service developments for example, patient surveys, operational information, quality and financial information.

Staff had access to information to support them in delivering good quality patient care. Staff told us they could easily access information systems and during our inspection staff demonstrated this on the wards and departments we visited.

The medicine division had a set of clear performance measures which were reported and monitored regularly a data quality team checked information to make sure it was accurate, valid and reliable.

Systems were in place to ensure information was managed in line with data security standards and other legislation. Information governance policies included General Data Protection Regulations, The Freedom of Information Act 2000 and the Confidentiality Code of Practice. Information governance was included in the mandatory training topics for all staff.

Systems and processes were in place to ensure notifications were submitted to external bodies as required, for example serious incidents to both the Care Quality Commission and commissioners of the service.

Engagement

The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

People’s views and experiences were gathered and acted on to shape and improve services. A staff engagement group and patient experience committee met regularly.

‘Your views matter’ leaflets were displayed in the ward and departments we visited encouraging patients and relatives to give feedback on their experience.

We saw the action plan arising from the national staff survey carried out in 2017. All areas that scored worse than the national average had actions in place to address the key factor. For example, ‘reporting errors, near misses or incidents witnessed in last month’ actions included improving reporting on the electronic reporting system, staff training and protected time for reporting
Representatives from the medicine division attended the local emergency care boards to gain an understanding of the shared challenges of the health and social care services in the region and contribute to local improvement plans.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust was named by the National Institute for Health Research (NIHR) in a list of the top 10 trusts for undertaking clinical research nationwide. The NIHR Research Activity League Table is published each year by the NIHR Clinical Research Network (CRN), to detail research activity across all NHS trusts in England. The table provides a picture of how much clinical research is taking place, where it is, in what types of trusts, and involving how many patients. In the year 2017/2018 the trust was involved in 150 research studies.

The trust research and development department produced a quarterly newsletter ‘taking part in research’ which contained brief summaries on research projects and clinical trials and other news worthy research related information.

The trust was involved in several accreditation schemes, for example, psychiatric liaison services were accredited by the psychiatric liaison accreditation network, the medical laboratories were accredited by the United Kingdom Accreditation Service and the endoscopy held Joint Advisory Group accreditation.

There were plans in place to assist with the delivery of mental health services. A range of quality improvement measures were being developed such as, improved training, recruitment of a Registered Mental Nurse to work in MAU to improve the care that patients receive who attend the hospital with mental health needs, development of a team of Healthcare Assistants who are specifically trained to work with patients who have mental health needs and require one to one nursing and improving links with local patient groups who represent those suffering from mental health issues.

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

We saw several examples of the trust sharing results of improvement work. For example, best practice learning from audit was shared at the East Midlands Clinical Audit Support Network which met 3 – 5 times per year.
University Hospitals of Derby and Burton NHS Foundation Trust (UHDBT) was formed on the 1st July 2018 following the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust. The latter acquired the former under its existing registration with the CQC. Our legal position is that the acquired trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data relate to the same legal entity as the acquired trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust has 399 inpatient surgical beds located across two acute hospitals; Royal Derby Hospital and Queen’s Hospital Burton.

Royal Derby Hospital has 266 surgical inpatient beds located across 26 wards and units.

Queen’s Hospital Burton has 119 surgical inpatient beds located across five wards:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast care unit</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Dental oral surgery</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Pre-operative assessment department</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Surgical assessment unit</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Ward 14</td>
<td>Female surgery</td>
<td>20</td>
</tr>
<tr>
<td>Ward 15</td>
<td>Male surgery</td>
<td>21</td>
</tr>
<tr>
<td>Ward 19</td>
<td>Trauma and orthopaedics</td>
<td>30</td>
</tr>
<tr>
<td>Ward 20</td>
<td>Trauma and orthopaedics</td>
<td>29</td>
</tr>
<tr>
<td>Ward 30</td>
<td>NHS / private patients</td>
<td>19</td>
</tr>
<tr>
<td>The Treatment Centre</td>
<td>Day surgery: ENT, General Surgery, Breast Surgery, Gynaecology, Urology, Maxofacial/oral surgery, plastic surgery, orthopaedics, ophthalmology, rheumatology</td>
<td>N/A</td>
</tr>
<tr>
<td>Sir Robert Peel Hospital</td>
<td>Day surgery: ENT, General Surgery, Breast Surgery, Gynaecology, Urology, plastic surgery, orthopaedics, ophthalmology, rheumatology</td>
<td>N/A</td>
</tr>
</tbody>
</table>
At the time of our inspection there was a reduction of surgical beds in Ward 19 and Ward 30 to manage the seasonal increase of medical patients. Day surgery for non-complex procedures for people aged 16 and over is provided by the trust at The Treatment Centre, QHB and at Sir Robert Peel Community Hospital, with consultant and nurse-led clinics offering consultations, investigations, minor procedures, post treatment follow-ups and health promotion.

The trust has 52 operating theatres.

Surgical specialties provided include ear, nose and throat (ENT), upper and lower gastrointestinal surgery, head and neck surgery, ophthalmology, oral and maxillofacial surgery, plastic surgery, trauma and orthopaedics and urology.

The trust also provides the following specialist surgical services:

- Bariatric surgery for Derbyshire, Nottinghamshire and Lincolnshire and robotic surgery for colorectal, head and neck and urological cancers.
- The vascular hub for Derbyshire, with interventional radiology capacity.
- Specialist spinal surgery as part of the East Midlands Spinal Network Centre.
- Hand surgery at the Pulvertaft Hand Unit located at Royal Derby Hospital.

(Source: Routine Provider Information Request AC1 - Acute context)

**Admission figures - Queen’s Hospital Burton**

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

The trust had 19,809 surgical admissions from August 2017 to June 2018. Emergency admissions accounted for 5,848 (29.5%), 2,571 (13.0%) were elective, and the remaining 11,390 (57.5%) were day case.

(Source: Hospital Episode Statistics)

**Admissions figures - University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

University Hospitals of Derby and Burton NHS Foundation Trust had 51,270 surgical admissions from August 2017 to July 2018. Emergency admissions accounted for 12,326 (24.0%), 7,883 (15.4%) were elective, and the remaining 31,061 (60.6%) were day case.

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**
Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all mandatory training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in surgery at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Load handling</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control – non-clinical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>179</td>
<td>180</td>
<td>99.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>179</td>
<td>180</td>
<td>99.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>178</td>
<td>180</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>173</td>
<td>180</td>
<td>96.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>170</td>
<td>178</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>171</td>
<td>180</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>170</td>
<td>179</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>169</td>
<td>180</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (collection)</td>
<td>43</td>
<td>47</td>
<td>91.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (administration)</td>
<td>274</td>
<td>304</td>
<td>90.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>161</td>
<td>180</td>
<td>89.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion theory (nursing)</td>
<td>137</td>
<td>154</td>
<td>89.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>158</td>
<td>179</td>
<td>88.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>154</td>
<td>178</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>118</td>
<td>141</td>
<td>83.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>129</td>
<td>158</td>
<td>81.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>50</td>
<td>64</td>
<td>78.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>20</td>
<td>36</td>
<td>55.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 91.5% for qualified nursing staff in surgery at Queen’s Hospital Burton. The trust’s mandatory training targets were met for 13 of the 21 mandatory training modules for which qualified nursing staff were eligible. Information received following our inspection showed the surgery division overall compliance rate was 91% in January 2019. The information was not broken down by subject.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in surgery at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
</table>

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The trust had an overall training compliance rate of 79.5% for medical staff in surgery at Queen’s Hospital Burton. The trust’s mandatory training targets were met for three of the 19 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with confirmed they had completed mandatory training and were reminded of their training requirements at least four months in advance, and that it would form part of their annual appraisal. Staff told us that there had been particular difficulties accessing life support training as there was a waiting list. However; staff that had not completed training had since been able to book as extra sessions had been scheduled.

National Institute for Health and Care Excellence (NICE) guideline 51 (NG51) Sepsis: recognition, diagnosis and early management recommends that all healthcare staff and students involved in assessing people’s clinical condition are given regular appropriate training in identifying people who might have sepsis. Staff we spoke with confirmed that sepsis training was provided at departmental level and we saw that this included the use of sepsis screening tools and sepsis care bundles.

Staff we spoke with told us that as part of their mandatory training they had also completed training to make them aware of potential needs of people with mental health conditions, learning disability, autism and dementia.

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Eligible</th>
<th>Completed</th>
<th>Compliance (%)</th>
<th>Target Compliance (%)</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>115</td>
<td>121</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>112</td>
<td>121</td>
<td>92.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load handling</td>
<td>11</td>
<td>12</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>104</td>
<td>121</td>
<td>86.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>104</td>
<td>121</td>
<td>86.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Doctors manual handling awareness</td>
<td>90</td>
<td>109</td>
<td>82.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion competency (administration)</td>
<td>64</td>
<td>80</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion theory (doctors)</td>
<td>86</td>
<td>109</td>
<td>78.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>95</td>
<td>121</td>
<td>78.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>95</td>
<td>121</td>
<td>78.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>94</td>
<td>121</td>
<td>77.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>92</td>
<td>121</td>
<td>76.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>92</td>
<td>121</td>
<td>76.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>16</td>
<td>22</td>
<td>72.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>65</td>
<td>91</td>
<td>71.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>85</td>
<td>121</td>
<td>70.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>11</td>
<td>18</td>
<td>61.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>18</td>
<td>30</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>34</td>
<td>58</td>
<td>58.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Following our visit, the leadership team provided us with updated information. We saw that there had been an improvement in compliance with mandatory training within the surgery service since the acquisition, with an overall compliance rate of 91%.

**Safeguarding**

The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Nursing staff located these documents easily on the trust’s intranet system. Staff we spoke with knew how to contact the safeguarding leads and told us they were easily accessible.

We saw evidence of safeguarding procedures being correctly followed for patients during our inspection. These included reporting concerns, daily reviews carried out by the safeguarding team and working collaboratively with other agencies such as the local authority.

**Safeguarding training completion rates**

Intercollegiate guidance: Adult safeguarding: roles and competencies for health care staff, August 2018 sets out minimum safeguarding training. The document states adult safeguarding competencies should be reviewed annually as part of staff appraisal in conjunction with individual learning and development, and three yearly refresher training. The guidance also requires there is a programme of safeguarding training and continuous professional development.

Staff were trained in safeguarding for adults and children to the required level specific to their role and had completed mandatory on-line and face to face training. All staff we spoke with were clear about what constituted a safeguarding concern and how to escalate a safeguarding referral.

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all safeguarding training modules.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in surgery at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent awareness</td>
<td>174</td>
<td>180</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>174</td>
<td>180</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>173</td>
<td>179</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>170</td>
<td>179</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>170</td>
<td>180</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 95.8% for qualified nursing staff in surgery at Queen’s Hospital Burton. The trust’s mandatory training targets were met for five of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in surgery at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 3</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>95</td>
<td>121</td>
<td>78.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>94</td>
<td>121</td>
<td>77.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----</td>
<td>-----</td>
<td>-------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>91</td>
<td>118</td>
<td>77.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>89</td>
<td>121</td>
<td>73.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>86</td>
<td>121</td>
<td>71.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 75.6% for medical staff in surgery at Queen’s Hospital Burton. The trust’s mandatory training targets were met for one of the six safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**

The service paid regard to The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. Infection prevention and control (IPC) principles and responsibilities were set out in an up to date trust policy and were applied consistently across the service. Staff followed the required precautions to minimise the risk of infection to others and sought and acted upon advice from the trust specialist IPC team where needed. Patients who had a known or suspected infection were nursed in isolation, with appropriate signage in place to alert staff and visitors of action they needed to take.

Microbiology protocols were in place to support staff when prescribing antimicrobials. These were reviewed by an antibiotic pharmacist to ensure they were in line with current recommendations in Public Health England Start Smart then focus: Antimicrobial Stewardship Toolkit and NICE Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use guidelines published August 2015.

All patient areas we visited were visibly clean. Staff actively cleaned and tidied according to cleaning schedules and other requests. Staff in the operating theatre department cleaned surfaces before surgery began and before patients arrived. A deep clean in the operating theatres was undertaken at the end of each day and after an infectious patient, to prevent the transmission of diseases, in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.

Separate clean and dirty utility areas were allocated in patient areas to ensure that the risk of infection transmission was minimised. Clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high-risk dirty linen. Surgical instrument trolleys were clearly labelled ‘clean’ or ‘dirty’ and instruments were wrapped and stored in the correct trolley. However; we noticed that clean and dirty trolleys were stored side by side in the main operating theatre corridor. Staff told us that this was because of limited space due to the design of theatre.

Details of each patient’s infection status, laboratory results, and treatment were documented in their records. Patients were screened for Meticillin resistant staphylococcus aureus (MRSA), either prior to admission as an elective patient, or on admission as an emergency patient. MRSA decolonisation is a procedure to reduce the presence and risk of transmission of MRSA. Patients were rescreened during their admission when their length of stay was longer than a week.

Staff understood their responsibilities for preparing and handling surgical instruments at all stages of the operative procedure. We saw staff followed National Institute of Health and Care Excellence (NICE) clinical guidelines [CG74] 2008 surgical site infections prevention and treatment within
theatres. Theatre staff were observed to adhere to best practice principles for scrubbing up (decontamination), gowning, and gloving prior to undertaking sterile procedures.

A hospital sterile services unit (HSSU) was located on the Queen’s Hospital Burton site for the decontamination of re-usable medical devices (surgical instruments) used at Queen’s Hospital Burton, and Sir Robert Peel Hospital. The sterile instrument store was spacious and enabled sterile instruments to be stored appropriately with sufficient stock levels to meet service needs. All instruments we checked were within their use by dates.

Staff were able to provide evidence that dirty instruments were transported to the HSSU in a timely manner.

Full tracking and traceability of surgical instruments offered a complete audit trail ensuring that each decontamination process was followed correctly. Deliveries of instruments requiring decontamination were made at least three times daily to HSSU using only authorised hospital transport.

In order to measure compliance with trust infection prevention and control policies, regular audits were undertaken as part of the ward assurance dashboard. The standard precautions audit incorporated aseptic non-touch technique (ANTT), source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, hand hygiene, optimal management of patients with diarrhoea, and consistently met the target of above 90% from January 2017 to January 2019.

Any infection prevention and control concerns would be highlighted to the nurse in charge. An action plan would then be formulated by the clinical team leader and concerns reported at site meetings if appropriate. The action plan was reviewed by the matron to ensure all concerns had been addressed.

NICE quality statement 61: 3 Hand decontamination states that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. There was access to hand washing, hand sanitiser and drying facilities in all patient areas and a good supply of personal protective equipment (PPE) was in use, which included disposable gloves and aprons. Adherence to hand hygiene policies was audited monthly in theatre and on the wards and showed consistently high rates of compliance.

We observed staff wash or cleanse their hands before, between, and after patient care, and follow best practice IPC guidance when administering intravenous fluids and medicines, for example. All staff were observed as bare below the elbow to enable effective hand washing. Visitors were encouraged to use hand sanitiser before entering and when leaving patient areas.

All equipment used by patients was visibly clean and appropriate for use. ‘I am clean’ stickers indicated where equipment had been cleaned.

Throughout the service, some privacy curtains were disposable and some were non-disposable. The disposable curtains had dates on them indicating when they were put up. Routine changes were scheduled in accordance with Health Building Note (HBM) 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known or suspected infection. Housekeeping staff maintained a record of when non-disposable curtains were changed, and these also met the requirements of HBM 00-009.
Deep cleans were arranged following the discharge or transfer of patients with infections. Cleaning schedules advised staff what type of cleaning to organise when a patient was discharged or transferred.

The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow. Porters and clinical staff described the waste disposal policy correctly and we saw that it was followed in all areas we visited.

The trust monitored the ventilation systems within theatres and these met with the health building regulations.

The National Institute for Health and Care Excellence (NICE) 2008 guidance states that all personnel entering or leaving the operating department should wear specific non-sterile theatre wear. Theatre staff we spoke with knew the practices regarding theatre uniform and the procedures to follow when leaving this area. There were spacious staff changing rooms and a sufficient supply of theatre scrubs and shoes. However, during our inspection we observed seven members of staff who did not adhere to the policy as they did not wear an outer jacket to cover theatre scrubs or change their shoes when leaving the theatre environment.

Senior nurses we spoke with were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes Legionnaire’s disease. Infrequently used taps and showers were flushed and recorded on a daily basis to monitor compliance. The ward managers reviewed the checks weekly to ensure compliance.

Environment and equipment

The design, maintenance and use of facilities and premises were appropriate. All surgical procedures took place in facilities that complied with department of health building note (HBN) 26: facilities for surgical procedures: 2004, which provides guidance for surgical procedures in all health settings, including for minimally invasive techniques. Patients at The Treatment Centre Queen’s Hospital Burton and at Sir Robert Peel Hospital were cared for in an environment which met the requirements of Health Building Note 10-02: Day Surgery facilities, 2007.

Patient areas were secure as access was limited to authorised staff using swipe card access, or an intercom and CCTV for visitors.

All staff we spoke with told us they had the required equipment to care for patients’ needs and felt the move towards standardisation of equipment since the acquisition of the trust in July 2018 was a benefit. All anaesthetic machines within the anaesthetic room and theatres conformed to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance, and we saw anaesthetic machines were checked at the start of each operating list by staff trained to do so.

AAGBI guidelines: Safe management of anaesthetic related equipment, 2009, state a replacement programme which defines equipment life and correct disposal procedures should be in place. It is recommended that anaesthetic equipment must be condemned and replaced before it becomes unreliable and endangers the patient, should be phased over a number of years, and is continuously updated. As a guide electrical equipment should be considered at five years and mechanical equipment at eight years. There was an equipment replacement programme in place which demonstrated compliance with these guidelines.
Tests to ensure electrical equipment and appliances were safe to use were carried out at least yearly, and visually when the equipment was in use.

In all patient areas we visited, staff had access to emergency resuscitation equipment and knew where it was located. This included an automated external defibrillator (AED). An AED is a portable electronic device used to diagnose life threatening cardiac conditions and enable treatment controlled electric shocks to re-establish a normal heart rhythm. Staff completed training in the use of AEDs and other emergency resuscitation equipment as part of mandatory life support training.

Resuscitation trolleys and emergency equipment and call bells were checked regularly by staff that were competent to do so. Resuscitation trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened or equipment used or tampered with since it was last used. Records we looked at showed that the resuscitation trolleys were all checked at least daily with stocks of equipment and consumables maintained by designated staff.

There were emergency call buttons, piped oxygen and suction equipment in each bed space, and in consultation rooms and recovery areas. Medical gas supplies were filled and turned off when not in use, and suction equipment was clean, working and ready for use.

 Maintenance and servicing of equipment was provided ‘in-house’ or by product manufacturers for specific equipment and was recorded. Staff knew how to raise faults or concerns about facilities or equipment and reported high levels of satisfaction with the maintenance services provided.

Staff demonstrated national safety alerts had been acted upon in relation to medical equipment and medicines and provided recent examples of where these had been communicated to all staff by email.

The difficult airway society launched guidelines for management of unanticipated difficult intubation in 2015. Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway. We saw trolleys in the main theatre area and the day care theatre area, which contained emergency intubation equipment. The contents of the trolleys met national guidance and current best practice, and we saw daily checks were completed in line with trust policy.

Control of Substances Hazardous to Health (COSHH) was in line with the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids stored in locked cupboards away from patient areas. COSHH information was available on the trust intranet and in data sheets.

**Assessing and responding to patient risk**

Integrated care pathways or general admission assessments were recorded and acted upon. Nursing staff used nationally recognised assessment tools to assess surgical patients’ needs, for example: risk of developing pressure ulcers, nutritional risks, falls, and risks associated with moving and handling. We saw that risks were reviewed regularly and measures were taken to reduce risks to patients where necessary, such as the use of equipment, specialist staff, and following care pathways.

The service met the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas which included; ward admission, anaesthesia, surgery and recovery.
The American Society of Anaesthesiologists (ASA) grades were used as a guide to assessing a patients’ fitness to undergo an anaesthetic. This was in line with national guidance issued by the National Institute for Health and Care Excellence (NICE). The ASA physical status classification system is a simple scale describing fitness to undergo an anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have. Patients with ASA1 or ASA2 only were admitted to Sir Robert Peel Hospital and The Treatment Centre at QBH. Patients with a score of ASA3 would be admitted to QBH.

There was no immediate access to blood transfusion at Sir Robert Peel Hospital or The Treatment Centre. This formed part of the decision that only people undergoing less complex surgery were treated at those locations. In the event of any life threatening haemorrhage patients would be transferred to Queen’s Hospital Burton.

Staff and managers we spoke with described the arrangements in place for the transfer of patients from Sir Robert Peel Hospital and The Treatment Centre to Queen’s Hospital Burton, including in the event of an emergency. There had been no such transfers in the last year. The transfer policy was last reviewed in 2017, however; it contained out of date information instructing staff to transfer patients to Heart of England Trust (now the University of Birmingham NHS Foundation Trust).

Staff told us that since the Trust acquisition in July 2018, patients from Sir Robert Peel Hospital and The Treatment Centre would normally be transferred to Queen’s Hospital We brought this to the immediate attention of the unit manager who told us corrective action would be taken and that the policy would be updated and all relevant staff would be notified.

There were arrangements in place for emergency access to medical care by surgeons and anaesthetists 24 hours a day including following discharge.

The World Health Organisation (WHO) five steps to safer surgery checklist (2008) was used to check and approve all safety elements of each patient’s procedure. All staff were clear in their responsibilities and roles in this area. This included, checking it was the correct patient, the correct operating site, and counting instruments, swabs and needles. We observed active involvement of relevant team members when following all stages of the surgical safety checklist, including at the sign in phase, stop moment, and sign out phase. Completion of the WHO checklists was reviewed at daily safety huddles as well as on a weekly basis during operating department team meetings.

The use of the WHO checklist was audited by reviewing all documentation produced by 15 operating lists during one theatre session a month. In addition to records audits an auditor observed the extent to which the checklist was undertaken throughout a minimum of five complete operating lists. There were consistently high levels of compliance (95 to 100 %) in the audits we looked at. Audit outcomes were reviewed at the surgical division quality and risk and clinical governance meetings and discussed with staff.

Following never events and serious incidents the service had added an additional three steps to the safer surgery checklist and had been applied in all the patient records we reviewed and in care we observed. These were: site marking, prosthesis and implant checks and local induction. These, with the five elements of the safer surgery checklist, were known as the NatSSIPS eight.

National Safety Standards for Invasive Procedures (NatSSIPS) were published in 2016 based on national learning from harm, near misses and never events to provide a strong systemic barrier to preventing harm. We saw a range of national and local safety standards for invasive procedures (LocSSIPS) published in trust policies, guidance and standard operating procedures were also applied.
Patients for elective surgery attended a pre-operative assessment consultation prior to their operation in line with national guidance. During the assessment required tests were undertaken; for example, Meticillin resistant staphylococcus aureus (MRSA) screening was undertaken for patients undergoing elective surgery, along with any specific blood test and risk assessments.

Procedures and processes were in place to manage surgical implants in line with national recommendations. We observed operating theatre processes with no issues or concerns identified.

We saw patients identified at risk were monitored more frequently by staff to reduce the risk of harm and that the risks were discussed at departmental based safety briefings and patient handovers. Risks would also be escalated to the leadership team as required and documented on the surgery division risk register.

NICE guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of VTE and bleeding as soon as possible after admission to hospital or by the time of the first consultant review and that reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changes. We looked at ten electronic patient records and found that all patients had received their initial VTE assessment and that it was reviewed and acted upon.

Each department audited the percentage of patients having a VTE assessment at and reported on these in their quality performance record. There were consistently high compliance rates throughout 2018.

There was a trust wide approach to managing deteriorating patients. The national early warning score (NEWS) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: ‘Acutely ill adults in hospital: recognising and responding to deterioration’ (2007). Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate, pain, and the monitoring of a patient’s clinical condition. There were clear instructions to follow when patients’ scores indicated deterioration, and members of staff spoken with were aware of these. The trust critical care outreach team visited surgical patients upon referral, to help with interventions to stabilise them and prevent them becoming more ill.

In all ten sets of electronic patient records we reviewed we found the NEWS was recorded and acted upon appropriately.

Sepsis is a life-threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs. Staff we spoke with had a good understanding of the actions required in detecting and managing sepsis. Posters in patient areas alerted staff and the public to the signs of sepsis.

The re was an up to date trust policy that incorporated a sepsis pathway which was displayed in clinical areas for staff to refer to. A sepsis tool enabled staff to detect the deteriorating patient and record when they had not followed the plan and used alternative treatments. The trust sepsis nurse specialist ensured continuity and compliance with NICE guidelines. Staff felt supported by the nurse specialist and confident in their knowledge, expertise and advice. Staff recognised the signs and actions to take where sepsis was suspected, and we saw they had access to a sepsis box which contained all the equipment required to manage such an emergency.

Patients were individually assessed for moving and handling assistance, which was documented and acted upon.
There were 18 falls reported within the surgery service from January 2018 to January 2019. Additional training had been provided to help staff prevent and manage falls.

**Nurse staffing**

**Planned vs actual**

The trust reported their staffing numbers for qualified nursing staff working in surgery at Queen’s Hospital Burton as below as of March 2018 and October 2018.

The number of qualified nursing staff in post remained similar in October 2018 in comparison to March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018 Actual staff (WTEs)</th>
<th>March 2018 Planned staff (WTEs)</th>
<th>March 2018 Fill rate</th>
<th>October 2018 Actual staff (WTEs)</th>
<th>October 2018 Planned staff (WTEs)</th>
<th>October 2018 Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital Burton</td>
<td>194.4</td>
<td>235.3</td>
<td>82.6%</td>
<td>195.2</td>
<td>228.3</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 16.2% for qualified nursing staff working in surgery at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Staffing levels were reviewed at an annual workforce planning meeting for medical and nursing staff. In addition, nurse staffing was reviewed weekly at the senior nurse meeting to identify any gaps requiring cover by moving existing staff or arranging temporary (bank or agency) staff. In order to ensure concerns about safe staffing levels were mitigated, the trust had closed 14 surgical beds on Ward 20 from May 2018 to December 2018. The beds were re-opened at the end of December 2018 with Ward 19 providing additional staff support. Staff had been moved from other areas within the service, and along with temporary staff this had filled identified gaps.

Patient acuity was considered when reviewing staffing levels; acuity is the measurement of the level of care required by a patient.

The trust followed national guidance on staffing ratios as recommended by the National Quality Board. Red flag events were monitored daily by the matrons. ‘Red flag events’ occur when there is a shortage of nursing staff and warn ward managers to act immediately. For example, patients not being provided with fundamental care such as pain relief or help to visit the bathroom.

Staff we spoke with told us that there had been a reduction in some vacancy rates. For example, on Ward 19 from 11 whole time equivalent (WTE) vacancies in 2017, to one WTE vacancy at the time of our inspection.

**Turnover rates**
From November 2017 to October 2018, the trust reported a turnover rate of 9.8% for qualified nursing staff working in surgery at Queen’s Hospital Burton. This was within the trust’s turnover target of between 8% and 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 6.8% for qualified nursing staff working in surgery at Queen’s Hospital Burton. This was higher than the trust’s target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in surgery.

From November 2017 to October 2018, the trust reported that 7.4% of qualified nursing staff hours in surgery at Queen’s Hospital Burton were filled by bank staff, while 5.6% were filled by agency staff. In addition, 1.3% of qualified nursing staff hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens Hospital</td>
<td>32,921</td>
<td>7.4%</td>
<td>25,110</td>
<td>5.6%</td>
<td>6,024</td>
<td>1.3%</td>
<td>446,405</td>
</tr>
</tbody>
</table>

Over the same period, the trust reported that 11.2% of unqualified nursing staff hours in its surgery services were filled by bank staff, while 1.3% were filled by agency staff. In addition, 1.9% of qualified nursing staff hours were not filled.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens Hospital</td>
<td>25,029</td>
<td>11.2%</td>
<td>2,904</td>
<td>1.3%</td>
<td>4,153</td>
<td>1.9%</td>
<td>223,496</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

There were sufficient theatre staff on duty during surgical procedures which included surgeons, anaesthetists, nurses, and operating department practitioners. This was in line with AfPP guidance which meant the service had assessed the risk to patients undertaking surgery.

Medical staffing

Surgery was consultant led and delivered. There was 24-hour access to emergency surgery teams, including theatres and consultants. During the night, there was a junior doctor present who covered the surgical wards and was supported by an on-call anaesthetist and an on-call consultant for surgery.

Planned vs actual
The trust reported their medical staffing numbers for surgery for March and October 2018 as below.

The number of medical staff in post in surgery at Queen’s Hospital Burton was similar pre and post-acquisition in March 2018 and October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>March 2018</th>
<th></th>
<th>October 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
</tr>
<tr>
<td></td>
<td>staff (WTEs)</td>
<td>staff (WTEs)</td>
<td></td>
<td>staff (WTEs)</td>
<td>staff (WTEs)</td>
<td></td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>22.5</td>
<td>24.9</td>
<td>90.6%</td>
<td>23.3</td>
<td>26.7</td>
<td>87.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From November 2017 to October 2018, the trust reported a vacancy rate of 7.4% for medical staff in surgery at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 9.8% for medical staff in surgery at Queen’s Hospital Burton. This was within the trust’s target a turnover rate of between 8% and 12%.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 6.8% for medical staff in surgery at Queen’s Hospital Burton. This was higher than the trust’s target of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From November 2017 to October 2018, the trust reported that 2.8% of medical staff hours were filled by locum staff. Over the same period no medical staff hours were filled by bank staff, no medical staff hours were reported as unfilled.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Locum hours</th>
<th>%</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital Burton</td>
<td>8,922.5</td>
<td>2.8%</td>
<td>324,439</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

As of September 2018, the proportion of consultant staff reported to be working in surgery at University Hospitals of Derby and Burton NHS Foundation Trust was the same as to the England
average. The proportion of junior (foundation year 1-2) staff was similar to the England average.

### Staffing skill mix for whole time equivalent staff working at University Hospitals of Derby and Burton NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

### Records

Staff maintained electronic patient records. The patient administration system allowed authorised staff to review multi-disciplinary records throughout the patient’s surgical pathway including pre-operative assessment and would indicate to the nurses when referral to other specialist staff needed to be sent. However; only agency nurses who regularly worked in the service had access to the electronic patient record system. This meant that not all agency nurses could review documented care plans and had no access to the medicine administration record without a permanent member of staff present.

Audits of records were completed on all wards as part of the ward assurance tool and we noted surgical wards were consistently compliant with the required standards most of the time in the last year.

Paper held records were securely stocked in lockable trolleys that were accessed by authorised staff only. Computer screens were attended when displaying patient information. Personal data was only accessible with a protected password.

Discharge summaries were sent in paper form to patients’ GPs at the point of discharge, to ensure continuity of care in the community. We saw evidence that details of surgery including any implant used was included in the discharge letter to patients and their GPs.

### Medicines

The commitment to, and arrangements for, safe prescribing, dispensing (including pharmacist review), storage, administration and disposal of medicines was set out in an up to date trust medicines management policy.
All medicines were procured and distributed through the hospital pharmacies at Queen’s Hospital Burton and Sir Robert Peel Hospital. Pharmacy staff were responsible for monitoring medicines stock and reporting any discrepancies.

Pharmacy services were available on weekdays from 8:30am to 5pm. There was an on-call pharmacist available out of hours who could be contacted for advice or supply of medicines. In addition, authorised nursing staff had 24-hour access to medicine stocks.

We reviewed ten electronic medicines administration records and found they were completed in accordance with the trust medicines management policy. Medicines would only be ordered by qualified personnel and dispensed against a signature of an authorised prescriber. Staff recorded known allergies in all of the patient records we reviewed.

Medicines were in date and stored securely in locked trolleys or cupboards with restricted access for authorised staff only. However, on one ward, we found storage of intravenous medical supplies was not in accordance with national or local good practice. On the same ward we also found a dose of an intravenous medicine drawn up in advance of administration that had been left in a tray in a storage cupboard. This was not safe practice and we brought both issues to the immediate attention of the nurse in charge who was unable to explain why the medicines were stored in this way and took corrective action.

Staff took steps to ensure that temperature sensitive medicines were stored correctly. Ambient room temperature levels for medicines stored in medicines cabinets and trolleys were also monitored. Temperatures outside of the correct range were reported and acted upon.

Pharmaceutical waste was disposed of in specially allocated boxes in line with trust policy. Pharmaceutical supplies surplus to requirement would also be returned to pharmacy and stored in a specially allocated locked box when awaiting return.

Staff understood the processes in place for the safe transportation and storage of medical gases.

Total parenteral nutrition is a way of supplying all the nutritional supplements of the body by bypassing the person’s natural digestive system by infusing the solution through the veins (intravenously). The trust had a policy for the administration of total parenteral nutrition (TPN) and we saw this was followed correctly.

Controlled drugs (CDs) (medicines that require additional security controlled under the misuse of drugs legislation 2001), were stored appropriately in locked cupboards. The keys to the controlled drugs cupboard were kept securely and separately from the keys to the main medicines cabinet; this was in accordance with local policy requirements.

Stationery used to order CDs was generally kept securely; however, on one ward we found some forms were not stored according to trust policy. We brought this to the immediate attention of the nurse in charge and saw that the stationery was then locked away for safe and secure storage.

Controlled drugs were managed safely in line with legal and good practice guidance.

Audits of the processes governing CDs were reported every quarter by the pharmacy department in accordance with the trust policy.

Emergency medicines were stored on wards in a resuscitation trolley in tamper proof packaging and were all in date. There was a separate box for medicines used if patients suffered a severe allergic reaction known as anaphylaxis. These medicines were easily accessible in case of emergency to all staff that may need to use them.
Staff we spoke with, including the leadership team, told us all nurses involved in medicines administration were required to complete medicines management training and competencies at induction. However, there was no requirement for refresher training, other than annual intravenous therapy. Agency nurses also had to complete medicines competencies prior to any medicines administration. However; due to limited access to the electronic patient record not all agency nurses could administer medicines.

Medicines that had been drawn up in advance into a syringe were clearly labelled and not left unattended.

**Incidents**

**Never events**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust we have used this to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, the trust reported one incident classified as a never event for surgery.

This occurred in March 2018 at Royal Derby Hospital and was of never event type “Wrong site surgery”.

**Burton Hospitals NHS Foundation Trust**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From January to December 2018, the trust reported no incidents that were classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))

Managers demonstrated that following never events measures would be put in place to prevent similar events occurring. These included an investigation, root cause analysis, and learning shared at divisional governance meetings, monthly governance reports, monthly patient safety group meetings, the trust newsletter, and staff intranet.

**Breakdown of serious incidents reported to STEIS**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because this data related to the same legal entity as the merged trust we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 25 serious incidents
In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Slips/trips/falls: six
- Pressure ulcer: five
- Sub-optimal care of the deteriorating patient: four
- Surgical/invasive procedure incident: three
- Diagnostic incident including delay (including failure to act on test results): two
- Medication incident: two
- Venous thromboembolism: one
- Treatment delay: one
- Blood product/transfusion incident: one

The time taken by the trust to report these eight SI’s to STEIS was variable:

- One took up to 14 days to report
- Five took between 61 and 90 days to report
- Two took more than 90 days to report

(Source: Strategic Executive Information System (STEIS))

Burton Hospitals NHS Foundation Trust

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

The trust used an online incident reporting system. All staff had individual user login. Staff we spoke with told us they felt confident in reporting incidents and were familiar with the trust incident reporting policy that set out their roles and responsibilities.
There were daily safety huddles in surgery wards and the operating theatre department attended by clinical and managerial staff which enabled a short multidisciplinary briefing to focus on patients at risk and agreed actions in reducing harm.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasons to support the person.

The service encouraged a culture of candour, openness and honesty at all levels, and encouraged staff to challenge poor practice. An up to date duty of candour policy set out staff responsibilities in this area, and principles of duty of candour were included in induction and mandatory training. The nursing and medical staff demonstrated understanding of their responsibilities regarding the duty of candour legislation.

Staff and managers said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. We saw examples of where the duty of candour had been applied, and where candour letters had been sent in a timely manner, in serious incidents and never events.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given, but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Safety thermometer data was not displayed in patient areas, however; ward assurance data was displayed which included: pressure ulcer management, falls risk assessment, nutritional assessment, eliminating preventable deaths, eliminating avoidable harm, venous thromboembolism assessment, privacy and dignity, for example.

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported 19 new pressure ulcers, three falls with harm and nine urinary tract infections in patients with a catheter in surgery.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at University Hospitals of Derby and Burton NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

Burton Hospitals NHS Foundation Trust

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

Data from the Patient Safety Thermometer showed that from November 2017 to November 2018 the trust reported 12 new pressure ulcers, three falls with harm and three urinary tract infections in patients with a catheter in surgery.
Total Falls (3)

Total CUTIs (3)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Urinary tract infections in patients with a catheter

Source: NHS Digital - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. They assessed staff compliance with guidance and identified areas for improvement. Staff we spoke with gave examples of where national standards and best practice evidence had informed local policies.

Work was in progress to update a range of trust policies to ensure consistency across all hospital sites. Where they were not yet completed location specific policies and guidelines were available and accessible on the staff intranet. They were based on national best practice guidance and supported by up to date references. Staff we spoke with were confident that any updates on new policies would be communicated by e-mail and through staff meetings and provided evidence of where this had happened.

Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all polices were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

Surgical enhanced recovery protocols are a national initiative that set out pre, peri-operative and post-operative care to help patients recover sooner and safely after surgery. The key elements of enhanced recovery protocols (ERP) included a multi-disciplinary approach to pre-operative counselling, optimisation of nutrition, and pain relief and early mobilisation.

We saw the introduction of ERP at Queen’s Hospital Burton to accelerate recovery after hip and knee replacement surgery, for example and that information was displayed for patients and the public to help them understand the approach. This standardised intervention process involved the multi-disciplinary team working together to optimise the rehabilitation procedure and reduce the time patients spent in hospital. ERP involved discharge planning from the pre-operative stage,
patients mobilising on the day of surgery, the re-establishment of patient medicines on the day of surgery and a follow up telephone call 48 hours after discharge from hospital. Staff told us this was ‘going well’.

**Nutrition and hydration**

Patients were given enough food and drink to meet their needs and improve their health.

Dietitians and speech and language therapy staff were available for people who had difficulty feeding, chewing or swallowing; for example, through referrals following a patients’ initial admission assessment or when their condition or needs changed.

Staff used special feeding and hydration techniques when necessary. We saw that where patients were referred to the nutrition team they were visited by a member of the team at least daily, and that all referrals and treatment were documented in patients’ individual care records.

Nursing staff were satisfied with the catering service and the service provide by the trust nutrition team. If patients had swallowing difficulties they would be referred to a speech and language therapist within the trust.

Patients’ nutrition and hydration needs were assessed by nursing staff using the malnutrition universal screening tool (MUST). This was in line with NICE guidance QS15 Statement 10: “Physical and psychological needs” 2012. The MUST tool calculates the overall risk of malnutrition. Patients considered a lower risk of malnutrition were scored and a prompt was given for nurses to assess and monitor, then repeat the assessment after three days. The assessment and MUST tool offered a guide to assist the nursing staff in deciding if a dietitian referral was required. We saw the assessments were reviewed and were up to date in all patient records we looked at.

Dietary adjustments were made for patients for religious, cultural, personal choice, or clinical reasons when required. All relevant staff, including catering staff, were made aware of patients’ specific dietary needs. A daily record of special dietary needs was maintained in patients’ individual care records and in the ward kitchen areas which were accessed by staff only.

Fluid balance charts were in place to monitor patients’ hydration. We reviewed five fluid intake and output charts and found that all were fully completed. This meant that patients’ fluid requirements were monitored accurately and acted upon.

We saw evidence in the patient records we reviewed where parental (intravenous) feed prescriptions were changed according to blood test results and requested further monitoring. The nutrition team recorded their contact details and the date they were going to next review the patient, which was at least daily.

Patients told us they were given clear written information about when to stop eating and drinking before their operation. Patients were instructed not to eat for six to eight hours before a general anaesthetic and were encouraged to drink sips of water up to two hours prior to a surgical procedure. Staff confirmed that following surgery patients would be encouraged to drink when ready, providing there were no contraindications.

Staff had access to snacks and drinks for patients between meal times. This helped to support patients’ nutritional intake and hydration. Patients we spoke with were generally happy with the food provided.
Patient mealtimes were protected to ensure patients could eat their meals without interruption. However; staff we spoke with told us there was flexibility for visitors to visit their loved ones at meal times, so they could provide assistance.

We observed a meal time on one ward and saw all staff engaged with the distribution of meals and that assistance was given to patients where required. Six patients required total assistance and were supported by ward staff and additional staff from a neighbouring ward to ensure patients’ food was still at the required temperature and could be provided in a timely manner.

Patients with nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients in the recovery area were given antiemetic medicine intravenously if they complained of nausea post operatively. We saw this given to good effect.

Patients had jugs of water within reach on their bedside tables. We observed that these were regularly refilled. Intravenous fluids were also prescribed and recorded appropriately.

**Pain relief**

Pain was managed effectively. Pain was risk assessed and recorded using the National Early Warning Score (NEWS) and assessments were completed on the electronic patient records and acted upon.

Commonly used pain relieving medicines were prescribed routinely but if these were not effective, the outreach team and pharmacists could be contacted for pain management advice and additional medicines to be prescribed, to ensure patients were pain free and comfortable. In addition, an anaesthetist was accessible for pain management advice 24 hours a day.

We saw patients provided or offered pain relief regularly and without delay. All the patients we spoke with said they were usually asked if they were in any pain during most interactions with staff. We also observed staff discussing pain during patient handovers and any concerns would be raised with relevant clinicians. Physiotherapists worked closely with nursing staff to ensure adequate pain relief was administered prior to post-operative mobilisation.

**Patient outcomes**

Audits, including external reviews, were used to maintain, and where necessary, improve patient care and quality standards decided by national guidance, patterns of incidents and clinical data outcomes. Ward assurance was the audit tool used to observe and report on patient care in 50% of patients on the day of audit, we saw that results from the audits from January 2018 to January 2019 had shown consistent ratings of between 95 and 100%. Results of the ward assurance were presented to a number of forums from individual wards and departments to the trust board.

During our visit, we saw a range of audit outcomes in anaesthetic, theatre and surgery. All audit reports had recommendations and action plans with executive board oversight.

**Relative risk of readmission**

**Queen’s Hospital Burton – elective admissions**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From June 2017 to May 2018, patients at Queen’s Hospital Burton had a similar to expected risk of readmission for elective surgical admissions compared to the England average.

- Risk of readmission for general surgery was higher than expected.
• Risks of readmission for ophthalmology and trauma and orthopaedics were lower than expected.

**Elective Admissions – Queen's Hospital Burton**

![Bar chart showing readmission rates for various specialties.]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Queen’s Hospital Burton – non-elective admissions**

From June 2017 to May 2018, patients at Queen’s Hospital Burton had a similar to expected risk of readmission for non-elective medical admissions compared to the England average.

• Risks of readmission for general surgery and trauma and orthopaedics were similar to expected.

• Risk of readmission for urology was higher than expected.

**Non-Elective Admissions - Queen’s Hospital Burton**

![Bar chart showing readmission rates for various specialties.]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

*(Source: Hospital Episode Statistics)*

**National Hip Fracture Database**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.
In the 2017 National Hip Fracture Database, Queen’s Hospital Burton’s risk-adjusted 30-day mortality rate was 7.4% which was within the expected range. The 2016 figure was 11.0%.

The proportion of patients having surgery on the day of or day after admission was 68.8%, which failed to meet the national standard of 85%. This was within the top 25% of trusts. The 2016 figure was 71.8%.

The perioperative medical assessment rate was 78.0%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 79.6%.

The proportion of patients not developing pressure ulcers was 90.4%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 97.1%.

The length of stay was 26.7 days, which falls within the worst 25% of trusts. The 2016 figure was 20.8 days.

(Source: National Hip Fracture Database 2017)

**National Bowel Cancer Audit**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

In the 2017 National Bowel Cancer Audit, 60.1% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2016 figure was 57.4%. The 2016 figure is included for context only. Please note that due to changes in methodology, the performance of trusts against this metric should not be compared between reports.

The risk-adjusted 90-day post-operative mortality rate was 7.2% which was within the expected range. The 2016 figure was 2.0%.

The risk-adjusted two-year post-operative mortality rate was 16.7% which was within the expected range. The 2016 figure was 21.6%.

The risk-adjusted 30-day unplanned readmission rate was 12.9% which was within the expected range. The 2016 figure was 14.3%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54.3% which was within the expected range. The 2016 figure was 52.1%.

(Source: National Bowel Cancer Audit)

**National Oesophago-Gastric Cancer National Audit**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 6.1%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 7.3%.

The 90-day post-operative mortality rate was not applicable to the trust in either 2015 or 2016.
The proportion of patients treated with curative intent in the Strategic Clinical Network was 42.5%. This was significantly higher than the national aggregate.

This metric is defined at strategic clinical network level. The network can represent several cancer units and specialist centres). The result can therefore be used as a marker for the effectiveness of care at network level. Better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), Queen’s Hospital Burton achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 73 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 37 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 42 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 27 cases.

The site’s risk-adjusted 30-day mortality rate was within the expected range. This was based on 73 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 the trust performed worse than the England average for patients reporting an improvement following surgery for groin hernias according to the EQ VAS index. However according to the EQ-5D index, the trust’s performance was similar to the England average.

The trust’s performance for patients reporting an improvement following hip replacement was similar to the England average according to the EQ VAS and EQ-5D indexes and the Oxford Hip Score.

The trust's performance for knee replacements was similar to the England averages according to all three indexes.

The trust’s performance for varicose veins was worse than the England average according to both the Aberdeen Varicose Vein Questionnaire and the EQ VAS index. However according to the EQ-5D index, the trust's performance was better than the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held regular supervision meetings to provide individual support and monitor the effectiveness of the service. Staff participated in ongoing continuing professional development through a structured learning and development programme delivered face to face or on-line.

Doctors in training spoke positively about the opportunities for learning and development of competencies. There was protected time for all grades of medical staff in the surgical division to attend a cross site directorate meeting on ten separate days a year. This provided the opportunity for them to complete mandatory training, and discuss issues such as patient mortality and morbidity, audit outcomes, and safety incidents.

There were enough recovery staff suitably trained in high dependence support and intermediate life support. They also had immediate access to anaesthetists and colleagues from the trust critical care outreach team with advanced life support qualifications in the event of a medical emergency.

Staff told us they completed a comprehensive induction when they commenced work at the trust. This included a trust wide corporate induction and local induction in their specialist area. The local induction was provided for permanent and temporary (agency, locum and bank) staff. We saw a
checklist of topics was completed by all temporary staff which included orientation to their work area and some local competencies, for example medicines management.

Three new staff working at different levels within the surgical service told us they found the induction programme useful and welcoming. The trust induction training included an introduction to the trust vision and values, and a range of other topics including information governance, managing emergencies, incident reporting, safeguarding, infection prevention and control, moving and handling, and fire safety. Students on placement had a qualified mentor who worked alongside the student to ensure essential skills were learnt and safety was maintained. Students had skills booklets and competencies to be achieved in each area. We spoke with students who felt well supported.

Competency packages enabled individuals to develop new skills and take on extra responsibilities. Nursing staff told us they had access to practice development facilitators who provided and supported the training and competency packages across the service. The practice development facilitators were visible and accessible throughout our visit, and provided information through face to face teaching, and on staff notice boards and the trust intranet. They also supported colleagues by working alongside them in clinical areas, particularly at induction and when working towards achieving new competencies.

Staff spoke positively about a suitable learning environment across the service, which included designated teaching rooms, a trust medical education centre, two simulation laboratories, and accessible on-line training.

Health care professional link champion roles were established in clinical areas to share and implement information from specialist teams. Link champions received extra training and communicated with relevant specialist practitioners to enable them to update other staff and resource files in their work area. For example: sepsis, infection prevention and control, tissue viability, safeguarding, dementia, learning disability, falls, stoma care, pain management, and diabetes. Lists of the link champions were clearly displayed in staff rooms so that staff knew where each responsibility lay and who to contact.

**Appraisal rates – Queen’s Hospital Burton**

From November 2017 to October 2018, 89.2% of staff in surgery at Queen’s Hospital Burton received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion targets were met for allied health professionals but were not met for the remaining six staff groups, including qualified nurses.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied health professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>147</td>
<td>164</td>
<td>89.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>67</td>
<td>75</td>
<td>89.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>37</td>
<td>42</td>
<td>88.1%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>27</td>
<td>31</td>
<td>87.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>85</td>
<td>101</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Multidisciplinary working

Nursing and medical staff on surgical wards and departments were supported by critical care (intensive care and high dependency) as well as pathology, radiology and other diagnostic services.

Therapy staff worked alongside the nursing and medical staff to assess plan and deliver care. On line referrals enabled a timely response. There was no dedicated social worker for the surgical service, however; staff had access to the trust social worker through the discharge team. We saw that occupational therapists, clinical nurse specialists, and members of the safeguarding team also worked closely with nurses, doctors, and community services to ensure patients’ social care needs were identified and met in a timely manner.

A pharmacist or pharmacy technician visited patient areas at Queen's Hospital Burton and Sir Robert Peel Hospital daily from Monday to Friday, to review medicines administration records, and monitor stocks of medicines. This included reviewing the use of antibiotics, PRN (when required) medicines, and reconciliation of medicines where the patient was a new admission. Out of hours, pharmacists were on call, and authorised nursing and medical staff would have access to medicines stocks.

Details of consultations, including appropriate clinical information were sent to each patient’s GP following agreed protocols for the transmission of patient data.

Seven-day services

Patients requiring elective surgery received a pre-anaesthetic and pre-operative assessment dependent on the procedure and their clinical needs. The pre-assessment service was nurse led, in conjunction with consultant anaesthetic colleagues and was available Monday to Friday 8am to 5pm.

Consultant cover by surgeons and anaesthetists was provided seven days a week. There was a consultant on-call rota 24 hours a day, seven days a week. Consultants were supported by middle grade and junior doctors.

Pharmacy services were available on weekdays from 8:30am to 5pm. There was an on-call pharmacist available out of hours who could be contacted for advice or supply of medicines. In addition, authorised staff had 24-hour access to medicines stocks.

Therapy services were provided between 8am and 7pm Monday to Friday, 10 am to 4pm on Saturday and as necessary through an on-call system on Sundays.

Diagnostic services including interventional radiology services were available 24 hours a day, seven days a week. Interventional radiology refers to a range of techniques which rely on the use of radiological image guidance, such as x-ray fluoroscopy, ultrasound, computed tomography (CT) or magnetic resonance imaging (MRI) to precisely target therapy.

The surgical assessment unit (SAU) provided 24-hour cover five days a week. The SAU service was located in an acute unit with four trolleys where patients were assessed for emergency surgical problems.
Staff we spoke with gave examples of where they had been supported with the immediate management of deteriorating patients by the trust’s critical care outreach team outside of core hours.

**Health promotion**

Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and according to individual needs.

During pre-assessment consultations nurses provided patients with information on how they could promote their fitness before their surgical procedure. For example: eating a healthy diet, moderating alcohol intake, increasing physical activity and giving up smoking. Similar information was provided to assist patients towards their recovery following surgery.

Up to date health promotion information leaflets were readily available for patients and members of the public visiting Queen’s Hospital Burton and Sir Robert Peel Hospital. Topics displayed on public notice boards included recognising signs of sepsis, advice for people living with dementia, diabetes, managing pain in someone with a learning disability or dementia, preventing pressure ulcers and information about managing mental health.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Staff understood their responsibilities and the procedures in place to obtain consent from patients prior to undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed (authorised) forms for treatment and exploratory investigations throughout our inspection.

Medical and nursing staff we spoke with explained the consent procedures and what to do if a person lacked capacity to consent to care and treatment. They were able to outline the principles of the MCA and the implications for their practice.

Patients we spoke with told us they were given all the information they needed in order to make an informed decision about the treatment being provided and had opportunity to ask for clarification. They felt medical and nursing staff had fully explained the procedure at their initial appointment, pre-operative assessment, and then again when they were admitted for surgery. This meant that when a patient was due to sign their consent form they had been provided with clear, concise information about the procedure and the associated risks and benefits and had a cooling off period.

The patient records we reviewed demonstrated that consent for surgery was completed in full and signed and dated appropriately.

The Deprivation of Liberty Safeguards (DoLS) protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Training in MCA and DoLS was included within safeguarding training.
Staff told us patients with a learning disability or those living with dementia undergoing elective surgery would be involved in a pre-operative meeting with their carer or family member wherever possible in order to ensure there was an effective plan in place for their admission. Staff said that carers or family members were encouraged to stay with the patient and operating lists would be adjusted to suit patient needs.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff at Queen’s Hospital Burton were eligible for two levels of combined MCA and Deprivation of Liberty Safeguards training. The completion target for both levels was 90%. This requirement was inherited from the predecessor trust. A breakdown of compliance for this module for the period from November 2017 to October 2018 level for qualified nursing staff in surgery at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty</td>
<td>129</td>
<td>141</td>
<td>91.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>safeguards - level 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty</td>
<td>31</td>
<td>39</td>
<td>79.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>safeguards - level 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 90% target was met for one of the two modules for qualified nursing staff in surgery at Queen’s Hospital Burton.

A breakdown of compliance for this module for the same period for medical staff in surgery at Queens Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty</td>
<td>70</td>
<td>89</td>
<td>78.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>safeguards - level 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty</td>
<td>6</td>
<td>32</td>
<td>18.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>safeguards - level 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 90% target was not met for either module for medical staff in surgery at Queens Hospital Burton. Six of the 32 eligible medical staff had completed level one training.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

**Is the service caring?**

**Compassionate care**

We observed staff were caring and compassionate with patients and their relatives throughout our inspection. Patients and relatives we spoke with praised staff for their kindness and their understanding of their needs. One patient on Ward 14 wrote in feedback: “I cannot explain in words how much I appreciate the treatment I have received. The staff were wonderful and caring”.
Relatives of a patient who was living with dementia told us they were generally happy with the care provided; however, they did not feel they were always consulted about their loved one’s individual needs.

Staff members spent time with patients and their loved ones and interacted with them during clinical interventions. We saw staff explained what was happening and what actions were planned, and patients’ and family members’ questions and concerns were also addressed.

Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way, and generally answered call bells without delay.

Staff used their first name when introducing themselves to patients and wore name badges. Patients told us they were informed of what to expect on the ward(s) and operating theatre(s) which put them at ease.

Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected patients’ privacy and dignity both on the wards and in theatres. We observed staff maintaining patient’s dignity on admission, prior to going into theatre, and during and post-surgery.

Nursing staff pulled curtains around the bed space during personal intervention. We attended a nursing handover on one ward which was held in an office away from the patients so that personal information discussed was not overheard by other patients.

**Friends and Family test performance**

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed.

The Queen’s Hospital Burton submitted no data to the FFT for July 2018.

From October 2017 to September 2018 (excluding July 2018) the Friends and Family Test (FFT) response rate for surgery at Queen’s Hospital Burton was 16.0%. This was based on 1,712 responses. This was lower than the England average of 25%.

A breakdown of FFT performance by ward for medical wards at this hospital over the same period is shown below.

All wards scored over 90% for these 11 months overall.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp12</th>
<th>Resp. Rate</th>
<th>Percentage recommended0</th>
<th>Annual perf1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 30</td>
<td>582</td>
<td>23%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 19</td>
<td>481</td>
<td>30%</td>
<td>99%</td>
<td>91%</td>
</tr>
<tr>
<td>TC</td>
<td>428</td>
<td>6%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 15</td>
<td>335</td>
<td>22%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 14</td>
<td>302</td>
<td>22%</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 20</td>
<td>164</td>
<td>23%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Treatment Centre

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.
(Source: NHS England Friends and Family Test)

**Emotional support**

Patients and their relatives told us staff responded to their needs and they felt able to speak openly about any concerns. They felt staff were approachable and provided emotional support when required. Private areas were used for confidential conversations wherever possible.

Patients’ spiritual needs were taken into account irrespective of any religious affiliation or belief. There was a trust wide multi-faith chaplaincy service available for patients, their families and staff and a chapel located near to the surgical wards and theatre at QBH was available. The chaplaincy liaised with communities to ensure they accommodated patients of all faiths.

A trust wide bereavement team provided emotional and practical support in all aspects of bereavement care.

Staff understood the emotional stress of patients having an anaesthetic prior to surgery. We observed staff being supportive and reassuring patients before their anaesthetic to minimise their anxiety and stress. Post-operative care within the recovery area was empathetic and staff did everything they could to ensure patients were comfortable and free from any pain.

Patients and staff were supported by a range of clinical nurse specialists across the surgical areas when specific emotional needs were identified. For additional advice and support staff also had access to liaison mental health nurses (from a neighbouring NHS mental health trust) based at Royal Derby Hospital and told us they really valued this service.

**Understanding and involvement of patients and those close to them**

Prior to having surgery, we observed patients being given a clear explanation of surgical procedures and what they may expect, by nurses, surgeons and anaesthetists before sedatives or anaesthetic agents were administered.

Patients we spoke with were very satisfied with the explanations given to them and felt they had sufficient opportunity to ask questions before and after surgery and after discharge.

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**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and delivered services to meet the needs and demands of local people. The executive management team worked with the local clinical commissioning groups to improve patient care and access to services.

The design, maintenance and use of facilities and premises were appropriate. All surgical procedures took place in facilities that complied with department of health building note (HBN) 26: facilities for surgical procedures: 2004, which provides guidance for surgical procedures in all health settings, including for minimally invasive techniques. Patients at The Treatment Centre Queen’s Hospital Burton and at Sir Robert Peel Hospital were cared for in an environment which met the requirements of Health Building Note 10-02: Day Surgery facilities, 2007.

**Meeting people’s individual needs**

Intentional rounding was undertaken at two to four hourly intervals on surgical wards we visited, to ensure nurses conducted checks on patients at set times to assess and manage their fundamental
needs including pain relief and repositioning. Patients we spoke with told us this normally happened and that staff would ask them a series of questions and record their answers when this occurred.

The delivery of care to patients in need of additional support was assisted by defined systems. For example, patient needs associated with dementia or a learning disability was included in the nursing assessment and care record, and patients could be referred to specialist services within or outside of the trust where appropriate.

A team of clinical nurse specialists supported other clinical staff and in many cases provided treatment themselves.

Staff knew which patients were living with dementia and identified their needs and planned their care accordingly.

When a patient with a learning disability used the service, they would be routinely offered a ‘hospital passport’. This was designed to help hospital staff understand each patient’s needs likes, dislikes and interests. During our inspection we did not see any people with a learning disability using the service. We were therefore not able to fully assess the impact of this.

Information leaflets about a wide range of topics were available and could be provided in other languages upon request. Interpreter services were available and accessible through a telephone language line.

**Access and flow**

All departments we visited had worked collaboratively to reduce delays and improve patient flow. The trust identified they struggled with continuing operational pressures and used escalation scheduled care beds when demand necessitated.

A bed capacity manager and hospital discharge team maintained at least daily contact with the ward staff and supported patients with their discharge plans. This included support for patients with specific health and social care needs.

A site meeting to assess ward and theatre capacity was held at least three times daily. The meetings were chaired by the senior nurse on duty and supported by information in the staffing assurance templates. This enabled staff with the required level of authority to redeploy staff to ensure that patient safety concerns due to staffing were mitigated and allowed the service to remain flexible and fully utilised. We observed a site meeting and saw that managers had the opportunity to talk about specific patients and their discharge options, and any elective surgery cancellations, for example. There was also representation at each meeting from the ambulance transport service which staff felt was useful.

All patients undergoing elective surgery attended a face to face pre-operative assessment. To avoid unnecessary inpatient admission or unnecessary waiting for appointments, there were nurse led surgical pre-operative assessment clinics. An elective admission unit open between 7.30am and 5pm allowed patients to wait for their surgery in a designated seating area rather than occupying a bed on the inpatient wards.

Patients admitted in an emergency usually came to theatre via the surgical assessment unit. In addition, a ‘hot clinic’ in the elective admission unit provided direct access for some patients to be seen and assessed in a timely manner.
The leadership team told us that since the acquisition and reconfiguration of services in July 2018 there was a steady improvement in referral to treatment times, and that in December 2018 the trust had been compliant with RTT for the first time in two years.

**Average length of stay**

**Queen’s Hospital Burton**

Data for Burton Hospitals NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

From July 2017 to June 2018 the average length of stay for surgical elective patients at Queen’s Hospital Burton was 2.6 days, which was shorter than the England average of 3.9 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in trauma and orthopaedics was similar to the England average.
- Average length of stay for elective patients in general surgery and urology were shorter than the England average.

**Elective Average Length of Stay - Queen’s Hospital Burton**

![Graph showing elective length of stay](image)

*Note: Top three specialties for specific site based on count of activity.*

For surgical non-elective patients, the average length of stay was 4.2 days, which was similar to the England average of 4.9 days.

Average length of stay for non-elective patients in general surgery, trauma and orthopaedics and urology were similar to the England averages.

**Non-Elective Average Length of Stay - Queen’s Hospital Burton**

![Graph showing non-elective length of stay](image)

*Note: Top three specialties for specific site based on count of activity.*

**Referral to treatment (percentage within 18 weeks) - admitted performance**
University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently better than the England average.

(Source: NHS England)

Burton Hospitals NHS Foundation Trust

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From November 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was better than the England average in seven out of eight months.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

From November 2017 to October 2018 the trust performed better than the England average for admitted RTT (percentage within 18 weeks) for four out of seven surgical specialties.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>86.1%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>83.9%</td>
<td>80.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>75.1%</td>
<td>67.3%</td>
</tr>
</tbody>
</table>
Over the same period there were three surgical specialties where the trust performed worse than the England average for admitted RTT. Performance for oral surgery was particularly poor, with only 5.5% of patients admitted within 18 weeks of referral.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>68.3%</td>
<td>72.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>52.2%</td>
<td>63.9%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>5.5%</td>
<td>58.4%</td>
</tr>
</tbody>
</table>

Burton Hospitals NHS Foundation Trust

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

From November 2017 to June 2018 the trust performed better than the England average for admitted RTT (percentage within 18 weeks) for three out of seven surgical specialties.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>80.0%</td>
<td>72.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>78.7%</td>
<td>63.9%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>73.1%</td>
<td>59.6%</td>
</tr>
</tbody>
</table>

Over the same period there were four specialties where the trust performed worse than the England average for admitted RTT. Performance for oral surgery was particularly poor, with only 11.7% of patients admitted within 18 weeks of referral.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>71.0%</td>
<td>80.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>63.2%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>54.6%</td>
<td>67.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>11.7%</td>
<td>58.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two-year period from quarter 3 (Q3) of 2016/17 to Q2 2018/19, Q2 2017/18 was the only quarter when the trust reported any last-minute cancellations where the patient was not treated within 28 days. Of the 66 cancellations in that quarter, 2% weren't treated within 28 days.

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Over the two-year period from quarter 3 (Q3) of 2016/17 to Q2 2018/19, the percentage of last-
minute cancellations at the trust where the patient was not treated within 28 days was lower than the England average in six out of eight quarters. The only exceptions were Q4 of 2017/18 and Q1 of 2018/19:

In Q4 2017/18, the trust cancelled 133 operations. Of the 133 cancellations 23% weren't treated within 28 days. This was a marked deterioration in the trust's performance from Q3 2017/18, when 2% of cancellations were not treated within 28 days.

In Q1 2018/19, the trust cancelled 122 operations. Of the 122 cancellations 14% weren't treated within 28 days. This was a marked improvement.

In Q2 2018/19, the last quarter for which data were available, performance continued to improve. The trust cancelled 131 operations. Of the 131 cancellations 8% weren't treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - University Hospitals of Derby and Burton NHS Foundation Trust**

![Graph showing percentage of patients whose operation was cancelled and not treated within 28 days]

Over the same two-year period, the percentage of cancelled operations at the trust was consistently better than the England average.

**Cancelled Operations as a percentage of elective admissions - University Hospitals of Derby and Burton NHS Foundation Trust**

![Graph showing cancelled operations as a percentage of elective admissions]

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Burton Hospitals NHS Foundation Trust**

Data for the pre-acquisition Burton Hospitals NHS Foundation Trust are included in this analysis. These data are provided for contextual purposes and are not used to form part of our judgement.

Over the 23-month period from quarter 3 (Q3) 2016/17 to Q1 2018/19, Q2 2017/18 was the only quarter when the trust reported any cancelled operations where the patient wasn't treated within
28 days. In that quarter the trust cancelled 66 surgeries. Of the 66 cancellations 2% weren’t treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Burton Hospitals NHS Foundation Trust**

Over the same 23-month period, the percentage of cancelled operations at the trust was consistently better than or similar to the England average.

**Cancelled Operations as a percentage of elective admissions - Burton Hospitals NHS Foundation Trust**

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*(Source: NHS England)*

**Learning from complaints and concerns**

Staff and patients understood the processes to be followed in the event of any complaints or concerns. Leaflets explaining what to do were clearly visible in patient areas we visited. Where possible complaints or concerns would be handled in a timely manner in a conversation with front line staff. Staff would refer people to the patient advice and liaison service (PALS) for further help and support where required.

We saw ‘you said, we did’ noticeboards in patient areas provided feedback on what each department was doing about patient complaints or suggestions for change made by patients and visitors. However; there was variation in the extent to which these were completed.

From October 2017 to September 2018 Queens Hospital Burton received 20 complaints about surgery. For the 17 complaints that had been closed at the time of data submission, the trust took an average of 36.8 working days to investigate and close these complaints. This was in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.
The three complaints that had not yet been closed had been open for an average of 82.7 days at the time of data submission. This was not in line with the policy statement above. Following our inspection, the trust provided additional information which showed that only one of the 17 was no longer in line with the trust target.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>7</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>1</td>
</tr>
<tr>
<td>Patient care</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 Queen’s Hospital Burton received 209 compliments about its surgery services. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Comments tab)

Is the service well-led?

Leadership

The surgical service was led by a divisional medical director, divisional nurse director and a divisional director for surgery. They were supported by the clinical lead for anaesthesia, associate lead for anaesthesia, service managers, matrons and clinical team leaders with the right skills and abilities to enable the service to provide high quality sustainable care. Business unit triumvirate leadership consisted of a general manager, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by ward/department managers’.

Staff we spoke with were able to identify the leadership team and their roles and responsibilities, and generally spoke positively about their accessibility. We saw leaders were visible and accessible at both Queen’s Hospital Burton, and Sir Robert Peel Hospitals.

Staff were confident that leaders had the right skills, knowledge, experience and integrity to meet the needs of the service. Managers at different levels gave examples of in house and external leadership development they had completed.

The senior leadership team understood the challenges to quality and sustainability and identified, reviewed, and implemented the actions they needed to address them.

Vision and strategy

There was a clear statement of vision and values driven by quality and safety. The overall vision of the newly established trust was ‘exceptional care together’, with the aim to deliver outstanding care for local people bringing together the expertise of 12 000 staff across five hospital sites. The
trust values were presented as: CARE compassionate, approachable, respect and excellence, and PRIDE: putting patients first, right first time, investing our resource wisely, developing our people and ensuring value through partnership.

Staff were familiar with the vision and values which were displayed in patient areas, were included in mandatory training sessions, and formed the basis of staff appraisals. The leadership team demonstrated that the trust vision and values were translated into a strategy for integration, consolidation and sustainability of surgery services.

Staff, including the leadership team, understood the surgery service strategy. They recognised there were a number of work streams occurring in the surgical division that aligned to this, and the national ‘Getting it Right First Time’ (GIRFT) initiative. For example, a focus on improvements in patient flow, reduced waiting times, and reduced occupancy of shorter stay patients. Progress against delivery of the strategy and local plans was monitored and reviewed at board meetings and in other relevant meetings below board level. Performance information was used to hold management and staff to account.

The leadership team told us the acquisition in July 2018 was attractive to new staff and provided more opportunities to existing staff. It was designed to improve local access to services, avoid duplication, and make financial savings.

**Culture**

Staff were largely positive about the integration of services across the trust since the acquisition in July 2018 and described the leadership team as supportive and open to ideas and feedback. Staff felt the cross site working of the leadership team as a result of the acquisition was beneficial to staff and patients and had improved communication between staff working in different locations. However; some junior staff we spoke with were less positive about the integration, as they felt uncertain and ill-informed about the future direction of the trust. This included staff that had been temporarily assigned to other wards and departments who told us they were unclear about how long their deployed arrangements were in place.

Staff at both hospitals we visited generally felt well supported by the local leadership team and told us managers undertook regular walkabouts in clinical areas, and that matrons visited each ward at least daily. We saw this to be the case throughout our visit. Staff were positive about the arrangements in place to support and promote their wellbeing, for example occupational health, availability of confidential staff counselling and the chaplaincy service.

Managers were also positive about the support and direction from the executive management team and felt the newly acquired trust offered a range of opportunities for staff. Staff felt their individual skills were recognised and utilised and felt positively encouraged to embrace change.

Several staff we spoke with had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support provided by the trust. They described a culture that encouraged learning and development. Newer members of staff spoke positively about the welcome they had been shown and described their induction as welcoming, well organised and relevant and felt the service was keen for new ideas and willing to listen.

All staff were encouraged to report and learn from incidents and to challenge behaviour and performance that was inconsistent with the vision and values of the trust. Staff we spoke with knew who the freedom to speak up guardian for the trust was and felt they were accessible.

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.
Governance

Audits, including external reviews, were used to ensure the service continuously improved patient care and were decided by national guidance, patterns of incidents and clinical data outcomes. During our visit, we saw a range of audit outcomes including in anaesthetic, theatre and surgery. All audit reports had recommendations and action plans with executive board oversight.

A divisional risk and quality group (DRQG) was responsible for clinical governance and for reviewing surgical procedures. The group met monthly and documented ongoing risks and agreed actions.

The trust had made changes to the leadership and governance structures since the acquisition, however; the changes had not yet been fully embedded across the service. Most operational policies were still site specific. The trust policies were reviewed as soon as was practicable, and discussed with nominated staff within each directorate, and at the monthly surgical division governance meeting. The policy review included revision of clinical and non-clinical guidelines, and standard operating procedures, and prioritised those that were due for review and those where there were clear differences between the hospitals.

Detailed work was taking place through the trust Clinical Guidelines Group to review clinical guidelines, to ensure they were safe and to identify whether they would continue as hospital site specific or if they should be combined.

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. However, not all staff, particularly more junior staff fully understood the new structure since the acquisition and were not aware of future plans for the service.

Management of risk, issues and performance

The MDT met daily to review the quality and risk status of each ward; and share information and ideas on how to improve patient outcomes.

There were processes in place for sharing information from each ward or department with the senior management team. These included; monthly ward or departmental staff meetings, monthly one-to-one meetings, and weekly ward assurance meetings. The matron(s) submitted a governance report to the divisional governance / business unit meeting each month.

A risk register was held within each division within the trust. The risk registers were reviewed at least monthly at the surgical divisional quality and risk group (DQRG) meetings with particular emphasis on risks scoring 15 or above. This was to ensure they were re-evaluated and any gaps in controls could be addressed. Risks included a description, controls in place to mitigate the risk, and a summary of actions taken. The leadership team and clinical team leaders had a good knowledge of the risks contained within this register, and we saw recorded risks reflected those identified through our discussions with the leadership team.

The trust had an emergency planning policy and there was major incident plan for Queen’s Hospital Burton. Staff understood their roles and responsibilities in relation to a major incident. There were also business continuity plans for each site. Staff were accustomed to receiving emergency patients that required stabilisation and were able to deal with these situations calmly.

In patient areas, performance was reported on quality dashboards using a ward assurance tool. Random samples of 20 patient records on each ward were reviewed monthly to review metrics such as pain management and prescribing.

NICE Quality statement 61 Organisational responsibility sets out guidance for organisations that provide healthcare to have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. We saw this was implemented and that there was board oversight of performance regarding antimicrobial prescribing and stewardship.
Information management

Information technology systems were generally used effectively to monitor and improve patient care. There were arrangements in place which ensured data was submitted to external providers as required, such as serious incidents and RTT performance. All permanent staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment using a secure records system that they could update. However; some temporary staff could only access IT systems in the presence of a permanent staff member. This provided a secure system; however, it was time-consuming for staff, as some agency nurses were unable to access or record information or administer medicines unsupervised for example.

We saw that Queen’s Hospital Burton and Sir Robert Peel Hospital used a different patient administration and record system to that of Derby Royal hospital. The two systems functioned independently and were configured differently. Whilst there was no evidence that this caused any problems staff and managers acknowledged that it was a risk, and we saw it had been added to the risk register. Work was in progress to simplify and integrate information technology systems.

Arrangements to ensure availability, integrity and confidentiality of identifiable data, records and data management were in line with data security standards.

Engagement

People’s views and experiences were gathered and acted upon to shape and improve the services and culture. This included involvement in decision making at ward level using the ‘You said we did’ model.

The trust had engaged with the ten Staffordshire and Derbyshire clinical commissioning groups in relation to the delivery of commissioned services across all the hospital sites. The relationship was supported by a number of regular formal forums and informal networks spanning strategic, tactical and operational levels.

The trust had partnered with an organisation called Clever Together who had developed an online platform to enable every member of staff to have a voice in decision making.

Although attempts were made to hold regular staff communication meetings, these had become increasingly difficult due to work load. However; managers and staff engaged in discussions about any relevant updates at patient handovers and safety huddles, and through email and we saw clinical managers produced and displayed staff newsletters on at least a monthly basis.

Learning, continuous improvement and innovation

The trust had a number of strategies to underpin their approach to embedding continuous improvement. For example, a research and development strategy enabled staff to contribute to national and local research initiatives to inform continuous improvement in clinical practice, support business development, and develop a culture of research and innovation.

The service was committed to improving services by learning from when things go well and when they go wrong. Staff were positive about the support they received to challenge existing practice and try out new ideas.

There were three national research studies open at QHB: two breast surgery trials, and a trial relating to amblyopia (lazy eye) in children. The principal researchers for all studies were consultants working within the service.

Ward 14 at QBH had won the trust Chief Executive’s award in 2018 in recognition of outstanding team work.
University Hospitals of Derby and Burton NHS Foundation Trust was formed on 1st July 2018 following the acquisition of Burton Hospitals NHS Foundation Trust (BHFT) by Derby Teaching Hospitals NHS Foundation Trust (DTHFT). DTHFT acquired BHFT under its existing registration with the CQC. Our legal position is that the acquired trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because this data relates to the same legal entity as the merged trust it is used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity, we expected the trust to be able to demonstrate how they responded to the data to improve services.

**University Hospitals of Derby and Burton NHS Foundation Trust**

The trust has 85 critical care beds. A breakdown of beds by type is displayed below.

**Breakdown of critical care beds by type, University Hospitals of Derby and Burton NHS Foundation Trust and England.**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>31.8%</td>
<td></td>
</tr>
<tr>
<td>Paediatric</td>
<td>4.7%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Adult</td>
<td>63.5%</td>
<td>94.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Queen’s Hospital Burton**

Queen's Hospital Burton provides level 2 and 3 critical care. The hospital is funded for 10 beds, of which four are level 2 and six are level 3 beds.

The units on the Queen’s Hospital Burton site provide 24/7 consultant intensivist led care. All the consultant workforce are also anaesthetists and liaise with colleagues to provide support to surgical cases in both elective and emergency settings.

Each unit provides critical care support by a critical care outreach nursing team who have intensive care experience. They also provide an acute pain service. There is a multi-disciplinary team approach to patient care.
Over the year 2017/18 the Queen’s Hospital Burton site admitted over 500 patients. Of these, the majority were emergency admissions. The units support the emergency department, acute medical and surgical admissions, obstetrics and elective surgery.

Queen’s Hospital Burton also offers a rehabilitation and/or a follow-up service for discharged patients.

(Source: Acute Routine Provider Information Request (RPIR) – Acute context tab)

Queen’s Hospital Burton

Queen’s Hospital Burton has two critical care wards with 10 inpatient beds:

- Intensive care unit: six beds
- High dependency unit: four beds

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all mandatory training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in critical care at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>59</td>
<td>60</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>59</td>
<td>60</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (administration)</td>
<td>118</td>
<td>120</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>58</td>
<td>60</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (collection)</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Qualified nursing staff in critical care at Queen’s Hospital Burton had an overall mandatory training completion rate of 94.8%. The hospital’s training targets were met for 16 of the 19 mandatory training modules for which qualified nursing staff were eligible.

The nurse educator monitored mandatory training compliance for all staff and ensured they had protected time for completion. All staff who were overdue for life support training were booked onto a course.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in critical care at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>55</td>
<td>60</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory (nursing)</td>
<td>55</td>
<td>60</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>55</td>
<td>60</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>30</td>
<td>36</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Food safety</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion theory (doctors)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Doctors manual handling awareness</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in critical care at Queen’s Hospital Burton had an overall mandatory training completion rate of 82.2%. The hospital’s training targets were met for three of the 15 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all safeguarding training modules.
A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in critical care at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>54</td>
<td>60</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in critical care at Queen’s Hospital Burton had an overall safeguarding training compliance rate of 96.1%. The hospital’s safeguarding training targets were met for all six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in critical care at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in critical care at Queen’s Hospital Burton had an overall safeguarding training compliance rate of 90.0%. The hospital’s safeguarding training target was met for two of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Senior staff nurses had training in safeguarding referral and escalation processes and worked with the trust’s safeguarding team to ensure patients at risk were assessed and cared for.

The safeguarding team mapped training provision and requirements against the safeguarding adults intercollegiate guidance; Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). The trust required all clinical staff to complete the UK government’s ‘Prevent’ counter terrorism strategy and the workshop to raise awareness of Prevent (WRAP3) training. All non-clinical staff complete basic Prevent training. This meant staff had training to national standards.

All staff we spoke with demonstrated a good level of awareness of the principles of safeguarding and their responsibilities under trust policy.

Between January 2018 and December 2018 staff reported one safeguarding incident. The team demonstrated appropriate and urgent action to keep the patient safe, including escalation to the trust safeguarding team and police.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
During our inspection we observed consistent standards of hand hygiene practice in line with World Health Organisation (WHO) standards and use of personal protective equipment (PPE). Staff washed their hands before and after examining patients and used antibacterial hand gel when entering clinical areas. Staff ensured visitors and colleagues from other departments adhered to trust standards of hand hygiene.

Staff completed monthly hand hygiene assessments to measure standards of practice with trust policy. However, the audits were completed inconsistently and from January 2018 to January 2019 audits were not carried out in five of the available 12 months. In the remaining months compliance was consistently good with an average performance of 97%. This formed part of a wider infection control audit that included environmental assurance and NHS Saving Lives Care Bundles and high impact interventions on a quarterly basis. In October 2018, critical care demonstrated overall compliance of 98%, which was better than the trust’s minimum standard of 95%. This was an overall figure across 17 measures of safety standards and practice and reflected compliance at or above 98% in all but two measures. The service scored 87% for the input of the matron into environmental standards and 90% for diarrhoea management. This improved in January 2019 when diarrhoea management was 100%.

From July 2018 to December 2018 critical care scored 100% compliance in a monthly audit of infection control standards of commode management. During our inspection we observed good standards of commode infection control.

The unit demonstrated a consistently good track record in managing infection risks. From April 2018 to November 2018 the unit had no instances of unit-acquired meticillin-resistant Staphylococcus aureus (MRSA) or vancomycin-resistant enterococci (VRE) and one instance of unit-acquired Clostridium difficile (C.Difficile). This represented an infection rate of 0.4%, which was the same as similar units nationally. The business unit reviewed the patient’s care and found no lapse in standards and identified no areas for learning. In the same period there were no unit-acquired bloodborne infections. During the same period there were no instances of central venous catheter (CVC) blood stream infections or ventilator associated complications.

The unit did not have a side room or negative pressure room, which presented the risk of cross-infection for patients with infectious conditions who would usually be cared for in isolation. The senior team had scoped the use of an isolation pod in the unit but there was not enough space to safely install this. To mitigate the risk, staff had undertaken more advanced training in infection control and barrier nursing. The unit had experienced no infection control incidents as a result of the lack of isolation facilities.

The clinical environment was cluttered and there was equipment stored in empty bed spaces and in any unused space around the unit. Staff recognised the restrictions caused by the size of the unit and used enhanced infection control measures to reduce risk. Each bed space in the intensive care unit (ICU) had a hand-washing sink, a stock of PPE and antibacterial hand gel. There were two hand-washing sinks in the high dependency unit (HDU) and each bed space had antibacterial gel and PPE.

**Environment and equipment**

Staff looked after the environment and equipment well. However, the service did not have all the premises and equipment it needed.

Staff maintained appropriate standards of hazardous waste management including classification, segregation, storage, labelling, handling and disposal in line with Department of Health and Social Care Health Technical Memorandum 07/07.

The fire safety advisor carried out annual fire safety checks and risk assessments as part of an
ongoing live system to identify new or emerging risks, in line with the requirements of the Regulatory Reform (Fire Safety) Order 2005 and the Department of Health and Social Care health technical memorandum HTM05-03. The advisor carried out a weekly walkaround of the unit to identify any issues that could be rectified immediately and to provide staff with on-going support. The most recent fire risk assessment took place in August 2018 and identified three fire safety risks for attention in addition to a risk identified in August 2017 that remained unresolved. All issues related to the environment required capital funding to be approved before they could be resolved. Staff had implemented short-term mitigation in the interim to reduce the risk. For example, the fire risk assessment identified faults with the emergency lighting system that required a substantial equipment upgrade. To address this temporarily, the fire safety advisor provided emergency portable lamps for use in the event of an evacuation when lighting would be reduced. Although the lamps were in situ we found very limited understanding of them amongst staff who usually worked in the area. We were unable to establish who was responsible for the maintenance and battery checks of this equipment and the trust did not provide a response to our request for this. Information received following our inspection confirmed the individual responsible and that battery checks had been carried out in November 2018.

Both fire risk assessments identified the partial blocking or obstruction of escape routes as an on-going issue. For example, the storage of equipment in corridors and in the vicinity of emergency exits would hamper an emergency evacuation. During our inspection we saw it was common practice for staff in the ICU to place bins in front of the fire exits from the unit. The main fire exit from the HDU was into the adjacent ward and staff in that ward stored several items of equipment, such as hoists and oxygen cylinders, immediately behind the doors. We spoke with a nurse in that ward who was unaware of the escape route from HDU and said it was normal practice to store equipment there. We spoke with the fire safety advisor and senior staff about this who addressed it immediately and reviewed the location of bins in the ICU. They said the storage of equipment in escape routes and bins in front of fire doors was a persistent issue.

Senior nurses at band six and above and fire wardens had enhanced fire safety training specific to the challenges in evacuating ventilated patients and those under sedation. The fire safety advisor told us fire wardens carried out weekly and monthly checks of the unit although we were unable to find evidence of this and none of the staff we asked on the unit knew who their fire wardens were. The unit had not carried out fire drills although the fire safety advisor was planning a table-top exercise for later in 2019. We asked the trust to provide evidence of fire warden checklists and we received records from April 2017.

Information received following our inspection showed the critical care clinical educator was developing a “real” evacuation scenario to be undertaken on the unit as clinical activity would allow. This was to include details of patient presentation and associated equipment and allow staff to evacuate to theatre recovery, thus enabling identification of particular challenges and adapting processes to overcome these. In addition, fire training now included table top scenarios for critical care staff to talk through how they would plan and undertake evacuation. Daily checks of obstructions to fire doors were also in place and demonstrated consistent compliance.

Resuscitation trolleys were located in both the ICU and HDU and staff documented daily safety checks on them. We looked at the records for the previous 14 weeks and found consistent standards of documentation. A difficult intubation trolley was located in the ICU. This was locked and staff had documented safety checks with two gaps in the previous four months. However, we found two items of disposable equipment had expired and had not been highlighted by the safety checks. We spoke with a member of staff about this who replaced the items immediately.

The resuscitation and clinical skills department carried out a six-monthly audit of resuscitation equipment. In July 2018, the team found resuscitation trolleys were missing items and in one case had an equipment checklist that had expired four years previously. The resuscitation team led a trust-wide improvement programme to address these issues and common themes of non-
compliance across clinical areas. In a re-audit in January 2019, the team found all equipment to be in situ and with up-to-date operational documentation. However, the audit found staff in HDU had not always recorded daily safety checks of essential equipment.

Staff used a dedicated agenda slot in each monthly management meeting to discuss technical updates to equipment. This ensured practice was guided by manufacturer updates.

The biomedical engineering department and facilities team monitored equipment on a rolling basis and a replacement schedule was in place.

Staff used a series of bedside safety checklists to check equipment and patient’s equipment such as intravenous lines and catheters. This included checks of consumables and static equipment. We looked at the safety checklists for each patient who received care during our inspection and found they were up to date.

We carried out checks on a sample of 10 items of ICU equipment. Each item was clean and had a green ‘I’m clean’ sticker prominently placed. Three items of equipment were overdue for servicing and the technician with oversight of equipment told us overall compliance for servicing in the unit was 87%. They worked with the biomedical engineering department to maintain an asset register and to plan maintenance to improve servicing compliance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The critical care outreach team provided an on-call service to wards across the hospital to provide a senior clinical review of patients with an increasing national early warning score (NEWS). NEWS is a system used to identify deteriorating patients through the monitoring of key vital signs. A higher number means a patient is at greater risk of deterioration. From February 2018 to February 2019 the team received 998 referrals. Of these, 20% were referred due to a nurse concern, 20% were referred due to an increasing NEWS score of five and above and 15% were referred for an acute pain review. The reason for a referral was not collected in 40% of cases. The team responded to 60% of referrals for NEWS above five, acute pain and nurse concerns within one hour. This was based on a risk assessment the outreach nurse carried out at the point of each referral, which they used to prioritise those with the most urgent need.

The service had established a system to ensure staff involved in invasive procedures shared learning and education outcomes. This was in line with national standards and demonstrated good safety practice.

Critical care assessed hospital-wide compliance with the National Institute of Health and Care Excellence (NICE) clinical guidance (CG) 50 in relation to the recognition of deteriorating patients. The service identified a good standard of compliance in the most recent review in February 2018.

From February 2018 to February 2019, staff achieved 100% compliance with venous thromboembolism (VTE) risk assessments and documentation.

A pharmacist antibiotic steward and a quality support nurse formed the sepsis team and led a 2018/19 sepsis ‘forward plan’ across the hospital. This included a quarterly audit carried out over two weeks amongst a sample of patients seen by the critical care outreach team. From January 2018 to December 2018 the outreach team achieved 95% compliance with trust sepsis screening standards during this period and 88% compliance with antibiotic administration compliance. The team was in the process of developing an e-learning sepsis package for staff to improve
knowledge and practice and a patient group direction (PGD) for nurses to take a lead role in the administration of intravenous fluids. PGDs enable non-prescribers to administer specific medicines to patients for a defined area of need.

In February 2019 90% of staff had up to date training in a level of life support commensurate with their role and responsibilities. This was an average figure and reflected a completion range from 80% amongst staff nurses with a critical care qualification to 100% completion amongst senior nurses, technicians, the healthcare support worker and the ward clerk. Completion rates per course were 98% for basic life support and 89% for immediate life support (ILS). All staff whose training had expired or was due to expire were booked onto the next available course. Senior staff acknowledged challenges in booking staff onto immediate life support (ILS) training due to a lack of capacity on courses and demonstrated how they ensured staff were allocated to the closest possible session to their expiry date.

All staff nurses with a post-registration qualification in intensive care nursing and all senior nurses at band six or above were required to have ILS training.

A senior staff nurse was a designated BLS trainer and was completing training to become an ILS trainer. This meant the unit could more closely manage the training requirements of the team and reduce the risk of lapses in competency assessments.

During a ward round we observed doctors carried out a full assessment of each patient, including respiratory, cardio-vascular, sedation and medicines.

During our inspection some staff said they were concerned patients with tracheostomies were discharged or stepped-down to medical inpatient wards that were not resourced to provide specialist care. We spoke with the senior critical care leadership team about this who said they prioritised two wards that had tracheostomy kits and where nurses had competency training.

Staff used a combination of paper records and electronic records for care and treatment plans and observations. Nursing care bundles included nine risk assessments and regular checks, including for vital signs, ventilation and invasive line management.

Nurses monitored patients’ waterlow score using an assessment as part of the nursing care bundle. We looked at a sample of six records and found them to be fully completed and up to date.

All staff had received training in the care of patients whose health deteriorated and whose behaviour presented challenges. For example, patients who experience delirium could behave violently due to a lack of understanding of their environment. Staff used advanced communication techniques to try and calm patients and where this failed, doctors were trained to provide chemical restraint where this was in the patient’s best interest. Senior staff were always available to support staff where situations escalated.

Nurse staffing

The service did not always have enough nursing staff to keep patients safe and provide the right care and treatment. Nurses had the right mix of qualification and skills.

The trust reported their staffing numbers by department below for qualified nurses in critical care at Queen’s Hospital Burton for the period from April 2017 to March 2018 and from November 2017 to October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

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Within critical care at Queen’s Hospital Burton, there was an overall nursing staffing level of 84.6% from November 2017 to October 2018, with a deficit of 9.8 WTE nursing staff. This staffing level was higher than previous period, April 2017 to March 2018, when it was 74.8%.

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

As of November 2018, there were 47 qualified nursing whole time equivalents (WTE) in the intensive care unit at Queen’s Hospital Burton, of which 21 (44.7%) had a post registration award in critical care nursing.

All 48 qualified and unqualified nursing WTE staff in the intensive care unit at Queen’s Hospital Burton had had up to date training in specialised unit equipment.

(Source: Acute Routine Provider Information Request (RPIR) – Critical care staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 23.8% for qualified nursing staff working in critical care at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

The breakdown by department was as follows:
- Intensive care unit: 28.5%
- Intensive care unit night nurse practitioner: 7.4%
- Critical care outreach: -0.2% indicating the unit was slightly over-established

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 4.5% for qualified nursing staff working in critical care at Queen’s Hospital Burton. This was lower than the trust’s target of a turnover rate between 8% and 12%.

The breakdown by department was as follows:
- Intensive care unit: 5.8%
- Intensive care unit night nurse practitioner: 0.0%
- Critical care outreach: 0.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 3.2% for qualified nursing staff working in critical care at Queen’s Hospital Burton. This was lower than the trust’s target rate of 3.8%.

The breakdown by department was as follows:
- Critical care outreach: 5.1%
- Intensive care unit: 3.5%
- Intensive care unit night nurse practitioner: 0.5%
The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in critical care at Queen’s Hospital Burton.

From November 2017 to October 2018, the trust reported that 3.8% of qualified nursing hours in critical care at Queen’s Hospital Burton were filled by bank staff and 3.5% by agency staff. 1.4% of qualified nursing staff hours were not filled by bank or agency staff to cover qualified nursing staff absence. Senior nurses documented competency checks and a basic induction for agency nurses. This covered essential information such as the location of clinical equipment and the escalation process for deteriorating patients.

Over the same period, the trust reported that 3.3% of unqualified nursing staff hours at Queen’s Hospital Burton were filled by bank staff, while no hours were filled by agency staff. There were no unqualified nursing staff hours that were not filled by either bank or agency staff to cover staff absence. Where direct care was augmented by non-qualified support staff, the senior team ensured they had appropriate training and up to date competence assessments.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Agency Hours</th>
<th>Agency %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>4,143.3</td>
<td>3.8%</td>
<td>3,827.3</td>
<td>3.5%</td>
<td>1,510.0</td>
<td>1.4%</td>
<td>109,128.1</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>106.5</td>
<td>3.3%</td>
<td>0.0</td>
<td>0.0%</td>
<td>0.0</td>
<td>0.0%</td>
<td>3,264.9</td>
</tr>
<tr>
<td>Total</td>
<td>4,249.8</td>
<td>3.8%</td>
<td>3,827.3</td>
<td>3.4%</td>
<td>1,510.0</td>
<td>1.3%</td>
<td>112,393.0</td>
</tr>
</tbody>
</table>

Staff used a standardised handover process at the beginning of each shift. This included a review of the status of the department and hospital and a review of each patient and the clinical plan for them. The clinical team used another established handover process when patients were discharged from the unit back to their specialist medical or surgical team. This followed a standard checklist to ensure critical aspects of safety were followed.

From January 2018 to December 2018 staff reported 13 incidents in which the nurse to patient ratio in the intensive care unit did not meet the minimum standards established by the Intensive Care Society (ICS). In each case one nurse provided care for two level 3 patients at the same time due to short staffing and non-availability of agency nurses. ICS standards are for a nurse to patient ratio of 1:1. Where staff escalated each case to the site operations team it was not evident appropriate action was always taken. We spoke with a senior nurse about this who said, ‘doubling up’ of staff was common and often cause by persistent staffing shortages in orthopaedics, which meant critical care nurses were redeployed.

Staffing levels were not planned using a nationally-recognised tool and instead were based on local patient acuity. However, a duty sister for the hospital was supernumerary to critical care and provided support for staffing levels and represented critical care in operational bed meetings.

The senior team had protected funding to implement extra staffing at short notice in the event of a surge situation. This occurred when there was unexpected, urgent demand on the service such as after a major incident. However, staff we spoke with said this rarely worked in practice and they had to move patients around the unit to ensure staff were not spread too thinly.
Physiotherapy staffing was sufficient to provide respiratory management and rehabilitation, including on an urgent out of hours basis.

**Medical staffing**

**The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**

The trust reported their staffing numbers below for medical staff in critical care at Queen’s Hospital Burton for the period from April 2017 to March 2018 and from November 2017 to October 2018. A breakdown of medical staff numbers by department was not provided.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>6.0</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Within critical care at Queen’s Hospital Burton, there was an overall medical staffing level of 100% from November 2017 to October 2018. This was the same as the level in the previous period, April 2017 to March 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 0% for medical staff working in critical care at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

Information received following our inspection showed, as of March 2019 the medical staff vacancy rate for critical care at Queen’s Hospital Burton was 16.67%. However, it should be noted this equated to one post out of six vacant.

From November 2017 to October 2018, the trust reported a turnover rate of 0% for medical staff working in critical care at Queen’s Hospital Burton. This was lower than the trust’s target of a turnover rate of between 8% and 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 1.5% for medical staff working in critical care at Queen’s Hospital Burton. This was lower than the trust’s target rate of 3.8%.

(Source: Routine Provider Information Request (RPIR) - Sickness)

The trust provided bank and locum staff usage data for medical staff in critical care at Queen’s Hospital Burton.

From November 2017 to October 2018, the trust reported that no medical staff hours in critical care at Queen’s Hospital Burton that were filled by bank or locum staff or left unfilled by bank or locum staff to cover staff absence.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
</tr>
</tbody>
</table>
A team of six substantive consultant intensivists and one locum consultant led care seven days a week. Shifts Monday to Friday included one specialist trainee doctor, one core trainee doctor and one foundation year one (FY1) doctor in addition to consultants. At weekends, one consultant and one trainee doctor led care. At all times a consultant anaesthetist was on site and provided on-demand support to the critical care team. FY1 doctors were supernumerary and worked on a rotation basis between critical care and anaesthetics. Medical staffing levels met the standards set by the Faculty of Intensive Care Medicine (FICM).

The service met FICM and ICS standards in relation to consultant-led care and treatment management. For example, consultants carried out twice-daily ward rounds, seven days a week and all admissions were led by a consultant. This sometimes occurred overnight when a consultant was available on-call and they maintained oversight of the process. A consultant reviewed all patients within 12 hours of admission. Consultants in the unit were free from other clinical responsibilities, which meant their time and expertise was dedicated to critical care.

A guardian of safer working monitored the safety of doctors’ working hours and reviewed exception reports, which junior doctors submitted when they had worked excessive or unsafe hours. Doctors in critical care had submitted no exception reports of excessive working hours from August 2017 to February 2019. This reflected the balanced working practices of doctor’s rotas and working times.

Between 9pm and 8am specialist registrars in the emergency department and medical registrars provided on-call support for the trainee medical team in critical care. The hospital at night team, always had a doctor or night nurse practitioner (NNP) with advanced airway skills available and the nurse in charge escalated patients to them in the case of deterioration.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The team carried out monthly audits of patient records completion to measure compliance with trust standards. Critical care performed consistently well and from January 2018 to December 2018 achieved 99% overall compliance, which reflected a monthly range from 97% to 100%.

In a critical care network self-assessment in February 2018 the service identified patient records during and following transfers as areas for improvement to fully meet NICE CG 50 and FICM guidelines for the provision of intensive care services (GPICS). This included the consistent use of a monitoring and investigation plan and the documentation of specific communication needs for each patient.

We reviewed six sets of patient records. In each case staff had recorded reviews legibly and included the time, date and their designation. Each record included the time of the decision to admit the patient, a summary of events that led to the admission and a first consultant review within 12 hours of admission. This was in line with ICS standards.

Medicines
The service did not always follow best practice in medicines management. There were unmitigated safety risks with the storage of some medicines and staff identified risks associated with the different prescribing systems used between critical care and inpatient wards.

A dedicated pharmacist and pharmacy technician provided daily support to critical care, including safety reviews of prescriptions and advice during ward rounds. The pharmacy team was proactive in responding to medicines risks in the unit and ensured staff knew about changes to practice. For example, the pharmacy team developed new insulin guidelines following a series of incidents based on the existing protocol. As part of the changes, the pharmacy team prepared new competencies for nursing staff to follow and the nurse educator worked with staff on their insulin calculation and administration skills. Staff involved in a medicines error or incident completed a reflective exercise as part of the investigation to identify where they could improve their process and practice. Staff had access to medicines study days and intravenous competency practical study sessions. This reflected a proactive approach to addressing medicines risks and incidents.

We reviewed the storage, safety and security of medicines on the unit. In the ICU, medicines were stored in a locked cupboard with restricted access, which was in line with best practice. All the intravenous injection fluids were in date and appropriately stored. Staff had not always labelled oral medicines with the open date, which meant they could not be assured these medicines were fit for use after opening. Potassium infusions were stored with other liquid medicines, which was not in line with safety guidance that these infusions should be isolated. We looked at a sample of 50 entries in the Controlled Drugs (CDs) register and each had been signed by two nurses, which reflected best practice. There was one gap in the CD stock check records in the previous two months, which we escalated to a member of staff.

Staff recorded the temperature of medicine storage areas, including fridges daily. Where temperatures had exceeded the safe limit established by the manufacturer, staff escalated this to the pharmacy team.

The medicine fridge in the ICU storage area was not locked and was stored in a room that non-critical care staff had routine access to. This presented a security risk and we discussed it with the nurse in charge of the shift and the senior divisional team who said they would review arrangements. Following our inspection a review was undertaken in conjunction with the chief pharmacist and a plan to remedy this was now in place. As a short term measure, a small store room within critical care had been identified that would store fluids and the drugs fridge. This was swipe access only with only registered nurses and medical staff having swipe access.

Senior nurses led improvements in medicines management practice following a series of incidents. This included new safety assurance when administering liquid medicine using a pump and more stringent standards of signing for medicines. The team also observed practice against intravenous therapy procedures to ensure staff prepared these at the patient’s bedside and discarded surplus immediately.

From January 2018 to December 2018, staff reported six incidents relating to medicines, including one failure to follow procedures and issues caused by critical care using a different prescribing system to the rest of the hospital.

The pharmacy team carried out an annual audit of safe and secure handling of medicines to assess compliance with Royal Pharmaceutical Society (RPS) standards. The most recent audit took place between April 2018 and May 2018 and found variable standards of practice, with nine areas of non-compliance against 25 standards in the ICU. Areas of non-compliance included a failure to act on previous audit action plans, unsafe storage of medicines and a lack of space for patient’s own medicine. There was no evidence the critical care team had acted on these findings.
in the audit documentation and issues with secure storage remained at the time of our inspection. Compliance in the same audit was better in the HDU, with four areas of non-compliance relating to storage and administration.

The pharmacy team carried out a periodic audit of CD management. The most recent audit for the HDU took place in November 2018 and found 20 areas of compliance out of 23 RPS standards. The audit highlighted on-going non-compliance with storage and documentation and were similar to the issues found in the annual audit in April 2018. The same audit in the ICU took place in January 2019 and highlighted improvements in practice, with 22 out of 23 areas compliant. Both the ITU and HDU demonstrated on-going non-compliance with documentation standards of CDs.

In all six patients’ records we looked at staff had recorded reviews of antibiotics and sedation. In addition, doctors reviewed each patient’s antibiotics during ward rounds.

**Incidents**

The service did not consistently manage patient safety incidents. Not all staff confidently recognised incidents and there was limited assurance they reported them appropriately. Although managers investigated incidents and shared lessons learned with the whole team and the wider service staff demonstrated limited understanding of outcomes. When things went wrong, staff apologised and gave patients honest information and suitable support.

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition as well as data for University Hospitals of Derby and Burton NHS Foundation Trust post-acquisition. This is provided for contextual purposes and it is not used to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, Queen’s Hospital Burton reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition as well as data for University Hospitals of Derby and Burton NHS Foundation Trust post-acquisition. This is provided for contextual purposes and it is not used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, Queen’s Hospital Burton reported one serious incident (SI) in critical care which met the reporting criteria set by NHS England from January to December 2018. This serious incident, which occurred in January 2018, was classified as a surgical/invasive procedure incident.

(Source: Strategic Executive Information System (STEIS))

From January 2018 to December 2018 staff reported 74 incidents. The most common categories of incidents were administrative processes (30%), environmental hazards (23%), hospital-acquired pressure ulcers (19%) and workplace or staffing pressures (19%). Staff recorded discharge delays and mixed-sex breaches as administrative processes and documented these appropriately. Such incidents included administrative errors that meant ward beds were allocated
to other patients and delays in securing ward beds, including one instance of a 58-hour discharge delay and one instance of a 57-hour discharge delay.

Senior nurses said mixed-sex breaches were their most common reason for completing an incident report and that staff nurses were proactive in this.

Senior staff maintained an incident tracker to identify themes and trends in incidents, such as a period of repeated challenges in obtaining suitable food from the catering supplier. Senior nurses provided feedback to colleagues in safety huddles and handovers. Team meetings for nurses were very infrequent but we saw the senior team displayed information in the staff room and communicated by e-mail to ensure all members of the team were aware of incident outcomes.

The education lead was responsive in introducing new training opportunities as a result of learning from incidents. For example, they identified a need for improved intravenous medicine competencies following a series of incident reports. In response they developed and introduced a new policy and competencies and required a senior nurse to sign off each staff nurse before they could practice.

All members of the multidisciplinary team had access to the incident-reporting system and demonstrated a good understanding of the process. Where a member of staff reported an incident that occurred on the critical care unit and they were not permanently based in the unit, they worked jointly with the critical care senior team to investigate the incident. For example, physiotherapists worked broadly across critical care, surgery, maternity and respiratory medicine. If a physiotherapist reported an incident on critical care, the therapies lead worked with the critical care team during the investigation. Therapists said this system worked well and said they received anonymised feedback following incident reports at team meetings.

Allied health professionals (AHPs) said they saw incidents as a learning opportunity. One member of the team said, “The investigations make us feel more secure. Staff report anything adverse, which is really important, and we all learn from it.”

Safety Thermometer

The service used safety monitoring results, collected safety information and shared it with staff, patients and visitors. Managers did not consistently use this to improve the service or to implement consistent, long-term improvements.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

Data from the Patient Safety Thermometer showed that Burton Hospitals NHS Foundation Trust reported five new pressure ulcers, no falls with harm and no new catheter urinary tract infections from December 2017 to July 2018.
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because this data relates to the same legal entity as the merged trust it is used to form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported four new pressure ulcers, no falls with harm and no new catheter urinary tract infections from December 2017 to December 2018.

Staff audited standards of tissue viability and skin integrity on a monthly basis and assessed the accuracy of waterlow scores and frequency of pressure area care. The team performed consistently well and from January 2018 to December 2018 overall compliance was over 99%. This reflected 11 months of 100% compliance and one month of 96.3% compliance.

The tissue viability team carried out a monthly audit and prepared an ‘excellence report’ to identify areas of compliance with trust standards. The most recent data supplied by the trust related to October 2018 and found overall compliance of 85%. This was significantly below the minimum standard of 95% and reflected a range of compliance in individual measures from 50% to 100%.

Between January 2018 and December 2018 staff reported 13 instances of hospital-acquired pressure ulcers. In each case staff worked with a tissue viability nurse to identify the cause and implement care to reduce the grade and impact on the patient.

All beds were equipped with air flow mattresses, which helped to reduce the risk of pressure
sores for patients who could not mobilise. Staff ordered other specialist mattresses and pressure relief equipment in consultation with the tissue viability team.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff had access to policies and procedures on the intranet. This included critical care and anaesthetic guidelines as well as trust-wide policies. We looked at a sample of four clinical guidelines with a clinician and found variable standards of access and availability. For example, the sepsis screening and central venous catheter insertion guidelines related to the trust’s other acute site and not to this hospital. The tracheostomy guidance had expired in December 2018. We spoke with a doctor about this who showed us there was limited consistency in policies. They said where no local guidelines existed they used the equivalent from the trust’s other hospital. Nursing care guidelines were from another NHS hospital and required a separate login from the critical care intranet page. We asked a senior nurse about this who said they were not familiar with the guidelines and had never seen a local copy specific to this hospital. We spoke with the senior leadership team about this who said standardising access to policies and guidelines was a priority following the formation of the new organisation.

Follow-up services were in line with National Institute of Health and Care Excellence (NICE) clinical guidance (CG) 68 in relation to patient rehabilitation. This included a structured follow-up programme at one month and two months post-discharge.

Critical care was an established member of a regional network that enabled extensive peer support and opportunities for learning from best practice and from areas for improvement. The service carried out a self-assessment in February 2018 to measure performance with network standards, which were based on national guidance from the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM) as well as the NHS England national service specification for adult critical care services (D16). The service met or partially met 102 of the 109 criteria. In November 2018 the network identified several improvements the unit had achieved. This included less unmet needs, a reduction in non-clinical transfers and a reduction in cancelled procedures. The number of out of hours discharges had decreased from 13 in the previous quarter to seven and the average delayed discharge time decreased by 13 hours.

Staff were proactive in identifying opportunities to establish new audits or to contribute to existing audits as a strategy to benchmark and improve care and treatment. For example, the service had identified data in the national emergency laparotomy audit had a potential benefit to the development of care and a senior nurse was undertaking an obstetrics audit of maternity patients admitted to critical care. Such activity helped to contribute knowledge and understanding to the clinical team.

The critical care team completed two audits in the previous 12 months, one based on clinical documentation and one to explore nurse-led weaning. A further three audits were planned and awaiting a start date including one audit to benchmark the standard of practice in relation to the situation, background, assessment, recommendation (SBAR) tool. Staff were planning to introduce a further four audits in 2019/20 as part of the critical care audit forward plan. Staff planned and
designed audits to improve patient care and assess standards of practice against trust policy. Planned future audits included on the consent process, end of life decisions and same-day cancellations of surgery.

Allied health professionals (AHPs) were in the process of reviewing policies and guidelines across the trust, which included those specific to critical care. This was part of work to ensure policies reflected the latest best practice guidance and to standardise practice across the hospitals.

Physiotherapists used the Chelsea critical care physical assessment tool (CPAx) to establish how able a patient was in each element of daily activities, such as getting dressed and walking. The team was in the process of compiling information for a CPAx audit to review compliance using the assessment tool since its introduction and to review patient scores following rehabilitation.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

The dietetics team provided training to critical care nursing staff on optimal use of the malnutrition universal scoring tool (MUST) and the use of enteral and parenteral feeding. The team joined ward rounds and visited the service daily to review patients and provide guidance to staff. Dieticians on the stroke unit were trained in total parenteral nutrition (TPN) and provided on-call support to critical care.

A speech and language therapy (SaLT) service was based on-site but staff described challenges in obtaining reviews. Stroke nurses had training to complete swallowing assessments, but critical care nurses had not and the SaLT team were not trained in swallowing assessments in patients with a tracheostomy. We asked a senior nurse about this who said the team ensured patients received adequate nutrition through a process of elimination using thickening agents.

During a ward round we observed doctors carried out a fluid balance and nutritional assessment of each patient. This meant they maintained an up to date understanding of each patient’s nutrition and hydration risks and needs.

In all six records we checked there was evidence of consistent review for nutrition and hydration, including involvement of the dietician team.

Dieticians had prepared an information pack for staff on the high dependency unit (HDU). This included support in identifying food for specific nutritional needs and guidance on carrying out swallowing assessments.

Dieticians worked closely with nurses to manage risks and intolerances. For example, a dietician had worked with nurses to provide safe TPN for patient with a dairy intolerance as well as a digestive disorder. This reflected good practice and demonstrated how teams worked together to manage complex needs.

Dieticians used an international classification system for preparing menus and nutritional supplements. The service was fully compliant ahead of a national deadline of April 2019. The team had prepared new printed information for patients and this was due for imminent launch.

Staff used a scoring system to identify triggers for fortified meals and additional supplements. This meant the team could begin patients on enhanced nutrition at an early stage to promote better outcomes.
Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The critical care outreach team provided an acute pain service and responded to referrals throughout the hospital as well as in critical care. From February 2018 to February 2019 the team received 146 referrals from outside of critical care and responded to 57% within one hour.

The critical care team monitored standards of pain relief against expected trust standards through monthly audits. The team performed consistently well and from January 2018 to December 2018 compliance was 100%.

Staff identified a risk in pain medicine prescribing when patients were admitted from wards in the hospital, which resulted in duplicate prescriptions. This occurred because the prescribing system in critical care was different to the systems used by the wards, which meant doctors sometimes prescribed duplicate medicines unknowingly. The outreach team and senior service team were working with colleagues at the unit’s sister site to identify opportunities for improvement through a new pain audit.

Nurses monitored pain scores using assessments in the nursing care bundles. We looked at a sample of six records and found them to be fully completed and up to date.

Two patients said they felt they had to wait extended periods for pain relief overnight and three relatives we spoke with said staff had managed the pain needs of their family members well.

Staff worked with patients to establish the most appropriate level of pain relief for them. For example, we observed staff in HDU discuss pain relief with each patient. Where a patient said they felt their pain could be better controlled, nurses discussed this with the medical team to find a solution.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. This is provided for contextual purposes and it is not used to form part of our judgement.

The trust had one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

A dedicated ICNARC audit nurse led data input and monitoring. They had identified errors in how data had previously been submitted in relation to delayed discharges. For example, for several years the unit had started the discharge time countdown from when a patient was ready to leave
the unit. This was not in line with ICNARC standards that the discharge countdown begins when patients are declared fit for discharge. This meant up to January 2019 the unit’s data submission for this measure was at odds with other units in the network.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. This is provided for contextual purposes and it is not used to form part of our judgement.

For the intensive care unit at Queen's Hospital Burton, the risk adjusted hospital mortality ratio was 1.2 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.1.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>496 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.1</td>
<td>1.2</td>
<td>1.0</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

During our inspection we asked the trust to provide us with their most recent ICNARC data. In the period April 2018 to November 2018 the risk adjusted hospital mortality ratio was 1.34.

For the intensive care unit at Queen’s Hospital Burton, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.1 in 2016/17. This was within expected limits. The figure in the 2015/16 annual report was 1.2.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>358 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>1.2</td>
<td>1.1</td>
<td>1.0</td>
<td>none</td>
<td>Within expected limits</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

During our inspection we asked the trust to provide us with their most recent ICNARC data. In the period April 2018 to November 2018 the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.31.

From April 2018 to November 2018 the average length of stay in the unit was five days, which was similar to the national average of 4.3 days.

From April 2018 to November 2018, 1.9% of patients were readmitted to critical care following discharge to a ward. This was similar to the national average of 1.3%.

The physiotherapy team was a key part of each patient’s rehabilitation and had introduced a physiotherapist assistant role to supplement the therapy available.
A senior nurse led a critical care follow-up programme for patients after their discharge as part of a rehabilitation and recovery package. The nurse worked with a consultant and psychologist to arrange escorted visits to the unit to enable patients to see the space in which they were cared for. The team discussed each patient’s care with them and encouraged them to answer questions about what they remember of their time in the unit. This helped to provide supportive reassurance to patients who could be mentally disturbed by uncomfortable memories.

Critical care demonstrated inconsistent intervention compliance with trust and commissioning for quality and innovation (CQUIN) standards for acquired kidney injury (AKI). In October 2018 five patients with AKI were admitted to critical care and an audit found overall compliance of 34%. This was an average and reflected a range from 0% to 100%.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The trust set a target of 90% for the completion of non-medical staff appraisals. They noted that the medical staff appraisal target is set at 100% by the General Medical Council for those who are due an appraisal within a year (this does not include staff on long-term sick leave, end of life care leave or a sabbatical of greater than six months).

From November 2017 to October 2018, 87.6% of required staff within critical care at the trust received an appraisal. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>163</td>
<td>182</td>
<td>89.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>13</td>
<td>20</td>
<td>65.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>191</td>
<td>218</td>
<td>87.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. However, qualified nurses had an appraisal rate of 89.6%, which was just below the 90% target.

From November 2017 to October 2018, 90.8% of required staff within critical care at Queen’s Hospital Burton received an appraisal. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>49</td>
<td>53</td>
<td>92.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>65</td>
<td>90.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. In addition, qualified nurses had an appraisal rate of 92.5% which met the 90% target.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The service did not meet the national ICS standard that a minimum of 50% of nurses hold a post-registration qualification in intensive care nursing. In February 2019, 44% of nurses held this qualification although this would decrease as a result of staff leaving the unit. The senior team had secured funding for more nurse places on the national course, which would help the unit to meet the 50% standard by the end of 2019.

The unit did not have a full time dedicated clinical educator who was supernumerary from the rostered nurse team.

A senior nurse was the education lead with a notional 20 hours per week allocated to training and education development for the team. However, this was not protected time and they regularly lost education time to work clinically. They had established mentor groups to help support staff in their development and complete competencies on a continual basis. The group structure empowered staff nurses to take the lead in their professional development with support from senior colleagues. Senior staff nurses led appraisals in their mentor groups.

The education lead had established a relationship with their counterpart at the trust’s other acute site following the acquisition. The other site offered greater opportunities for training days and events and the education lead planned to offer staff access to these.

Staff joined an annual blood handling training day to align their practice with national standards. The blood transfusion and infection control teams joined the training day and supported nurse competencies. The education lead had introduced an equipment study day as a new initiative for 2019 to address gaps in equipment competencies. The lead had worked with senior staff nurses to establish a series of checklists for the safe use of items clinical equipment. The study day would be supplemented by the checklists, which would form part of information guides for staff. The technician led equipment competencies for clinical staff.

Staff adopted champion roles in areas of interest and experience and provided support and guidance to colleagues in those areas. For example, a blood transfusion champion and a moving and handling champion wrote competencies for colleagues and attended meetings and training events with specialist teams to ensure they remained up to date in their knowledge and skills. A senior nurse was the network transfer lead and delivered training and checked competencies to the local team. They had introduced a transfer study course to help build skills and confidence amongst the team.

A trust practice education team led competency training at a hospital level, including a clinical skills day for new staff and nasogastric tube training for all eligible staff.

The critical care outreach team self-managed training and clinical competencies in line with the needs of patients and staff skillsets. They also delivered ad-hoc bedside training opportunities for colleagues on inpatient wards.

The nurse educator had introduced competencies for the national ICU Steps programme for all nurses. ICU Steps is a programme to support recovery and rehabilitation amongst patients and their relatives after a critical care inpatient stay. All staff had completed competencies to level one and completed levels two and three during the post-registration intensive care course.

Physiotherapists worked to the competencies established by a respiratory special interest group. This meant the team undertook training aligned with an established skill set. The physiotherapy
team worked in a buddy system that meant they worked together when patients presented with complex needs.

The physiotherapy team had introduced assistant therapy apprentices as part of an integrated working model to train new staff in elements of patient care. This team supported nurses with personal care and other non-clinical tasks.

The lead educator had established super-user training for filtration equipment that staff did not regularly use. This reduced the risk nurses would lose skills in the use of the system and would remain ready to provide safe care at any time. Filtration equipment provides kidney and renal support when organs cannot filter the blood effectively.

**Multidisciplinary working**

**Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**

Multidisciplinary working was demonstrably embedded in care and treatment coordination and delivery. We saw examples of extensive multidisciplinary working with specialists across the spectrum of care specialties to provide patients with an appropriate treatment and rehabilitation plan. Staff worked with colleagues in community and social services and in primary care to prepare coordinated care packages. For example, one patient had been treated in the unit for several months. When staff ensured they were medically fit for discharge, they worked with the patient’s GP and identified on-going community-based care that could be delivered to the patient without the need to remain in hospital. Where the GP was unable to manage some aspects of regular medication, the critical care team arranged for them to return to the unit periodically.

Staff coordinated the use of do not attempt resuscitation (DNAR) orders with colleagues in other services, including in the community. This meant a patient was protected by continuous coverage of a DNAR because staff worked together to establish and ensure validity.

Staff worked with colleagues in other clinical specialties when patients had complex needs. For example, one patient had been readmitted to the unit three times after an initial stay and the consultant team was working with colleagues in respiratory medicine to identify a new treatment plan to prevent future readmission.

Patients had access to clinical psychology during their stay on referral from a consultant and as part of the follow-up programme. A lead nurse in delirium supported patients during their treatment.

The service identified the availability of SaLT, mental health services and interventional vascular and non-vascular radiology as areas of non-compliance with national standards. A senior nurse said they had been unable to obtain a voice box for a patient because the SaLT team only had one and it was broken. They said, “It’s not a viable service; there was no resolution to this situation and the SaLT team were too busy to help.”

A lead nurse for delirium provided on-call support for staff and coordinated multidisciplinary care plans prior to discharge or step-down to an inpatient ward. The nurse worked with the follow-up programme lead to ensure patients had access to care plans that promoted recovery and rehabilitation.

A microbiologist carried out a daily ward round with consultants and reviewed each patient. However, laboratory services were based off-site and staff said they regularly waited up to four days for diagnostic results. This was a significant deterioration from the previous standard of three hours and the clinical lead had escalated this to the divisional director for action. Clinical staff said the laboratory often cancelled tests without notifying them, which caused a further delay
as they needed to repeat it. Overall staff described an on-going problem with communication with the laboratory.

Occupational therapists were not a common presence in critical care. However, the senior team had engaged with a therapist based elsewhere in the hospital who had visited the unit to begin exploring opportunities for shared pathways and care plans.

An HIV consultant was based in the sexual health service and available to support coordinate treatment plans and work with the microbiologist for patients with complex needs.

A technician was based in the unit with responsibility for interdepartmental transfers, such as when patients needed to go to x-ray or for a diagnostic scan. The technician was trained in the use of the transfer trolley, which was stored in the medical equipment library.

The critical care outreach team provided on-call services to deteriorating patients across the hospital. Overnight a clinical site practitioner provided the same service. This team reviewed all patients with a tracheostomy daily, wherever they were cared for in the hospital. They also reviewed all patients daily after discharge from critical care until they were no longer needed. This ensured each patient remained under the care of a multidisciplinary team with critical care competencies. We reviewed the care of a patient who was discharged from critical care to an inpatient medical ward. The outreach team supplied tracheostomy equipment for the ward team and supported them with risk assessments and safety checklists.

Allied health professionals (AHPs) were involved in step-down planning with consultants and ward teams. They worked together to identify the most appropriate ward for a patient to be discharged to and linked with community hospitals to plan longer-term care after the patient left the acute hospital.

We observed a ward round and a medical handover and noted both processes were multidisciplinary. Consultants, junior doctors, an outreach nurse and nurse in charge attended the handover and ward round, which was additionally attended by each patient’s nurse and a pharmacist. This was supplemented by a multidisciplinary board round to review patients three times each week.

We spoke with AHPs in the multidisciplinary team who said they felt involved in decision-making in critical care. For example, a physiotherapist said, “We have a voice here. Clinicians respect our input and judgements.” This meant multidisciplinary working was embedded in care and treatment planning.

**Seven-day services**

A range of multidisciplinary services were available seven days a week. This included microbiology and physiotherapy and at weekends a physiotherapist with respiratory competencies was always available on site during the day. A respiratory physiotherapist was always available on call.

The critical care outreach and pain team provided care seven days a week with a named consultant each day. Overnight clinical site practitioners provided the same service.

Pharmacy cover was provided seven days a week; from 9am to 5pm Monday to Friday and from 9am to 12.30pm Saturday and Sunday. Outside of these hours an urgent on-call pharmacy team was available.

**Health promotion**
The unit had adopted the national PJ Paralysis campaign. This was an evidence-based campaign to encourage patients to get out of bed and get dressed during the day to promote recovery and wellness. The physiotherapy team provided support in this and identified the primary method of transfer for each patient on each shift. For example, physiotherapists identified whether a patient would benefit from sitting out of their bed and how best to achieve this, such as through using a PAT slide.

Physiotherapists worked with a local service provided to arrange specialist exercise classes and activities for patients discharged from the hospital with specific needs. This meant patients had access to immediate exercise as part of their follow-up rehabilitation on leaving the hospital.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.**

Staff within critical care at Queen’s Hospital Burton were eligible for two levels of combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The completion target for these courses was 90%. These requirements were inherited from the predecessor trust.

A breakdown of compliance for MCA and DoLS training for the period from November 2017 to October 2018 level for qualified nursing staff in critical care at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>23</td>
<td>24</td>
<td>95.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>31</td>
<td>36</td>
<td>86.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met by eligible qualified nursing staff in critical care at Queen’s Hospital Burton for the MCA and DoLS level 2 module. However, 86.1% of qualified nursing staff had completed the level 1 module, which was below the 90% target.

A breakdown of compliance for MCA and DoLS training for the period from November 2017 to October 2018 level for medical staff in critical care at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met by medical staff in critical care at Queen’s Hospital Burton for the MCA and DoLS level 2 module. No medical staff were eligible for the level 1 training module.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

The safeguarding team supported staff in caring for patients with a DoLS authorisation or where staff believed this would be in their best interests. Staff described significant challenges in
obtaining DoLS approvals from the local authority and said they typically received a response several weeks after a patient had left the unit. The safeguarding team provided support for interim measures, such as the use of soft mittens where patients tried to remove critical tubes.

We found variable standards of mental capacity assessments. Staff had fitted soft mittens to one patient who was at risk of injuring themselves by removing tubes. Although staff maintained an up to date risk assessment for the use of restraint they had not completed a mental capacity assessment or best interest assessment since the patient had been admitted from another hospital.

Staff used national-standard tools to assess patient’s cognition and cohesion. This included the Glasgow coma score and the confusion assessment method for the ICU (CAM-ICU) confusion assessment.

AHPs who delivered rehabilitation therapy used the Richmond agitation-sedation scale (RASS) and delirium process to ensure patients could consent to sessions and understood their purpose. The team carried out intensive, short-spell rehabilitation sessions for patients who struggled with concentration.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Critical care did not participate in the NHS Friends and Family Test (FFT) or an equivalent measure of patient’s experience. However, we observed consistently kind, compassionate care delivered by a team that demonstrably had patients’ needs at the centre of their work. In addition, the lead nurse for the follow-up programme carried out a survey amongst patients who participated in the programme to establish the extent to which their needs were met.

Staff were flexible in care delivery and sought out ways to deliver care that was meaningful to each patient. For example, two patients had experienced stillbirths in the unit and staff had arranged for them to keep their babies in cold cots at their bedside. Although staff described this as very challenging for them they recognised the importance of the experience to the patients.

The unit regularly received thank you cards and letters from patients and relatives and the team displayed these on the unit. We spoke with two patients and three relatives, all of whom described excellent standards of care. One patient said, “I’ve been treated like a queen. It couldn’t have been better.” One relative said, “No-one actually wants to be in critical care but I’m glad this is the hospital [my relative] has ended up in, the treatment has been spectacular.”

During the transfer of a patient into the high dependent unit (HDU) we observed staff provide a very high standard of compassion and support. Each member of the team introduced themselves to the patient and explained what was happening. They paid attention to detail and said they knew the noises in the department could be worrying and explained what they were. The nurse who greeted the patient was personable, used humour to help the patient relax and matched their communication to the mood and responses from the patient.
Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff assessed patients for signs of depression or post-traumatic stress disorder (PTSD) using the hospital anxiety and depression scale and referred them to a psychologist where this would help their rehabilitation.

We spoke with the bereavement team who described a good relationship with the critical care team. Staff on critical care contacted the bereavement team proactively for support and liaised with the coroner on the request of patients.

The bereavement centre contacted bereaved families and discussed the official cause of death, returned personal belongings and supported them to register death. They provided signposting to specialist groups for further support.

Critical care staff had undertaken specialist training in September 2017 around how to communicate with children of critically ill parents on the ward. Staff used memory boxes to give to bereaved relatives which included a candle, knit angel and a handprint. Boxes for children included a teddy bear, seeds, balloons and books aimed at children who were bereaved. To further support young people, staff had adopted the national Winston’s wish charter for bereaved children.

The chaplaincy service was available 24-hours, seven days a week and there was an on-call service out of hours. Staff we spoke with demonstrated a good understanding of how to contact the chaplaincy, who offered religious and holistic services in the chapel and at patient’s bedside.

Nurses carried out on-going assessments of patients’ mood and state of mind and used a general anxiety score to identify where additional emotional and psychological support could be beneficial.

We observed a physiotherapist provide an excellent standard of emotional support to a patient who was very upset in the HDU. The patient was worried they were not making progress in their recovery and felt demoralised. The physiotherapist spent time with them and explained why they should not worry and what they had to be pleased about using specific reassurance about their treatment. When the patient cried, the member of staff was empathetic and used good humour to calm the patient down and help them to feel better. This was a consistent theme during our inspection and staff went out of their way to make patients feel welcome and calm. We saw one patient became very agitated and upset because of continuous pain. A member of staff held their hand and said, “Don’t get upset, these things take time. We’re going to make sure you get better, all you have to do now is let us.” This approach had a demonstrable, positive impact on the patient.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff held regular coffee mornings for patients and relatives as a tool to involve them in understanding care and treatment both during and after an inpatient stay. This had provided successful and staff had sourced a larger venue to accommodate everyone who was interested.

Staff had a clear understanding of the distress patients often experienced after receiving care when sedated, intubated or unconscious. To support their recovery, staff kept a written diary for
each patient. They recorded key events each day, such as when their relatives visited, and recorded when they spoke to the patient. A senior nurse led a follow-up programme and gave each patient their diary to read during or after their first session. Patients who participated in the follow-up programme provided consistently positive feedback about how they felt involved through the use of a diary. In feedback provided to the service patients said reading diaries helped to fill in gaps in memory and helped them to understand how sick they had been. Staff encouraged relatives to contribute to diaries during a patient’s stay and write down details of when they visited. Comments included, “It took me a long time to read the diary and at first it was as if I was reading it about somebody else. I eventually read the diary and it was very emotional to read;” “I found it very helpful as I could relate to events and things that had happened to me and meet the critical care team who had looked after me” and “I think it’s a good idea as I found it helpful and think it goes some way to aid my recovery.”

Multidisciplinary teams and specialist staff worked with relatives and patients as part of the follow-up programme and discharge care-planning. For example, the lead nurse for delirium provided input into care plans and worked with relatives to help them understand the nature of their family member’s systems and how they could best respond to delirium.

Staff understood the stress relatives experienced when visiting their family member in hospital and had established processes to help them concentrate on spending time together. For example, the unit provided free on-site parking for visiting relatives and arranged overnight accommodation in a dedicated apartment in the unit.

Staff supported patients to leave the unit and spend time in the grounds or gardens of the hospital. A pet therapy organisation visited the hospital regularly and critical care staff had completed risk assessments and infection control plans to enable pet therapy dogs to visit patients where they considered this would improve the patient’s wellbeing and state of mind without presenting a clinical risk.

Policies were in place to help people to visit relatives safely. Staff had established criteria to enable children to visit their relatives if this would be beneficial to the patient. Although a minimum age limit was in place staff offered flexibility if seeing the child was likely to contribute to the patient’s wellbeing. Similarly, if a pregnant visitor wanted to visit their family member, staff spoke with them about the risks to their unborn child due to the infections that may be present on the unit and helped them to make an informed choice.

Staff worked extensively to make sure they met the needs of relatives. For example, the relatives of one patient who died on the unit did not want them transported to the mortuary in a body bag because they felt this would be too traumatic for them. Staff worked with the infection control and mortuary teams to facilitate this and ensured the patient was transported on a hospital bed.

We spoke with two relatives who said staff had kept them informed in the progress of their family member and said they had always had access to refreshments and flexible visiting times. Two patients said the unit was noisy at night and it was not always easy to get the attention of staff. We noted none of the patients in the unit had a nurse call bell within reach.

We observed staff routinely involve patients in decisions about their care. For example, we saw a nurse ask a patient when they wanted to have a wash or a shower that day and if they would like help to do so. Another patient declined a full wash and staff worked with them to provide basic hygiene instead.

During a ward round we observed staff included patients and their relatives in discussions about their care where this was appropriate.
Is the service responsive?

Service delivery to meet the needs of the local people

The trust planned and provided services in a way that met the needs of local people.

The unit had two visiting rooms for relatives to use. The first room had a sofa and a TV and relatives were able to sleep there if needed. The second room had a coffee machine, books for children, information board, concessionary parking information and leaflets about organ donation in a variety of languages.

A specialist nurse in organ donation (SNOD) worked with the clinical team to proactively identify patients who may be suitable for organ donation after circulatory death (DCD) and organ donation after brainstem death (DBD). The SNOD audited patient deaths in the unit to identify opportunities for improvement in donation processes, including in identifying patients and in the consent process. From March 2018 to January 2019 the service retrieved eight organs for donation and three tissues for donation. The SNOD reviewed practice to identify missed opportunities. In this period, they identified two such instances. Where a SNOD was not available we found clinicians were proactive in exploring the possibility of DCD and DBD.

Staff were proactive in talking to patients and relatives about organ donation and handled this sensitively and respectfully. The unit had a brainstem testing kit ready for use 24 hours a day and nurses began the process by discussing what would happen with relatives. The unit received consistently good feedback about organ donation and displayed the photographs of previous patient donors on the unit.

A senior staff nurse had established a checklist for colleagues involved in preparation for transfer to the mortuary after a patient’s death. Staff said this helped them follow procedures and meant there was consistency during shift handovers and during busy periods.

Physiotherapists worked with community colleagues to ensure each patient had a continuous, seamless care plan. Community physiotherapists had access to the notes and care plans of hospital-based therapists, which meant patients were cared for without gaps when moving between services.

From January 2018 to January 2019 staff transferred seven patients out of critical care. This included one transfer for bed capacity, one transfer for non-clinical reasons to another hospital and two patients transferred home directly from the unit. The hospital did not have the equipment to carry out MRI scans on ventilated patients and did not have continuous on-site renal or ear, nose and throat specialists. Four patients were transferred to another hospital in the trust to access these services. A standard operating procedure was in place for renal consultant or registrar-led review twice-weekly and this team carried out ward rounds with critical care doctors to reduce the need for transfers. Outside of the ward rounds and site visits the renal team provided a 24-hour, seven-day advice service on request from the trust’s other acute hospital and a renal consultant was on site one day per week.

Meeting people’s individual needs

A consultant and senior nurse led a follow-up programme as part of patient’s rehabilitation and recovery. The programme had a structured approach and included visits to the unit at one- and two-months post-discharge. The outreach team, physiotherapists and occupational therapist joined the meetings and helped patients to understand their experience and treatment using diaries and photos taken during their stay. The clinical team included the hospital chaplain,
community colleagues and psychologist where they had been involved in the patient’s care and could provide support. Staff facilitated a patient and relative’s support group that met as frequently as people found useful for their recovery and the follow-up lead nurse facilitated a secure social media group for patients and relatives.

Staff said it was rare to have a patient admitted who was living with dementia. However, they had a dementia champion nurse and resources to help patients and relatives. They encouraged relatives to bring in items from home that would be reassuring to the patient, such as teddies, dolls and blankets.

Critical care regularly cared for patients living with a learning disability. The liaison nurse provided care and support to each patient and their relatives and guided staff in communication techniques. Staff encouraged carers and relatives to stay with the patient whenever they wanted. Staff began a patient diary on the first day of admission to supplement the learning disability hospital passport, which relatives completed to help staff understand each patient. The learning disability team maintained an intranet resource page for staff and a communication package was also available on the website and in the medical equipment library.

A nurse-led learning disability team provided support to critical care patients and the nursing team. For example, the team had recently coordinated a discharge plan for a patient with a learning disability who had a tracheostomy. The learning disability team helped staff to communicate effectively and meaningfully with patients and to use hospital passports to build relationships.

The NHS Accessible Information Standard was a standard implemented to improve equitable access to information about care and treatment and all hospitals were expected to have completed work towards this. We asked the trust to provide evidence of work completed towards this, but they did not complete this request.

The critical care team asked ward staff to visit patients ahead of a planned discharge. This helped to streamline the transfer process and meant patients had the opportunity to meet members of the team who would take over care. Staff used this process to explain to patients what their next ward was like and what they would expect to find. This helped to reduce patient’s anxiety and helped ward staff to prepare for their arrival with any specific needs.

The service provided a children’s reading corner in the waiting room for visiting relatives. This included donated books, colouring materials and games. On-site accommodation was available for relatives to stay overnight and the waiting area included food and drink preparation facilities.

The physiotherapy team had used charitable funds to purchase exercise equipment for patients as part of their step-down. This meant the team could begin a rehabilitation plan immediately when patients left critical care.

A dedicated catering dietician worked with the catering team to establish menus and snack options that met individual choices, cultural and religious needs. A nutrition group worked to establish resources and processes to meet individual needs and preferences, such as the provision of adapted cutlery.

For several years there had been errors in how data had previously been submitted to the Intensive Care National Audit Research Centre (ICNARC). For example, the unit had started the discharge time countdown from when a patient was ready to leave the unit. This was not in line with ICNARC standards that the discharge countdown begins when patients are declared fit for discharge. This meant up to January 2019 the unit’s data submission for this measure was at odds with other units in the network. As a result we were not assured the Department of Health standard for mixed sex accommodation had been adhered to.
NHS services are expected to eliminate mixed sex accommodation where it is in the best interests of the individual or reflects personal choice. There are some exceptions, including: In the event of a life-threatening emergency. Where critically ill patients need one-to-one nursing care in critical care.

Department of Health guidance states; within critical care, some patients may have a clinical need to be in that environment, and therefore should be recorded and monitored locally as a justified breach. Once the patient no longer needs that level of critical care, they become an unjustified breach and should be recorded both locally and nationally.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Between April 2018 and November 2018, critical care admitted 224 patients, of which:

- 64% were elective admissions following planned surgery
- 62% were unplanned emergency admissions
- 50% were admitted from an inpatient ward
- 36% were admitted following emergency surgery.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. This is provided for contextual purposes and it is not used to form part of our judgement.

From November 2017 to June 2018, Burton Hospitals NHS Foundation Trust saw adult bed occupancy fluctuate. With the exceptions of November 2017, January 2018 and June 2018, the rates were similar to the England averages.

**Adult critical care Bed occupancy rates, Burton Hospitals NHS Foundation Trust.**

Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because this data relates to the same legal entity as the merged trust it is used to form part of our judgement.

From November 2018 to October 2018, the adult bed occupancy rates at University Hospitals of Derby and Burton NHS Foundation Trust were consistently similar to the England average.

**Adult critical care Bed occupancy rates, University Hospitals of Derby and Burton NHS Foundation Trust**
Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

The most recent occupancy data available was for November 2018 when occupancy ranged from 83% to 91%.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. This is provided for contextual purposes and it is not used to form part of our judgement.

For the intensive care unit at Queen’s Hospital Burton, there were 3,650 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 1.2%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 0.7%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,650 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>0.7%</td>
<td>1.2%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

After our inspection we asked the trust for more recent data. From April 2018 to November 2018 78% of patients were discharged from the unit within four hours of being ready, 16% were discharged between four hours and 24 hours and 6% were discharged in over 24 hours.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. This is provided for contextual purposes and it is not used to form part of our judgement.

For the intensive care unit at Queen's Hospital Burton, there were 527 admissions in 2016/17, of which 0.2% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.2%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>527 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>
After our inspection we asked the trust for more recent data. From April 2018 to November 2018 there were no non-clinical transfers to another unit.

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. This is provided for contextual purposes and it is not used to form part of our judgement.

For the intensive care unit at Queen's Hospital Burton, there were 395 admissions in 2016/17. Of these, 0.8% were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 4.0%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>395 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>4.0%</td>
<td>0.8%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

After our inspection we asked the trust for more recent data. From April 2018 to November 2018 there was one out-of-hours discharge to a ward. This reflected 0.6% of admissions overall and was better than the national average of 1.7%.

The clinical team had adapted The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients in relation to allocating named clinicians to each patient in line with the needs of the department. Each patient was admitted under the responsibility of a named critical care medical lead whilst maintaining allocation to the last surgeon to operate on them or the medical consultant who began the admission process. Consultants in ITU worked on a service week pattern, which meant patients might not see their named responsible consultant again if they are admitted towards the end of that individual’s working week. Consultants discussed this with patients and their relatives to ensure they understood the system and knew the names of key people involved in their care they could contact for information or support.

Staff used a protocol for planned, elective admission for patients being treated for cancer. This included the use of bank staff at short notice to facilitate patient admissions and reduce the risk of delays in urgent care. This issue was included on the service risk register as a moderate risk and the use of an established protocol controlled the risk.

During a medical handover doctors discussed patients under assessment and review elsewhere in the hospital to begin to prepare for possible admissions. For example, one patient was undergoing monitoring in the emergency department and critical care consultants were liaising with colleagues to identify what needed to be in place in the intensive care unit (ICU) if they decided to admit. Doctors used the handover to review elective admissions in advance to ensure resources and appropriate staff skill mix were in place.

From April 2018 to November 2018 4% of patients were discharged home directly from the unit. This was slightly less than the national average of 5.1%.

The team maintained one bed in ICU ready for patients who needed ventilation.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
From November 2017 to October 2018 the trust received three complaints about critical care. All three of these complaints related to critical care at Royal Derby Hospital.

The trust took an average of 58.3 working days to investigate and close these three complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>2</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
</tbody>
</table>

From November 2017 to October 2018 the trust received no complaints about critical care at Queen’s Hospital Burton.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The department had received no formal complaints since April 2017 reflecting a consistent track record. Staff demonstrated understanding of the trust complaints procedure and knew what to do if a patient, relative or visitor wished to make a complaint or raise an informal concern.

From October 2017 to September 2018 the trust received 23 compliments about critical care. The trust did not provide a breakdown by subject for compliments received.

From October 2017 to September 2018 the trust received nine compliments about critical care services at Queen’s Hospital Burton. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We spoke with the patient advice and liaison service (PALS) about critical care. They had received no formal concerns about the unit from patients or relatives in the previous 12 months and had received 11 queries. Of these, eight were compliments and positive feedback about the unit and two were further requests for information. Both were from bereaved relatives of a patient nursed on critical care and involved requests around wanting to discuss the patient’s journey. PALS liaised with the clinical team to facilitate such requests. None of the queries involved concerns about care or staff.

Contact information for PALS was displayed prominently on the unit and in the relative’s waiting area, including in languages commonly spoken in the local community.

Is the service well-led?

Leadership

We found a range of safety-related governance issues and areas for improvement in audit leadership. This meant we were not assured managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
Triumvirate leadership was provided at divisional level by a divisional medical director, divisional director and divisional nurse director. Business unit leadership consisted of a general manager, lead nurse, matron and clinical director. Divisions were supported by a finance business partner and human resources business partner. Local leadership was provided by an associate clinical director (ACD) and Band 7 Sisters / Charge Nurse.

The lead nurse was an existing role for the Derby legacy trust, which had been included in the new trust as cross-site. The previous post holder retired in November 2018 and the new appointment came into post in February 2019 to support the matron, improve nurse representation in the network and develop cross-site working after the acquisition. The matron was responsible for critical care and critical care outreach, trauma and orthopaedics, the fracture clinic and pre-operative assessment.

Staff described an extended period of changes in leadership and management but felt there was support from senior staff and said some individuals made themselves available to discuss concerns and problems. They said they had met the divisional leadership team since the acquisition and felt able to contact them to ask any questions.

Although the leadership structure was appropriate for the scope and needs of the service, we were not assured the senior team had sufficient oversight or the right skill-mix for effective governance and sustainability. This was because we found numerous examples of sub-standard safety and clinical effectiveness that had not been addressed by the senior team and there were not always structured plans in place to address these.

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups.

Staff had established a philosophy of care based on six ‘Cs’: care, compassion, competence, communication, courage and commitment. This was prominently displayed on the unit and all staff we spoke with were aware of it and could demonstrate how it influenced their practice.

Following the acquisition, the lead nurse planned to implement more streamlined practices and standards across the critical care services. The senior team offered expressions of interest to staff to work collaboratively over both sites.

At our last inspection in July 2015 we found critical care did not have a vision or strategy or a specific, local development plan. The senior leadership team had not addressed this and said it was not a priority for critical care to have a vision and strategy that was separate from the trust’s overarching plan. However, a cross-site integration team was working with similar departments in the trust without a well-established development strategy to create a five-year plan.

Staff had worked together to establish a service standard for patients arriving into the unit. This included an update of their condition and confirmation of their safe arrival to a named relative within 15 minutes and a medical review within two hours.

Allied health professionals (AHPs) worked with critical care nurses and clinicians to deliver care and treatment. We spoke with a range of staff from this team who said they had recently started strategy meetings. This was part of their drive to ensure they continually evolved the service and
identified opportunities for improvement, such as identifying opportunities to involve occupational therapists in care planning and therapy.

AHPs had taken part in strategy planning exercises with the director of therapies and were establishing how they contributed to the trust’s overarching vision and strategy. The team had their own strategy and ensured new staff engaged with this to understand the importance of their role.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Nurses did not have access to regularly scheduled, structured meetings. Although staff kept up to date with changes and developments in the service and the trust through newsletters and daily safety huddles, there was limited opportunity for more formal meetings. One staff member said team meetings were frequently arranged and then cancelled due to clinical demand.

Consultants described a cohesive, shared approach to care and treatment planning that represented continuous senior-level delivery. Staff said there was a good working atmosphere between clinicians and no disparities or conflict in decision-making. One member of staff said there was a, “Healthy level of challenge” amongst colleagues.”

All staff we spoke with said they felt the unit was a positive place to work and they felt content and supported professionally. Senior staff said they felt the unit had a good reputation in the network and attracted new talent through its multi-cultural, stable workforce.

In July 2018 the trust had completed a acquisition of another organisation. Staff said they felt the trust had communicated with them frequently about the acquisition, but they felt anxious and uncertain about the future as they did not have details of how it would ultimately affect them. We spoke with the senior team about this who said they were arranging joint meetings between teams at both hospital sites and felt the trust had implemented appropriate strategies to ensure staff felt valued. For example, staff from the critical care unit at the trust’s other hospital had visited and spent time observing practice and discussing opportunities for standardisation.

AHPs said they felt positive about the working environment, which encouraged multidisciplinary projects and development. For example, the physiotherapy team had worked with their counterparts at the trust’s other acute hospital site following the acquisition to establish if cross-site working would be beneficial. Similarly, dieticians had established new diet review sheets because of cross-site exploratory meetings.

Governance

The trust did not always use a systematic approach to continually improve the quality of services and safeguard high standards of care. Although staff felt supported to develop the service, the environment did not support excellence in clinical care and we found a number of areas of concern.

Pre-acquisition Critical Care was part of the Anaesthetics, Theatres, Intensive Care, and Orthopaedic Business Unit and now part of the Anaesthetics and Theatres Business Unit. The service had an overarching governance group with a dedicated governance lead to oversee the services. The matron, divisional risk and patient safety manager and various a consultant
anaesthetists and operational managers contributed to monthly group meetings. We reviewed the minutes from the three most recent meetings, which took place between May 2018 and October 2018. The group systematically reviewed incidents and tracked action plans and updates to trust protocols. However, there was very little evidence critical care was embedded into the work of the group and the focus was primarily on surgery. Critical care clinicians and managers did not attend any of the three meetings and it was limited evidence of embedded working between the specialties in the business unit.

Clinical governance processes were well-established and the senior team were exploring opportunities to work more closely with colleagues in the trust’s other critical care service. We looked at the minutes of three governance and management meetings that took place between October 2018 and February 2019. There was a consistent focus on identifying opportunities for developing and improving the service through learning from practices at the unit’s sister service in the trust. Senior staff reviewed practice against national best practice guidance and engaged with colleagues in other services to achieve them. For example, staff used a paper-based prescribing system in critical care, which was not in line with the rest of the hospital or trust. Senior staff used the clinical governance process to learn from the pilot phase of e-prescribing at the sister site and to use extended pharmacy opening hours on a weekend to improve pharmacist oversight of the implementation of e-prescribing.

In November 2018 the mortality review lead and the mortality assurance group lead established a new monthly review meeting for mortality, which coincided with the reimplementation of a mortality database in the trust. The new governance approach meant individual clinicians would have more input into mortality review of their patients with more robust opportunities for sharing learning and outcomes.

The divisional business unit team monitored incidents as part of monthly quality assurance. In November 2018 critical care had 23 incidents awaiting review. This was significantly more than every other service in the business unit and reflected 47% of all incidents awaiting review in the division.

Management of risk, issues and performance

The trust did not have effective systems that supported the identification of risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Divisional staff used a risk register to identify, monitor and assess risks to the service. There were seven active risks at the time of our inspection, of which one was rated as extreme, two were rated as high, three were rated as moderate and one was rated as low. The extreme risk related to potential service disruption caused by the ageing consultant workforce, which would result in planned retirements and an inability to backfill the posts. The service had failed to recruit from three successive recruitment cycles and senior staff were working with colleagues across the trust to identify potential solutions through cross-site working. High risks related to the lack of post-registration specialist training for nurses and a lack of isolation rooms for patients with infectious conditions. A moderate risk and a low risk related to challenges to effective, continuous infection control due to a lack of environmental control.

The senior team was working with network partners and the trust’s other site to identify opportunities to address the consultant shortfall identified in the risk register. Following
unsuccessful recruitment drives the team was considering alternative, interim options such as locum consultants and the use of advanced care practitioners.

Senior staff and shift leaders demonstrated a detailed understanding of the key risks to the service and to the control factors in place. However, the risk register did not assign named, accountable individuals to specific risks and did not include a timeline of updates and progress made in reducing each risk. This meant the service did not document key updates to risks and had limited assurance of the efficacy of control measures.

A trust virtual incident quality assurance group monitored and reviewed incident reports after clinicians and service staff had investigated them. This ensured each incident had senior-level scrutiny where necessary and provided individual staff with structured feedback and an outcome.

A deteriorating patient group worked across the hospital with representation from the critical care outreach team. The team had established cross-site communication with colleagues at the trust's other acute hospital and were in the process of streamlining processes. For example, the two hospitals had different practice observation policies in place. The trust was in the process of introducing a more up-to-date version of NEWS. This had been implemented at the Royal Derby Hospital in December 2018. In response the deteriorating patient team was carrying out a review of processes at this hospital to identify opportunities for improved working.

Each service or ward in the hospital used a peer-led ward assurance system. This enabled local teams to monitor quality and safety standards through an independent review carried out by colleagues from another service. From September 2018 to November 2018 critical care achieved 99% compliance, which reflected consistently good standards. However, staff were critical of the ward assurance process. They said it was time-consuming and one member of staff described it as, “a laborious task that takes us away from providing care.”

The senior team used a monthly divisional quality report to maintain oversight of performance, risk and safety. We looked at the reports for November 2018 and January 2019 and found variable and inconsistent monitoring measures. Most monitoring data related to theatres and anaesthetics and critical care was included sporadically with data presented for the intensive care unit (ICU) and not the high dependency unit (HDU). In addition, data was amalgamated with other clinical services and it was not possible to identify specific performance data for critical care, such as for audit of NEWS and cardiac arrests. Extensive data was included for the trust's other hospital but from our discussions with senior staff it was not evident this was an embedded or standardised process.

The fire safety advisor had a good understanding of the shortfalls in staff training and consistent risk assessment in the environment. They had engaged with their counterpart at the trust's other acute site following the acquisition and planned to improve practical training using resources that had not been available on this site. For example, staff had not been able to undertake practical fire extinguisher training due to a lack of equipment. However, the acquisition meant the staff could access training fire extinguishers at the other site.

**Information Management**

The trust collected, analysed and used information to support all its activities, using secure electronic systems with security safeguards. However, these were not always effective or consistently managed.
Information management was in line with the EU General Data Protection Regulation 2016/679 (GDPR). Staff locked computer screens when they were not in use and they kept confidential paper records secure.

Staff described significant challenges with internal information management when liaising with other hospital departments. For example, staff said it was difficult to communicate with the learning and development team and administrative processes were slow. For example, one nurse was denied a pay increment because the administration team thought the nurse had not completed required competencies. This was caused by a 20-day delay in processing the nurse’s documents as evidence of completion. Staff said the lack of communication was frustrating and made it difficult to keep on top of their training records.

The team monitored their response times to NEWS calls but did not have access to electronic devices that recorded specific performance, such as the time from the initial call to first seeing the patient. Instead the team recorded this information manually and retrospectively, after they had attended a patient. This meant although data was useful for guidance it could not be used to measure performance accurately. The trust acknowledged this and said they planned to introduce electronic observation charts later in 2019, which would improve data collection.

The service demonstrated a reflective approach to the quality and accuracy of audit data. The senior team had identified areas of inconsistency with other networked critical care units. As a result, a network service development project was underway to identify opportunities for improved consistency to ensure staff could use audit data to its full potential of improving care and patient outcomes.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The nurse lead for the follow-up programme used a questionnaire to gather feedback from patients. We looked at eight questionnaires received in the last 12 months and found patients gave consistently positive feedback about their experience. All patients said the follow-up programme had been useful and the right length of time. Patients provided detailed insight into the usefulness of the experience, such as meeting staff whose voices they recognised from their treatment. Patients said it was beneficial to them to understand more about their treatment and recovery and one patient said the programme made them feel special because they realised how much effort staff had put into their care.

The lead nurse for critical care had recently been appointed and planned to increase cross-site working and engagement between sites following the acquisition. This included the establishment of an eight-week rotation programme for nurses and exploration of the feasibility of cross-site matron roles.

The site team redeployed nurses from critical care to fill gaps in other services where this would not compromise care in the unit. Senior critical care nurses worked with their teams to identify their level of experience and skill set in other clinical services to ensure temporary transfers were safe and appropriate. For example, staff in critical care were not trained to use the electronic prescribing system in use on inpatient wards but had advanced resuscitation skills, which helped to establish where their skills could be most appropriately used.
The nurse educator had notional protected time to deliver training and for educational work. However, they did not always achieve this due to short staffing and pressures on the unit to remain clinical during education time. In addition, they had cancelled weekly training sessions because so few staff could attend because of pressures on the service. We spoke with the senior team about this who said the allocated time to education was proportionate, but they acknowledged their time needed more protection and staff required more training opportunities. The lead nurse and nurse educator planned to establish more robust, dependable training opportunities through closer working with the trust’s other acute site.

Staff had access to psychologist support following stressful and challenging situations and the senior team encouraged them to access this.

Allied health professionals (AHPs) were actively involved in winter planning strategies and in events to improve their representation in the trust.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a clear ethos of engagement between staff and wider networks and clinical service organisations as a strategy to ensure practice reflected the latest international understanding and practice. For example, staff were encouraged to attend network conferences and present their work and audits and the pain team attended national events led by the Royal College of Anaesthesia.

The unit was highly active in the regional critical care network and demonstrably used benchmarking and development exercises to assess and improve care. For example, the team had participated in a network-wide major incident simulation exercise in June 2018 that measured key factors such as the establishment of additional capacity and staffing for critically-injured patients. The simulation contributed to the service’s emergency planning and helped staff to identify how they could improve contingency for short-notice urgent situations.

The lead nurse had identified opportunities for staff development by engaging with opportunities and resources at the sister site. They were in the process of establishing more substantive links following the acquisition and planned to ensure staff had access to a wider range of specialist and advanced training. The two sites were a significant distance apart and the senior team did not enforce cross-site travel and supported staff who had an interest in working between the units.

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queen’s Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

Staff were recognised for their contribution to the service. For example, the nurse lead for the follow-up programme had won a trust ‘PRIDE’ award as well as a network award for outstanding contribution to patient follow-up. The practice education team had awarded two certificates of recognition to nurses following positive feedback from colleagues about their commitment to care.
Maternity

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on 1st July 2018 by the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust. The latter trust acquired the former under its existing registration with the CQC. As such, our legal position is that the acquired trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust has 136 inpatient maternity beds across three sites. 33 inpatient maternity beds are located within five wards and units at Queen’s Hospital Burton:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Inpatient beds/rooms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal clinic</td>
<td>N/A</td>
</tr>
<tr>
<td>Early pregnancy assessment unit</td>
<td>N/A</td>
</tr>
<tr>
<td>Labour ward</td>
<td>Seven birthing rooms, including one with a birthing pool</td>
</tr>
<tr>
<td>Ward 11: maternity ward</td>
<td>21</td>
</tr>
<tr>
<td>Ward 12: maternity ward and assessment unit</td>
<td>12</td>
</tr>
</tbody>
</table>

There is one obstetric theatre at Queen’s Hospital Burton.

In addition, the trust runs a six-bedded 24-hour midwife-led unit at Samuel Johnson Community Hospital in Lichfield. The unit has three birthing rooms and cares for women experiencing a normal pregnancy with no adverse medical history or previous pregnancy complications. There are no doctors based at the unit.

Samuel Johnson Community Hospital also hosts an antenatal clinic and maternity outpatients service provided by a visiting consultant once every fortnight.

The trust runs seven community midwifery teams, which provide community midwifery care and a home birth service.

The trust is part of both the Derbyshire Local Maternity System and the Pan-Staffordshire Local Maternity System.

(Source: Trust Provider Information Request – Acute sites; Acute RPIR – context acute tab; trust website)

The data on deliveries and gestation periods below cover time periods from prior to the date of
the acquisition. Data from the acquired Burton Hospitals NHS Foundation Trust is included for contextual purposes and does not form part of our judgement.

**Burton Hospitals NHS Foundation Trust**

From July 2017 to June 2018 there were 3,339 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

**Number of babies delivered at Burton Hospitals NHS Foundation Trust – comparison with other trusts in England**

<table>
<thead>
<tr>
<th></th>
<th>BURTON HOSPITALS NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3,263</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>51</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>102</td>
<td>3.1%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,620</td>
<td>79.1%</td>
</tr>
<tr>
<td>35-39</td>
<td>494</td>
<td>14.9%</td>
</tr>
<tr>
<td>40+</td>
<td>98</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td>3,314</td>
<td>596,828</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
The trust had no valid gestation period data for the period from April 2017 to March 2018. *(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)*

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

**Number of deliveries at Burton Hospitals NHS Foundation Trust by quarter**

![Graph showing number of deliveries by quarter](image)

There were more deliveries at the trust in quarter 2 of 2017/18 and quarter 1 of 2018/19 compared to the equivalent quarters one year earlier. However, in quarters 3 and 4 of 2017/18, the number of deliveries was less than in the equivalent quarter one year earlier. *(SOURCE: Hospital Episode Statistics - HES Deliveries (April)*

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.*

**Mandatory training**

Overall the service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all midwifery staff at Samuel Johnson Community Hospital had completed three of the mandatory training modules required for their role. Also, medical staff for Queen’s Hospital Burton had not all completed the mandatory training.

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce training figures for the whole trust.

**Queen’s Hospital Burton maternity department**

Staff at Queen’s Hospital Burton, Samuel Johnson Community Hospital and the Burton community midwifery service had a mandatory training completion target of 90% for all mandatory training. This target was inherited from Burton Hospitals NHS Foundation Trust, which previously provided these services.

A breakdown of compliance for mandatory training courses from November 2017 to October
2018 for midwives in maternity at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>89</td>
<td>89</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load handling</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>88</td>
<td>89</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>87</td>
<td>89</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>85</td>
<td>89</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>85</td>
<td>89</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory (nursing)</td>
<td>77</td>
<td>81</td>
<td>95.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>84</td>
<td>89</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>82</td>
<td>87</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>83</td>
<td>89</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (administration)</td>
<td>150</td>
<td>162</td>
<td>92.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>82</td>
<td>89</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>82</td>
<td>89</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>79</td>
<td>87</td>
<td>90.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>76</td>
<td>84</td>
<td>90.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>79</td>
<td>89</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion competency (collection)</td>
<td>62</td>
<td>72</td>
<td>86.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Neonatal life support</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation of the newborn</td>
<td>74</td>
<td>89</td>
<td>83.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The matron for the delivery unit explained that where training completion rates were below the 90% trust target rate, this was due to some staff being on long term sick and maternity leave. The service’s training figures included these staff which meant the figure was lower than the actual completion rates for staff at work.

The trust’s mandatory training data provided before the inspection showed there were no maternity medical staff based at Queen’s Hospital Burton. However, staff told us there were eligible medical staff at Burton. Following the inspection, we requested mandatory training figures for medical staff at Burton. The trust responded there were 22 eligible medical staff for obstetrics and gynaecology at Burton. The mandatory training completion rate for these staff in February 2019 was 80.5%.

**Samuel Johnson Community Hospital maternity services**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for midwives in the maternity services at Samuel Johnson Community Hospital is shown below:
The trust had an overall training compliance rate of 86.7% for midwives in Samuel Johnson Community Hospital’s maternity services. The trust’s mandatory training targets were met for six of the 15 mandatory training modules for which midwives were eligible.

The training figures included staff who were on long term sick or maternity leave. Due to the low staffing numbers at the Samuel Johnson Community Hospital maternity service, this meant if one member of staff could not attend training the figures were lowered significantly.

We asked the managers of the service why the training figures were low. They explained that there were eight eligible staff for the service rather than nine. They stated the completion rates for the service as of February 2019 were 87% for resuscitation of the newborn, 87% for basic life support and 62% for neonatal life support. They said staff due training were booked on to attend in the next two months.

**Burton Community midwifery service**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for midwives in the Burton community midwifery service is shown below:
<table>
<thead>
<tr>
<th>Training Module</th>
<th>Required</th>
<th>Provided</th>
<th>Percentage Passed</th>
<th>Compliance Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Departmental induction</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>22</td>
<td>25</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>22</td>
<td>25</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The service had an overall training compliance rate of 93.1% for midwives. The trust’s mandatory training targets were met for 10 of the 14 mandatory training modules for which midwives and qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The matron for the community midwifery team confirmed that the training completion rates included staff who were on long term sick and maternity leave. This meant the figures were lower than the actual figure for staff at work.

The maternity service had developed and established well-structured multidisciplinary PROMPT training in partnership with another local trust. Staff at all levels attended a whole day of PROMPT training consisting of lectures and scenarios in clinical areas. The service provided the training monthly and changed the content each year to provide a variety of scenarios. The scenarios included simulated emergencies. The prompt training included Sepsis recognition and treatment and recognition of the deteriorating woman. Prompt training was attended by consultants, doctors, anaesthetists, midwives, community midwives and maternity support workers. Midwives delivered sections of the training as part of their role. Staff completed the proformas during the training to ensure the learning could be transferred to practice.

Staff also completed mandatory e-learning training on the trust’s online system. Staff completed training to care for women with mental health needs and learning disabilities as part of the safeguarding level three training.

In the early pregnancy unit, a trained sonographer carried out scans on women. Two midwives for the service were undertaking scanning training to reduce delays for women. In addition, two midwives were undertaking scanning training in the third trimester, to work in the maternity assessment unit (MAU). The third trimester begins in week 28 of pregnancy and lasts until the woman gives birth.

Queens Hospital Burton (QHB) followed the National Institute for Health and Care Excellence (NICE) classification system for the interpretation of cardiograph tracing (CTG) at QHB, a consultant offered CTG training for staff once a week for an hour.

Matrons told us training was closely monitored with staff. Staff and managers could see when a member of staff’s training was becoming out of date as the system sent an automated email with an amber marker against required training. Managers produced a monthly report from the system which showed staff who were due for training. Managers rostered staff onto training when required.

Managers attended bi-monthly confirm and challenge meetings where mandatory training was discussed. The Head of Maternity, matrons and senior midwives attended the meetings to ensure
staff had completed or were booked onto the required training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

**Queen’s Hospital Burton maternity department**

Staff at Queen’s Hospital Burton, Samuel Johnson Community Hospital and the Burton community midwifery service had a mandatory training target of 90% for all safeguarding training modules. This target was inherited from Burton Hospitals NHS Foundation Trust, which previously provided these services.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for midwives in maternity at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 4</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>87</td>
<td>88</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>87</td>
<td>88</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>77</td>
<td>88</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 95.9% for midwives in Queen’s Hospital Burton maternity department. The trust’s mandatory training targets were met for six of the seven safeguarding training modules for which midwives and qualified nursing staff were eligible.

We spoke with the matron for the service who explained that safeguarding training figures included staff who were off long-term sick and maternity leave. This meant the figures were lower than the actual training completion rates for staff at work. The matron showed us the training completion figure for the child protection three module for January 2019 was 96% which was over the trust target of 90%.

**Samuel Johnson Community Hospital maternity services**

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for midwives at Samuel Johnson Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The trust had an overall safeguarding training compliance rate of 97.9% for midwives in Samuel Johnson Community Hospital’s maternity services. The trust’s mandatory training targets were met for five of the six safeguarding training modules for which midwives were eligible.

**Burton Community midwifery service**

Staff in the Burton Community midwifery service (the midwifery service previously provided by Burton Hospitals NHS Foundation Trust) had a training completion target of 90% for all safeguarding training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for midwives in the Burton community midwifery service is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>25</td>
<td>25</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>21</td>
<td>25</td>
<td>84.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The service had an overall training compliance rate of 95.3% for midwives. The trust’s mandatory training targets were met for five of the six safeguarding training modules for which midwives were eligible.

The matron for the service confirmed that safeguarding training figures included staff who were off long-term sick and maternity leave. This meant the figures were lower than the actual training completion rates for staff at work.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The service had a vulnerable women’s team which led on safeguarding. Staff alerted the team by email or telephone when they identified a woman as at risk of abuse. Staff completed a notification of vulnerable woman form providing information about the woman’s pregnancy, professionals involved in her care and a description of vulnerability. A member of midwifery staff from the team spoke with the woman at routine antenatal hospital appointments. Staff referred women with learning disabilities and mental health concerns to the vulnerable women’s team.

We spoke with a community midwife who explained they spoke with women about potential safeguarding issues at each appointment in their homes and at antenatal clinics at Samuel Johnson Community Hospital and Queens Hospital. Any concerns were raised with the vulnerable women’s team. Where necessary a referral was made to the local authority safeguarding team.
We spoke with five members of staff who had a good understanding of how to recognise safeguarding issues and what action they needed to take. The service had an abduction policy staff could access on the trust’s intranet site.

The service did not have a teenage pregnancy service. Training on the recognition of Female Genital Mutilation (FGM) was included in the child protection level 3 training. Staff explained they would speak to a member of the vulnerable women’s team if they were concerned about a woman or child.

Following the birth of a baby, midwives carried out a full handover by phone with the woman’s allocated community midwife. This enabled any safeguarding issues to be discussed and any actions to be taken before the woman and her baby left hospital. Community midwives liaised with health visitors about any safeguarding concerns about women ready for the health visitor’s post-natal visit, normally ten days after the women and baby arrive home.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The service’s wards and clinics were clean and tidy, including the seven delivery rooms at Queen’s Hospital and three delivery rooms at Samuel Johnson Community Hospital.

The service employed domestic staff to carry out cleaning routines. Domestic staff were allocated to the wards and took pride in providing an excellent service. Delivery rooms were cleaned thoroughly after every birth, including birthing pools. A member of staff at Samuel Johnson Community Hospital showed us the two birthing pools and explained how staff spent over an hour cleaning a pool after a birth and each room also had a deep clean each week.

On the wards at Queen’s Hospital, bathrooms and toilets were cleaned three times a day. Staff had placed signs in these areas reminding women about personal hygiene to encourage clean facilities for all women.

The trust’s domestic supervisors carried out fortnightly checks on the cleanliness of all areas of the service at Queen’s Hospital. The matron carried out a monthly environmental audit and submitted the results to the trust’s infection prevention and control team (IPC team). The IPC team carried out its own monthly checks of the service. If there were any issues, the IPC team submitted an action plan for the matron to action and provide a response to the team. The matron fed back any issues to staff with any actions staff should take.

The matron for the delivery suite at Queen’s Hospital carried out twice daily cleanliness checks on delivery rooms. The senior midwife carried out daily cleanliness checks at Samuel Johnson Community Hospital.

The service provided facilities for hand washing with availability of sanitising hand gel for entering and leaving different areas. We observed in antenatal clinic staff washed their hands before taking women’s blood for tests. The service provided long gloves if staff required these for water births. The matrons carried out hand hygiene audits and gave feedback to staff where necessary.

Staff told us that women who had a suspected or an actual infection were placed in a side room. Staff took infection prevention measures such as wearing gloves and aprons when caring for the woman.

The maternity assessment unit was well maintained. The ultrasound room was very clean, with no evidence of a gel on the probes or the floor. There was no clutter and the couch was prepared for the next patient.

**Environment and equipment**
The service had suitable premises and equipment and looked after them well. However, the service did not have robust measures in place to keep babies secure on the delivery suite and postnatal ward at Queen’s Hospital. The trust took immediate action and put into place measures to ensure the units were secure.

Equipment in all areas was serviced at required intervals and was labelled with the service due date. We saw that staff had carried out daily checks of equipment such as the Cardiotocography (CTG) machine for recording the fetal heartbeat and uterine contractions during pregnancy. Also, infant warming lamps, baby resuscitation equipment, oxygen cylinders and call bells.

Staff had labelled sealed emergency equipment kits such as adult ward packs and neonatal resuscitation packs with the expiry date. Equipment inside packs lasted until the expiry date on the outside of the pack.

The service had one theatre for elective and emergency caesareans. The theatre and recovery area was clean and tidy. Equipment was readily available and was clean. Staff had labelled and stored equipment logically in the theatre store room to make it easy to retrieve.

Delivery rooms were furnished with appropriate equipment at Queen’s Hospital and Samuel Johnson Community Hospital. Equipment was clean and within service dates. There was a net available for each birthing pool in case of an emergency, so staff could assist women out of the pool.

Community midwives carried their own equipment. The service had just invested in new standardised home birth bags for community midwives. Staff told us they everything they needed to carry out their roles.

On the postnatal ward we saw two breast pump machines which were out of service date by nearly a year. Staff told us they should not have been on the unit as normally there was just one machine. We saw the correct machine had been serviced within the last year. Staff took immediate action to report the incident and remove the equipment to prevent it being used.

The service had closed bins for the storage of products of birth which were emptied three times a day and the contents were collected for destruction.

The maternity wards had an issue with ventilation. Managers said there was no immediate risk to women or babies and a solution was due to be implemented in the next two months.

The service did not have robust measures in place to keep the delivery suites and postnatal ward secure at Queens Hospital and Samuel Johnson Community Hospital. On the delivery suites and postnatal wards women and members of the public could leave the units by pushing a button to release the doors. People could leave the units without a member of staff to open the doors. Staff told us there were cameras on the doors of the units and a screen to observe the images at the midwife station. However, it was not guaranteed that staff would see someone leave. Also, at Queen’s Hospital there was access from the postnatal ward through to the maternity assessment unit ward which also allowed people to leave without a member of staff. The Department of Health guidance, the health building note for maternity care facilities, stated that the use of centrally managed access control using one of the following systems should be considered essential: swipe card, proximity or biometric recognition.

During the inspection, the trust took immediate measures to risk assess the access and egress of all maternity areas. The trust had identified where improvements to the exit points were required and had ensured funding was available for the work. The service had implemented additional
measures to ensure staff were aware of the issue and carried out extra checks when people left the units.

Assessing and responding to patient risk

**Staff completed comprehensive risk assessments for women from referral to the service through pregnancy, birth and postnatally.** They kept clear records and referred women for specialised services where necessary.

Community midwives completed a referral and booking form with women at an initial clinic appointment at Queen’s Hospital normally at seven to nine weeks of pregnancy. The form included risk factor such as previous pregnancies, the woman’s health history and medical factors such as family history. This was to ensure the woman’s care was adapted to her needs. An aspirin assessment was included to see if the woman needed to start taking aspirin during the pregnancy to prevent blood clots forming.

The community midwife contacted the diabetic centre for women who were diabetic. If the woman met any of the criteria for a glucose tolerance test the midwife booked the test for after the 12-week scan and again at 28 weeks of pregnancy. The midwife also arranged a latex test for women who had a latex allergy. The midwife made a referral for women to the anaesthetist clinic if required.

The community midwife also carried out social assessments on women at the initial booking appointment. If the woman required an interpreter, staff used an external interpretation service used by the trust. The assessment also included the support the woman had at home, housing, tobacco, drug and alcohol use. The midwife completed a mental health assessment with women and referred women to the mental health team at the hospital if necessary.

Staff carried out blood tests and carbon monoxide tests on women during the booking appointment to assess what support women needed.

Staff used a (VTE) risk assessment to check whether a woman needed medication to prevent blood clots during and after pregnancy. The assessment was used at the initial clinic appointment, on admission to hospital and after delivery.

Staff told us they could refer women to an obstetrician if needed. Staff said the obstetricians were always helpful and offered support and advice. An obstetric consultant was available 24 hours a day to review women and babies and in case of emergency caesareans. If a woman arrived in labour who had not been booked, there was always consultant presence to review the woman.

Staff were trained to recognise when a woman’s health was deteriorating. Staff completed an enhanced handover sheet to alert colleagues to women who were at higher risk. For example, women who had a postpartum haemorrhage (blood loss 24 hours after birth) of over 500 millilitres or had pre-eclampsia (a condition that can develop in pregnancy that can be dangerous for women and babies). A consultant led a weekly wash meeting with staff on the delivery suite to discuss high risk cases to decide the treatment the women required. Midwifery staff used a paper based early warning assessment tool known as the modified obstetric early warning score (MEWS) to assess the health and wellbeing of all inpatients. We reviewed eight MEWS records which were completed appropriately.

Staff used a newborn track and trigger chart to monitor babies for red flags that showed their health had deteriorated. Staff could escalate concerns with a consultant if they identified a red flag.
We saw in three sets of women’s notes, cardiotocograph (CTG) traces were checked by a second member of staff to give a “fresh eyes” view. ‘Fresh eyes’ is an approach where a colleague reviews fetal monitoring readings as an additional safety check to prevent complications from being missed as recommended by NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth. We saw documentation standards were consistent and in line with the trust’s fetal monitoring guideline.

The service could refer women to the critical care unit at Queen’s Hospital if they required intensive care. The matron for the labour suite told us women were transferred to the critical care unit if it was necessary.

In theatre, we observed staff followed the three steps in the WHO surgical safety checklist to reduce errors and adverse events. Staff entered onto the electronic patient records that the checklist had been followed which enabled managers to audit results.

The transfer rate of women from Samuel Johnson Community Hospital to Queen’s Hospital was 22% which was in line with the national average. The trust had an agreement with the local ambulance trust to transfer women from Samuel Johnson Community Hospital to Queen’s Hospital in the case of an emergency. The response time for an ambulance was eight minutes. The senior midwife for the community hospital reviewed all transfers to check the correct decisions were made.

Hospital and community midwives were trained to complete the newborn baby checks within 72 hours of birth. At Queen’s Hospital there was always one midwife on duty between 7am and 3pm who was trained to complete the checks.

**Midwifery staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people protected from avoidable harm and to provide the right care and treatment. The antenatal clinic at Queen’s Hospital had low staffing levels but managers planned cover and longer-term solutions.

**Planned vs actual**

In March and October 2018, the trust reported their staffing numbers for midwives working in maternity as below.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>October 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
<td>Actual staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>162.1</td>
<td>174.5</td>
<td>92.9%</td>
<td>157.0</td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>82.8</td>
<td>83.5</td>
<td>99.1%</td>
<td>76.3</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>6.0</td>
<td>7.1</td>
<td>84.7%</td>
<td>6.0</td>
</tr>
<tr>
<td>Community midwives</td>
<td>86.0</td>
<td>94.6</td>
<td>90.9%</td>
<td>84.2</td>
</tr>
<tr>
<td>Total staff</td>
<td>336.8</td>
<td>359.7</td>
<td>93.6%</td>
<td>323.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**
From November 2017 to October 2018, the trust reported a vacancy rate of 7.0% for midwives working in maternity. The trust had a target vacancy rate of 6%.

The breakdown by site was as follows:

- Royal Derby Hospital: 7.4%.
- Queen’s Hospital Burton: 6.0%
- Samuel Johnson Community Hospital: 5.3%
- Community midwives: 8.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 9.3% for midwives working in maternity. This was within the trust’s target rate of between 8% and 12%.

The breakdown by site was as follows:

- Royal Derby Hospital: 9.7%.
- Queen’s Hospital Burton: 6.1%
- Samuel Johnson Community Hospital: 0.0%
- Community midwives: 12.2%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 4.8% for midwives working in maternity. This was higher than the trust’s target rate of 3.8%.

The breakdown by site was as follows:

- Royal Derby Hospital: 3.9%.
- Queen’s Hospital Burton: 5.9%
- Samuel Johnson Community Hospital: 4.2%
- Community midwives: 5.4%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

The matron for the delivery suite and postnatal ward at Queen’s Hospital said they had seen a sickness rate over the trust target in the last two years. The matron explained the sickness had been managed in line with trust policy and members of staff were starting to come back to work on phased return.

The matron for the community midwives explained the sickness rate was due to long term illness but staff had started to return to work. Staff had experienced several changes in managers over the last two years, changes in practices and a trust acquisition. However, there was a stable manager in place and the trust’s acquisition had been in place for over six months.

Bank and agency staff usage

The trust provided bank staff usage data for qualified midwifery and unqualified midwifery in maternity.
From November 2017 to October 2018, the trust reported that 4.1% of qualified midwifery hours in maternity were filled by bank staff. There had been no agency staff usage at Queen’s Hospital. In addition, 2.1% of qualified midwife hours were not filled by bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital</td>
<td>2,683</td>
<td>1.7%</td>
<td>33</td>
<td>0.0%</td>
<td>161,092</td>
</tr>
<tr>
<td>Samuel Johnson</td>
<td>129</td>
<td>1.1%</td>
<td>0</td>
<td>0.0%</td>
<td>11,886</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>10,997</td>
<td>10.7%</td>
<td>8,845</td>
<td>8.6%</td>
<td>103,029</td>
</tr>
<tr>
<td>Community midwives</td>
<td>5,020</td>
<td>2.8%</td>
<td>687</td>
<td>0.4%</td>
<td>179,293</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18,829</strong></td>
<td><strong>4.1%</strong></td>
<td><strong>9,564</strong></td>
<td><strong>2.1%</strong></td>
<td><strong>455,300</strong></td>
</tr>
</tbody>
</table>

Over the same period, the trust reported that 5.5% of unqualified midwifery staff hours across the trust were filled by bank staff, while no hours for this staff group were filled by agency staff. In addition, 1.0% of hours for this staff group were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital</td>
<td>70</td>
<td>0.1%</td>
<td>0</td>
<td>0.0%</td>
<td>51,221</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>10,368</td>
<td>8.1%</td>
<td>2,002</td>
<td>1.6%</td>
<td>128,346</td>
</tr>
<tr>
<td>Community midwives</td>
<td>30</td>
<td>0.3%</td>
<td>0</td>
<td>0.0%</td>
<td>11,730</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,468</strong></td>
<td><strong>5.5%</strong></td>
<td><strong>2,002</strong></td>
<td><strong>1.0%</strong></td>
<td><strong>191,297</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

**Midwife to birth ratio**

From July 2017 to June 2018 Derby Teaching Hospitals NHS Foundation Trust had a ratio of one midwife to every 15.8 births. This was better than the England average of one midwife to every 25.5 births.

The midwife to birth ratio for the maternity service at Burton Hospitals NHS Foundation Trust was not available for the equivalent period in the Electronic Staff Records (ESR) data. The maternity dashboard submitted by the trust also did not contain a figure for midwife to birth ratio.

(Source: Electronic Staff Records – ESR Data Warehouse; Routine Provider Information Request (RPIR) P77 – Queen’s Hospital Burton maternity dashboard)

A matron told us the labour suite and postnatal ward at Queen’s Hospital followed the birth rate plus tool which advised on safe staffing numbers for maternity services. The service followed a minimum of one midwife for eight births and one midwife for 14 births at night. The senior midwife for rostering was alerted by a staffing red flag if staffing level were below the minimum number. The senior midwife alerted the matron for the service so that action could be taken to reduce any risks.

The antenatal clinic at Queens Hospital had lower staffing numbers than required. The antenatal
The clinic was short by one midwife and one maternity support worker. Also, three reception staff had recently left due to retirement and moving on to new roles leaving three vacancies on reception. The staffing shortage had meant the senior midwife had to complete clinical work such as scan reviews and also run the clinic. A midwife had to cover the maternity support worker vacancy and support a consultant with their clinic. The senior midwife did not have time for management tasks and more experienced staff could not provide robust training and mentoring for new staff. This had been the case for several months.

The matron for the antenatal service said staff from other areas of the maternity service had been brought in to support where needed. Managers were working towards longer term solutions including recruitment. A receptionist had recently been appointed and the outstanding reception vacancies were advertised. Managers planned to start to build a clerical bank network to prevent future issues with staffing. Where staff were on long term sick or maternity leave the service could only fill vacancies with bank staff which was difficult. A maternity support worker was due to return in the next month.

**Medical staffing**

**Planned vs actual**

In March and October 2018, the trust reported their medical staffing numbers for maternity as below.

All these medical staff were allocated to Royal Derby Hospital in the trust’s staffing data.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Royal Derby Hospital</td>
<td>25.2</td>
<td>27.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 4.6% for medical staff in maternity. The trust had a target vacancy rate of 6%.

As explained above, all these staff were allocated to Royal Derby Hospital in the trust’s staffing data.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 19.0% for medical staff in maternity. This was higher than the trust’s target rate of between 8% and 12%. As explained above, all these staff were allocated to Royal Derby Hospital in the trust’s staffing data.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 4.8% for medical staff in maternity. This was higher than the trust’s target rate of 3.8%.
As explained above, all these staff were allocated to Royal Derby Hospital in the trust’s staffing data.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From November 2017 to October 2018, the trust reported that no medical staff hours in maternity across the trust were filled by bank staff. Over the same period 0.2% of medical staff hours (109.5 hours) were filled by locum staff. In addition, five medical staff hours (less than 0.01% of total medical staff hours in maternity) were not filled by bank or agency staff to cover staff absence.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

In September 2018, the proportion of consultants reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the 77.4 whole time equivalent staff working in maternity at University Hospitals of Derby and Burton NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Obstetric consultant presence for the labour suite met the recommended 40 hours per week. Consultants carried out daily ward rounds. Junior doctors felt supported by consultants. One junior doctor told us once they had received specific training such as examinations of women, they then saw patient alone and suggested plan to the registrar. They said there is enough registrar cover for them not to have to make the plans alone.

Consultant obstetricians and anaesthetists were either resident on the unit or on-call 24 hours per day, seven days per week. In addition, the delivery suite had access to middle grade obstetric staff 24 hours a day. There was a dedicated middle grade anaesthetist for the maternity unit.
Records

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The trust used a combination of paper and electronic records for women who used the maternity service. Staff completed care records on paper, including WHO checklists, consent and handover maternity sheets. Staff gave women their own set of hand held antenatal care notes at the initial booking appointment to bring into hospital with them. For postnatal care staff gave women a new set of postnatal notes. The service also held medical records relating to each woman. Staff recorded women’s booking and birth delivery details electronically.

We reviewed nine sets of hand held records in detail and saw they were in line with the trust’s maternity record keeping standard. Women’s individual care records were written and managed in a way which kept them protected from avoidable harm. Information needed to deliver care and treatment was available to relevant staff in a timely and accessible way. Staff stored medical records securely in restricted areas or in lockable trolleys in line with data protection policies.

A summary of care was included in the postnatal notes for the community midwife following discharge from hospital. A discharge summary was included in the notes to be sent to the GP and health visitor prior to discharge from the community midwife.

Staff did not always record carbon monoxide monitoring in women’s paper records. Staff told us they recorded this electronically. In the prescription charts we looked at, staff had not recorded the women’s weight.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

We checked drug cupboards and trolleys at Queen’s Hospital and Samuel Johnson Community Hospital and found them to be locked and secure which minimised the risk of theft or tampering.

We saw staff consistently checked the temperature of fridges used to store medicines. Staff recorded the minimum and maximum temperatures and any action taken when the temperature was outside of the normal range. This meant staff were assured medicines were being stored at the correct temperature.

Controlled drugs (a medicine that is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in locked cupboards. The stock of the controlled drugs was checked by two members of staff.

The hospital used electronic prescription and medication administration charts for women. We looked at six prescription charts. Staff recorded women’s allergies on the prescription chart. The records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. This meant women were receiving their medicines as prescribed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
Never events

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, the trust reported one incident which was classified as a never event for maternity. This was a retained foreign object post-procedure and occurred in October 2018.

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition. We only provided this for contextual purposes and it is not used to form part of our judgement.

From January to December 2018, the trust reported no incidents that were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust they are used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January to December 2018.

The breakdown by incident type was as follows:

- Maternity/obstetric incident: baby only (this include foetus, neonate and infant): four.
- Confidential information leak/information governance breach: one
- Maternity/obstetric incident: mother and baby (this include foetus, neonate and infant): three
- Surgical/invasive procedure incident: one
- Maternity/obstetric incident: mother only: one

Six of these six SI’s were reported to STEIS within 14 days of occurrence. The other four took between 15 and 30 days to report.

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the date of the
acquisition are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January to June 2018. *(Source: Strategic Executive Information System (STEIS))*

Staff reported incidents through the trust’s electronic incident reporting system. Root cause analysis investigations had taken place in relation to serious incidents (root cause analysis is an approach for identifying the underlying causes of why an incident occurred). Obstetric consultants led on serious incident investigations and staff held monthly risk and governance meetings to discuss outcomes. We saw staff produced an action plan following a serious incident including actions to review policy and processes and training for staff.

Staff told us learning from incidents was shared through emails and staff handovers and could ask for one to one feedback. We saw information displayed in staff areas which gave staff information about incidents and the lessons learned.

Staff told us about an example where learning from incidents had been applied. Incidents had been reported about staff handover to anaesthetists and as a result the handover process had been improved.

Staff we spoke with understood their responsibilities about the Duty of Candour (DOC) regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. DOC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff explained how they kept women and their families informed at all stages of incident investigations.

**Safety thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Maternity services took part in the maternity national safety thermometer scheme designed to support improvements in women’s care and experience. The maternity thermometer recorded data on one day a month to show the proportion of women who have experienced harm free care. It records harm associated with maternity, such as perineal trauma, postpartum hemorrhage and the number of normal deliveries. A senior midwife who led on risk and governance told us any trends in harm incidents were reviewed and improvements implemented by staff.

The service did not have an automated dashboard. The trust had planned for Burton based service to have the same dashboard as the Derby based service from May 2019. In the meantime, managers were manually extracting figures from the electronic recording system.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. However, guidelines were not always up to date and were difficult for staff to access.
Local policies and guidelines were written in line with evidence-based standards and guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE), Nursing and Midwifery Council (NMC) and the Royal College of Obstetricians and Gynaecologists (RCOG). Midwives and medical staff we spoke to were able to describe how their practice was informed by evidence and guidance.

We spoke with two staff who showed us the guidelines staff accessed on the trust’s intranet. Staff showed us the guidelines for the service at Derby. We reviewed 14 Derby guidelines and found three out of date for review and nine had out of date references, meaning references were not reviewed when the guidelines were updated and indicated their process for review may not be robust. The staff were unaware of how to access the guidelines for Burton. We saw that the guidelines for Burton were on the intranet site but were not in a logical location on the site. We spoke with leaders of the service about the misalignment of guidelines across the trust, they told us they had started the process of alignment; however, it was a lengthy one which could not be completed within a few months.

Following the inspection, we requested a copy of the service’s internal clinical audit programme. The trust confirmed there had been several internal audits on different themes, including the use of stickers to promote cardiotocograph (CTG) fresh eyes, the management of reduced fetal movements and the use of low dose aspirin in pregnant women with pre-existing diabetes. The trust had made improvements to the service following the audits and measured the success of the improvements.

**Nutrition and hydration**

**Staff gave women enough food and drink to meet their needs.**

Pregnancy care plans included an assessment of hydration and nutrition and staff told us women were encouraged to eat and drink normally in labour if it was safe to do so.

Women at Queen’s Hospital were offered buffet style meals where they could choose what they would like to eat and drink. Snacks were also available throughout the day.

Women at Samuel Johnson Community Hospital could decide when they wanted to have a meal and what they would like to have. Women could help themselves to meal and marked what they had in a folder. Women also had access to snacks between meals and we saw tea, coffee and water was available. Women’s partners could also pay a small amount to have a meal.

The maternity service at Queen’s Hospital had achieved full accreditation in the UNICEF Baby Friendly initiative accreditation programme. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding and raise standards of care for all babies. We saw posters displayed within the unit to promote breastfeeding.

Staff monitored the expressed breast milk stored in the milk fridge. Milk was signed in and out by women, together with a member of staff. Staff told us it could remain in the fridge for up to 24 hours and then would be disposed of appropriately.

There were several café’s, restaurants and vending machines within proximity of the wards for the use of women and their partners and relatives.

**Pain relief**

**Staff assessed and monitored women regularly to see if they were in pain and administered pain relief in a timely manner.**
Women could access pain relief during labour, birth and post operatively in a timely manner. There were birthing pools on the delivery suite at Queen’s Hospital and Samuel Johnson Community Hospital women could use to ease their pain in labour. At Samuel Johnson Community Hospital, staff offered an aromatherapy service to facilitate relaxation. Staff said women really benefitted from aromatherapy in pregnancy as it helped them to cope with pain, anxiety and tension.

Epidurals (an injection of anaesthetic into the spinal area) were available for women on the delivery suite 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. An anaesthetist we spoke with told us women generally received epidurals within 30 minutes.

An assessment of pain was included and scored on the MEWS chart and we saw staff escalated to anaesthetists if they were caring for women and could not control their pain, for example post caesarean section.

Women we spoke with were happy with the options they had been given for pain relief and did not report a long waiting time for any pain relief.

Nitrous oxide (a pain-relieving gas) was available in all birthing rooms on the delivery suite. Painkiller by injection was available for women who required stronger pain relief.

Staff assessed and monitored patients regularly to see if they were in pain. They supported women unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

**Patient outcomes**

**Managers monitored the effectiveness of care and treatment and used the findings to improve them.** However, the maternity service at Burton did not have a complete dashboard due to the systems used. Managers had to manually extract data from the birth register and other records to produce some figures for monitoring patient outcomes.

**National Neonatal Audit Programme**

**Queen’s Hospital Burton**

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

In the 2017 National Neonatal Audit Queen’s Hospital Burton’s performance in the two measures relevant to maternity services was as follows:

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 77 eligible cases identified for inclusion. Of these, 81.6% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital did not meet the audit’s recommended standard of 85% for this measure.
Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 11 eligible cases identified for inclusion. Of these, 18.2% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5% and put the hospital in the middle 50% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Standardised caesarean section rates and modes of delivery

The data on standardised caesarean sections rates and modes of delivery below cover time periods from prior to the acquisition.

Burton Hospitals NHS Foundation Trust

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

From April 2017 to March 2018 caesarean section rates were similar to expected for both elective and emergency caesareans.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>BURTON HOSPITALS NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>403</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>483</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>886</td>
</tr>
</tbody>
</table>

In relation to other modes of delivery, the table below shows the proportions of deliveries recorded by method in comparison to the England average from April 2017 to March 2018:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>BURTON HOSPITALS NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
</tbody>
</table>

Page 443
<table>
<thead>
<tr>
<th>Total caesarean sections¹</th>
<th>886</th>
<th>26.7%</th>
<th>28.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental deliveries²</td>
<td>389</td>
<td>11.7%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>2,039</td>
<td>61.5%</td>
<td>59.3%</td>
</tr>
<tr>
<td><strong>Total deliveries</strong></td>
<td>3,314</td>
<td>100%</td>
<td>100% (n=596,828)</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of the 4th December 2018 the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

This audit was carried out before the acquisition.

Burton Hospitals NHS Foundation Trust

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.97.

This was up to 10% higher than the average for the comparator group rate of 4.79. This flagged as worse than expected in CQC Insight.

(Source: MBRRACE UK)

We spoke to the lead consultant who explained that the service was now using the national standardised Perinatal Mortality Review Tool (PMRT) to support systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death. The lead and staff held round table reviews of all stillbirths to look at the circumstances and to discuss improvements to be made.

The service at Burton produced figures for a maternity quality dashboard but this was not easily accessible to staff due to the electronic system used. Managers had to manually extract data from records as there was no automated dashboard. Senior managers told us the Burton service was due to have an automated dashboard in line with the Derby service from May 2019.

The service reported on some clinical outcome indicators recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008, including postpartum haemorrhage and perineal trauma 3rd and 4th degree. However, the trust could not provide full dashboard figures for the maternity service at Burton such as induction of labour rate and a breakdown of type of birth.

The service had introduced episiotomy scissors to reduce 3rd and 4th degree perineal tears (OASIS) following an episiotomy. The outcome of their audit of 3rd and 4th degree tears was to encourage the use of ventouse instead of forceps as the 3rd degree tears rate was 3% using ventouse as opposed to 15% when using forceps.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

From November 2017 to October 2018, 91.3% of staff within maternity at the trust received an appraisal compared to a trust target of 90% (100% for medical staff).

The trust’s appraisal completion target of 100% for medical staff was not met.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>316</td>
<td>344</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>107</td>
<td>118</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>478</strong></td>
<td><strong>524</strong></td>
<td><strong>91.2%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Over the same period, 97.5% of staff within maternity services at Queen’s Hospital Burton received an appraisal. Training targets were met for all staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>75</td>
<td>78</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
<td><strong>121</strong></td>
<td><strong>97.5%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust did not provide appraisal rates for medical staff at Burton.

Over the same period, 87.5% of staff within maternity services at Samuel Johnson Community Hospital received an appraisal. The 90% training target for non-medical staff was met for administrative and clerical staff only. It should be noted that the numbers of staff involved were very small.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Over the same period, 90.6% of staff in the trust’s community midwifery service had received an appraisal. The 90% target for non-medical staff was met for all staff groups except additional clinical services staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>83</td>
<td>91</td>
<td>91.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>106</td>
<td>117</td>
<td>90.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The maternity service at Queen’s Hospital and Samuel Johnson Community Hospital had developed PROMPT mandatory training in partnership with another local trust. Staff at all levels attended a whole day of training annually consisting of lectures and scenarios in clinical areas. Topics covered included major obstetric emergencies including neonatal resuscitation, haemorrhage and maternal collapse, shoulder dystocia (where a baby’s shoulders get stuck during a vaginal delivery), breech birth, cord prolapse, pre-eclampsia (a serious complication of pregnancy), sepsis and fetal wellbeing and CTG interpretation. Staff were proud of the PROMPT training which was recognised as excellent training.

Practice development midwives were working with band five midwives and provided sessions during inductions as well as an annual resilience study day.

There were a variety of specialist midwife roles, for example for tissue viability and infection prevention and control.

Midwives on the postnatal ward at Queen’s Hospital and Samuel Johnson Community Hospital had completed training in performing the new-born and infant physical examination (NIPE) checks. Staff at Queen’s Hospital told us there was always one midwife on duty between 7am and 3pm who was NIPE trained. The checks were within the role of the midwives, although many were undertaken by paediatric doctors on the ward. Community midwives held clinics for NIPE checks for any home births and outpatient appointments.

The maternity unit did not provide maternal critical care. The service worked in partnership with the critical care outreach team and the hospital high dependency unit. Women were transferred to the high dependency unit if they required specialised care.

Women on enhanced care on the maternity ward were highlighted on the multidisciplinary handover and were reviewed first as a priority by medical staff twice a day.

The role of the supervisor of midwives was discontinued on 1 April 2017 following changes to legislation. The trust implemented the new A-EQUIP (advocating education and quality improvement) model of midwifery supervision, with professional midwifery advocates (PMAs). The service employed four PMAs to provide support to midwives at Royal Derby Hospital and another two worked across the trust, including Queen's Hospital, Burton.

**Multidisciplinary working**
Staff on the wards and in the community, worked together as a team to benefit women. Doctors, midwives and other healthcare professionals supported each other to provide good care.

All necessary staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. For example, neonatal teams worked with obstetricians and fetal medicine specialists during the antenatal period to produce care plans for babies. Community and hospital staff liaised for the continuity of care for women.

The twice daily multidisciplinary handover meeting involved a registrar, consultant, labour ward coordinator and midwifery staff sharing information and planning care using the Situation, Background, Assessment and Recommendation (SBAR) methodology. We observed there was a good rapport between senior and junior doctors during handover. Junior doctors could ask questions. Staff introduced themselves and each woman was discussed as to the background, recent assessment and plan. Discussions were respectful and professional.

Staff in theatre worked collaboratively and provided an effective service for women. We saw there was good communication and teamwork throughout the theatre.

Staff held a weekly wash meeting which was a multidisciplinary forum where incidents and lessons learned were discussed. This was chaired by the labour ward lead or the clinical risk midwife. This was followed up with feedback to those involved.

Seven-day services

The service ensured people received appropriate care and treatment seven days a week.

Community midwives made home visits and held antenatal and postnatal visits seven days a week and were available 24 hours per day, seven days per week to facilitate home births.

Consultant obstetricians and anaesthetists were either resident on the unit or on-call 24 hours per day, seven days per week. In addition, delivery suite had access to middle grade obstetric staff 24 hours a day.

The obstetric theatres were always available for emergency procedures and there was a dedicated middle grade anaesthetist for the maternity unit.

Health promotion

Staff provided useful and relevant information to women to promote their health and wellbeing.

Initial booking risk assessments and ongoing screening monitored and identified abnormalities or risk factors for example raised body mass index, low blood haemoglobin levels and smoking. These were then discussed and care planned with all relevant parties, including women and partners. We saw for the whole trust that between 1 July 2018 and 30 September 2018, 100% of eligible women were tested for HIV, hepatitis B and Syphilis.

Staff told us they encouraged women to stop smoking. Carbon monoxide testing was offered to all women at booking, regardless of their smoking status. The labour suite matron told us staff made referrals to the vulnerable women’s team for women who needed support to stop smoking.

Healthy eating and weight management advice was also provided as part of diabetic care for women during pregnancy. Specialist midwives held clinics and provided training for midwives to care for and support women. A woman in antenatal care told us they had received a lot of information about diabetes and pregnancy.
Midwives with a special interest in diabetes and infant feeding worked across the trust. The trust had a range of specialist midwives and midwives with special interests in substance misuse, antenatal screening, fetal medicine, postnatal screening and newborn infant physical examination, bereavement, practice development and safeguarding.

Specialist midwives supported women in vulnerable circumstances to access health and social care services which would improve outcomes for women and babies.

We saw posters in the antenatal clinic promoting a range of parent education classes, including antenatal and postnatal exercise classes. There were many leaflets on offer for women such as help to stop smoking, postnatal exercises and advice and information about pregnancy screening.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

**Mental Capacity Act and Deprivation of Liberty training completion**

It should be noted that as of October 2018, staff from the two predecessor trusts continued to complete two different sets of legacy mandatory training modules. Because of this, it would not be meaningful to produce overall training figures for the whole trust.

**Queen’s Hospital Burton**

Staff at Queen’s Hospital Burton were eligible for two levels of combined MCA and Deprivation of Liberty Safeguards training. The completion target for both levels was 90%. This requirement was inherited from the predecessor trust.

A breakdown of compliance for MCA and Deprivation of Liberty Safeguards training for the period from November 2017 to October 2018 level for midwives in maternity at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>73</td>
<td>85</td>
<td>85.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 1</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for either module for midwives in maternity at Queen’s Hospital Burton.

It was not clear how many eligible medical staff there were for this training based at Queen’s Hospital Burton.

**Samuel Johnson Community Hospital maternity services**

A breakdown of compliance for MCA and Deprivation of Liberty Safeguards training from November 2017 to October 2018 for midwives in maternity at Samuel Johnson Community Hospital is shown below.
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for midwives in maternity at Samuel Johnson Community Hospital for Mental Capacity Act and Deprivation of Liberty Safeguards level 2. This was the only module relevant to this subject for which these staff were eligible.

Matrons for the service explained that training completion rates were below the 90% trust target rate due to some staff being on long term sick and maternity leave. The service’s training figures included these staff which meant the figure was lower than the actual completion rates for staff at work.

Burton community midwifery service

A breakdown of compliance for the trust’s Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training from November 2017 to October 2018 for midwives in the Burton community midwifery service is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 95% target was met for midwives in the trust’s community midwifery service for Mental Capacity Act and Deprivation of Liberty Safeguards level 2. This was the only module relevant to this subject for which these staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections or instrumental deliveries. We observed written consent was obtained from women prior to surgery and checked by theatre staff prior to commencing procedures. Staff asked for verbal consent from women prior to any procedures or care.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Friends and Family test performance

University Hospitals of Derby and Burton NHS Foundation Trust
Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired trust they are used to form part of our judgement.

Please note that no data for the four maternity Friends and Family Tests were published by NHS England for November 2017 due to data quality concerns. Therefore, in the charts below, data for October 2017 to October 2018, excluding November 2018, have been included to provide 12 months of data.

Friends and family test performance (antenatal), University Hospitals of Derby and Burton NHS Foundation Trust

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was quite consistent. The trust never scored below 94% and its performance was consistently better than or similar to the England average.

Friends and family test performance (birth), University Hospitals of Derby and Burton NHS Foundation Trust

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was quite consistent. The trust never scored below 95% and its performance was consistently better than or similar to the England average.

Friends and family test performance (postnatal ward), University Hospitals of Derby and Burton NHS Foundation Trust
From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (postnatal) performance (% recommended) was consistent. The trust never scored below 95% and its performance was consistently better than or similar to the England average.

Friends and family test performance (postnatal community), University Hospitals of Derby and Burton NHS Foundation Trust

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was consistent. The trust never scored below 94% and its performance was consistently similar to the England average.

Burton Hospitals NHS Foundation Trust

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

Please note that no data for the four maternity Friends and Family Tests were published by NHS England for November 2017 due to data quality concerns. Therefore, in the charts below, data for October 2017 to October 2018, excluding November 2018, have been included to provide 12 months of data.

Friends and family test performance (antenatal), Burton Hospitals NHS Foundation Trust

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was consistent. The trust never scored below 95% and its performance was consistently better than or similar to the England average. In both January and February data were suppressed to protect patient confidentiality, due to low numbers of responses.

Friends and family test performance (birth), Burton Hospitals NHS Foundation Trust
From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistent. The trust never scored below 96% and its performance was consistently better than or similar to the England average.

**Friends and family test performance (postnatal ward), Burton Hospitals NHS Foundation Trust**

From October 2017 to October 2018, excluding November 2017, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was consistently better than or similar to the England average. The trust scored 100% in February, April and May 2018 and never scored below 98%.

**Friends and family test performance (postnatal community), Burton Hospitals NHS Foundation Trust**

The trust scored 100% for maternity Friends and Family Test (postnatal community) in October 2017. However, from December 2017 to June 2018, the trust’s performance (% recommended) was consistently worse than the England average. The trust’s performance deteriorated to 65% in February 2018 compared to the England average of 98%, before improving to 93% in March 2018, and 90% in June 2018.
We spoke with the matron for the Burton community midwifery teams. The results appeared to be linked to changes in working procedures for community midwives at that time. The postnatal model changed. This meant that instead of the traditional model of home visits for women at days one, five and 10, home visits were changed to day 10 and day 21. Staff found this change very difficult as they felt women were more at risk due to not being seen the first day after discharge from hospital. The model has since been reviewed and changed.

**CQC Survey of women's experiences of maternity services 2017**

**Burton Hospitals NHS Foundation Trust**

Data from the pre-acquisition period for Queen's Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

Burton Hospitals NHS Foundation Trust performed better than other trusts for one of the 16 questions in the CQC maternity survey 2017:

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.8</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.7</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, do you feel that the length of your</td>
<td>7.0</td>
<td>About the</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stay in hospital after the birth was appropriate?</td>
<td>same</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>6.4</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>8.3</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.9</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>8.4</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.2</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.7</td>
<td>About the same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Staff understood and respected the personal, cultural, social and religious needs of women and those important to them. Women and their relatives we spoke with, without exception, told us they were treated with dignity, kindness and respect. We spoke with eight women and their relatives across the maternity unit who made complimentary comments, such as “you can call anytime”, and staff, “always give good advice”. One woman said, “staff couldn’t do more and they go above and beyond.” Another woman said, “the care has been outstanding.”

We saw cards of thanks displayed on all wards with positive comments about staff. One comment was, “one to one service was brilliant, having a dedicated midwife without having to deal with different people was great”. Staff said they received personal feedback from managers when women sent in positive comments.

We observed interactions between members of staff and women, their relatives and visitors. We saw all staff including midwives, receptionists and midwifery support workers took time to interact with women who used the service and those close to them in a respectful and considerate way.

A woman told us staff and doctors were thorough and helpful, for example delivery suite staff found a charger for her to charge her phone.

Staff protected women’s privacy and dignity by using curtains to draw around beds during discussions and care.

The bereavement suite was away from the labour suite and postnatal ward. There was a quiet room opposite the suite which the privacy and dignity of women and their families.

**Emotional support**

Staff provided emotional support to women to minimise their distress.

We saw staff supported women with breastfeeding to help them emotionally when it was difficult. A woman on the postnatal ward at Queen’s Hospital told us staff were always on hand to offer support 24 hours a day. At Samuel Johnson Hospital women could drop in at any time day or night to receive support from staff with breastfeeding. Women could stay for several hours if they chose to.
Staff provided compassionate care for women and relatives who had suffered a bereavement. A specialist bereavement midwife directly supported women and provided support and guidance to staff to enable them to meet family’s needs. The service provided spiritual care and religious support for women and relatives as required. For example, women could be referred to the chaplaincy service for support 24 hours a day, seven days a week.

The bereavement midwife worked closely with families to support them in numerous ways, for example emotional support and access to other services such as counselling but also practical things such as paperwork.

Staff regularly assessed women’s mental health, both in the antenatal and postnatal period, using recognised assessment tools in line with National Institute for Health and Care Excellence (NICE) guidance.

Staff told us and we saw women’s physical and psychological needs were regularly assessed and addressed whilst in the maternity unit. These assessments included nutrition, hydration, pain, personal hygiene and anxiety. Women we spoke with told us all their needs had been met.

**Understanding and involvement of patients and those close to them**

**Staff involved women and those close to them in decisions about their care and treatment.**

Staff routinely involved women who used the services and those close to them in planning and making shared decisions about their care and treatment. All women we spoke with told us they were given sufficient information to make choices about their care.

Birth partners were included and involved in the care of their partner and baby. Partners could stay at the hospital to provide additional support to postnatal women and keep families together. We spoke with a partner who told us they felt involved and included in the decisions about their partner’s care.

We observed in the antenatal clinic a midwife taking a woman’s blood as part of routine tests. The member of staff reassured to the woman and explained what they were testing for, how long the test would take and how she would hear about results.

We spoke with two women who were being monitored antenatally. Both explained how consultants and midwives had kept them constantly up to date with what was happening. One of the women told us how staff had introduced themselves to women when they changed shifts which meant she had felt well informed.

A woman told us their partner and children had been involved in their care. Staff had called her partner immediately after contractions began. She said their two other children were allowed on the ward to meet the baby.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**The trust planned and provided services in a way that met the needs of local women.**

**Bed Occupancy**

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the acquired
trust they are used to form part of our judgement.

From April 2017 to September 2018 the bed occupancy level for maternity at Derby Teaching Hospitals NHS Foundation Trust (from July 2018 the new trust) was higher than the England average in four out of six quarters. The trust had 65.6% occupancy in quarter 2 2018/19 compared to the England average of 59.7%.

The increase in occupancy in quarter 2 of 2018/19 was more pronounced than the equivalent increase one year earlier. This reflected the inclusion of Queen’s Hospital Burton’s maternity beds in the data for the new combined trust for the first time.

The chart below shows the occupancy levels compared to the England average over the period.

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**Burton Hospitals NHS Foundation Trust**

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

From April 2017 to June 2018 the bed occupancy level for maternity at Queen’s Hospital Burton NHS Foundation Trust was higher than the England average in four out of five quarters. There was a considerable increase in occupancy from 54.7% in quarter 1 of 2017/18, to 91.3% in quarter 2 of 2017/18. Occupancy was then 100% in quarters 3 and 4 of 2017/18, and 99.9% in quarter 1 of 2018/19.

This increase in bed occupancy was caused by a reduction in the number of available maternity beds: from 33 in quarter 1 of 2017/18, to between 15 and 17 in the later four quarters. The number of beds occupied remained stable, from 18 in quarter 1 of 2017/18, to 15 or 16 in subsequent quarters.

The chart below shows the occupancy levels compared to the England average over the period.
Women could access a range of antenatal and postnatal care. Midwife led community clinics were mostly held in GP surgeries. Midwifery led and consultant led clinics were available across the trust.

Women assessed as low risk from across the trust could choose the midwifery led unit at Royal Derby Hospital, Queens Hospital Burton or at Samuel Johnson Community Hospital. At Queen’s Hospital there were two midwife led delivery rooms within the suite. One of the rooms had a birthing pool. At Samuel Johnson Community Hospital, there were three birthing rooms, two with pools and one with a wet room. The availability of a wet room meant more choice for disabled women who could not get in and out of a birthing pool or who used a wheelchair.

The trust was working on a project to raise awareness of the importance of the golden hour following delivery and the impact on the birthing experience by keeping families together rather than separating partners. Discussions included neonatal cannulation and intravenous antibiotics, alongside cots which had been provided, return to theatre events, performing blood spot, vitamin K and hypo while skin to skin, skin to skin in theatre and how they could improve while supporting families when a baby went to the neonatal intensive care unit. Staff said the project had helped to raise awareness among staff and challenged them to think differently about practice.

The trust employed several midwives in specialist interest posts to provide care for women and support staff to care for women with additional needs.

A consultant led fetal medicine clinic was held weekly in the antenatal clinic at Queen’s Hospital. Staff saw women with a high chance of abnormalities from the antenatal screening programme (conditions such as Down’s, Edwards and Patau Syndromes). The service did not offer medical and surgical termination of pregnancy (TOP) for abnormality.

Two bereavement specialist midwives worked between them to cover a working week. They supported and trained staff to provide care for families after a pregnancy loss. They provided guidance to staff to ensure all women and families were offered appropriate care and supported to make informed decisions at a difficult time. A bereavement midwife supported women and their families throughout until twelve weeks following a post mortem report. A consultant met with
families to discuss the post mortem report and all notes. Planning for next pregnancy was discussed.

We visited the Snowdrop Suite, a bereavement suite situated in a quiet area away from labour rooms and self-contained at the end of the labour ward. The suite comprised one labour room to allow for partners or relatives to stay overnight. Women and their families could stay for as long as they wished, and staff provided a cuddle (cold) cot to ensure babies could stay longer with their parents. The room had been considerately furnished and equipment covered to make the room feel more like a home environment. The Snowdrop Suite Charity had provided baby clothes and blankets for women to use. The charity had created a library of books for visiting children who could take a book away with them to keep.

The service had close links with the chaplaincy service, bereavement office and local funeral services. The service signposted women to local support networks and coffee mornings.

Memory boxes, which included photographs and hand and footprints were made up for parents who suffered a pregnancy loss.

The bereavement midwife reported to the trust’s monthly perinatal mortality and morbidity panel as well as MBRRACE and followed the National Bereavement Pathway.

The service had two self-contained flats on the labour ward where women and partners could stay with their babies before going home. This was for women whose babies had spent some time in the neonatal unit. This allowed families to stay together in a homely environment and have support from staff if needed before going home.

We did not see adjustments or support in place for young women aged under 20 to use antenatal care services.

**Meeting people’s individual needs**

The service took account of women’s individual needs.

All women were assessed at booking for birth place choice. Community midwives supported and promoted home births. The home birth rate was just under 1%. There was no trust target set on home births. Service leads told us they always promoted the home birth service but the numbers were usually low due to the clinical and social complexities of women.

Mental health and wellbeing was discussed with all women throughout pregnancy. These discussions included difficult and sensitive issues such as previous experience of poor mental health, domestic violence, sexual abuse, drug use, female genital mutilation and child sexual exploitation.

There was a wide range of information available on the trust’s website accessible to women and their families including Our Service, Maternity Video Tour, Your Pregnancy, Health Eating and Lifestyle, Labour and Birth and After Baby is Born. All information tabs opened to show further information in a variety of formats and languages. There were information leaflets available on the website, specifically relating to maternity. All information was available in a range of languages and information videos had a choice of subtitles. All were available in a hard copy when requested from a midwife or at an antenatal clinic. An interpreting service was available for non-English speaking women. Staff we spoke with knew how to access the interpreting service. We saw a midwife was using resources in Romanian for a woman on the postnatal ward, such as an explanation of checks carried out on babies.
We saw there was a wide range of leaflets available and up to date information displayed in all the clinical areas, they included sleep safe, breastfeeding, bottle feeding, flu vaccine and skin to skin contact with your baby. Women we spoke with said they found them useful. Postnatal exercise classes, breast feeding cafe, water birth workshops, home birth sessions and events for parents of multiple births were some of the opportunities promoted on the wards.

Community midwives told us they provided parent education classes in the form of open meetings at different sites and at varied time of day to enable women to book on when it was most convenient for them.

Women could choose from a range of meals including food suitable for specialist diets and cultural preferences, for example halal, vegetarian, gluten free and for those with a nut allergy. Menus were also available in a range of different languages. We saw on the maternity assessment unit a woman was in a side room due to a severe nut allergy.

The antenatal clinic waiting area was spacious with information boards displaying educational topics such as an app to give advice about fetal movements, flu and whooping cough vaccine and exercise in pregnancy.

**Access and flow**

**Women could access the service when they needed it.**

Women had timely access to initial assessment, test results, diagnosis and treatment. We did not see women waiting for long periods of time for appointments in antenatal clinic or for maternity assessment unit.

The labour suite at Queen’s Hospital had two birthing rooms and Samuel Johnson Community Hospital had three birthing rooms for women assessed as low risk and appropriate for midwifery led care. More women were presenting with complexities assessed as high risk, therefore the units were not used as often as it was. However, staff and managers were proactive in optimising women booking and birthing on the low risk pathway.

There was one obstetric theatre for elective and emergency caesareans. Staff told us this could cause delay for elective caesareans but there were normally only one to two a day. The service had access to another theatre close to the labour suite which could be used if needed. Staff told us consultants and anaesthetists and the theatre team were reactive in emergencies.

The neonatal intensive care unit at Queen’s Hospital was situated close to the labour ward. The unit was for newborn babies and preterm babies born after the 29th week of pregnancy requiring intensive care.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

**Summary of complaints**

**Trust level**

From November 2017 to October 2018 the trust received 36 complaints about maternity. For the 35 complaints that had been closed at the time of data submission, the trust took an average of 41.7 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.
The one complaint that had not yet been closed had been open for 165 days (approximately five and a half months) at the time of data submission. This was also not in line with the policy statement above.

Service leads accepted multi-service complaints often led to prolonged times for complaints to be fully investigated and close as well as having no divisional coordinator for complaints. They told us the process was under review as part of the acquisition as the electronic systems across the trust were disjointed.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions and discharges</td>
<td>4</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>12</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
</tr>
<tr>
<td>Patient care</td>
<td>7</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Trust admin/policies/procedures</td>
<td></td>
</tr>
<tr>
<td>including patient record management</td>
<td>2</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

**Queen's Hospital Burton**

From November 2017 to October 2018 the hospital received two complaints about maternity. Both were already closed at the time of data submission. The trust took an average of 37.5 working days to investigate and close these two complaints. This was in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

Both complaints concerned clinical treatment.

Over the same 12-month period the trust received no complaints about its maternity services at Samuel Johnson Community Hospital, or about its community midwifery service.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From October 2017 to September 2018 the trust received 71 compliments about maternity. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service monitored complaints, concerns and compliments as part of the clinical governance. We reviewed the Women and Children’s Clinical Risk Group minutes from July 2018 to January 2019 and saw the number of complaints and themes were included in the discussions. All complaints had a lead investigator who was normally a matron or consultant.
Staff told us they helped respond to complaints and feedback from women and families to try to improve the service. Senior staff we spoke with told us they learned from complaints, for example, improving communication with women.

**Is the service well-led?**

**Leadership**

**Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.** However, staff did not fully understand the new structure since the acquisition and were not aware of future plans for the service.

University Hospitals of Derby and Burton NHS Foundation Trust provided maternity services as part of the Division of Women and Children Services. The division was split into business units which were maternity and gynaecology, paediatrics, neonates, sexual health and fertility. The division was led by a clinical director, a divisional general manager, a deputy general manager, a director of midwifery (DOM) and a head of midwifery (HOM). The division was split into individual specialities. The HOM was supported by matrons across both sites. Each of the maternity wards had a band 7 ward manager and a band 6 deputy manager.

The senior leadership team worked across both sites, however they were based at Queen’s Hospital Burton. Overall staff said leaders were visible, however, the antenatal clinic manager was based at Royal Derby Hospital and spending time in the antenatal clinic at Queen’s Hospital Burton was not always possible.

There was a non-executive director for maternity, who staff described as enthusiastic and proactive in engaging with staff. Service leads told us they were in the very early stages of implementing changes the trust’s acquisition of Burton Hospitals NHS Foundation Trust and had plans to create a more robust management and governance structure.

Staff we spoke with said senior managers were approachable and had access to them when they needed to.

The service at Queen’s Hospital Burton had a vacancy for the professional development midwife post. The interviews were due to take place soon after the inspection. The clinical risk lead was off work and staff at Burton were not sure about the future of the role. These two roles meant senior managers at Queen’s Hospital were spending time carrying out risk and training management tasks as well as their substantive roles.

**Vision and strategy**

**The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**

Senior leaders told us the vision was that at the end of three years women would receive the same service, level of care across all the trust’s sites. The vision was for the trust to have fully integrated care for the pregnant woman.

The maternity service was to be aligned to ‘Better Births’, the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation Programme. Service leads told us there were different work streams, working with other providers and commissioners in the local maternity system.
We saw posters in staff areas detailing the trust’s promises, the six Ps, which related to patients, people, places, partners, performance and potential. Staff understood these promises.

**Culture**

**Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

Services on both sites and the community were run by one maternity management team. They were regarded and reported upon by the trust as one service. There were few integrated guidelines and policies across Derby and Burton and staff reported there felt some separation between the trust’s maternity units.

The staff we spoke with told us the needs and experience of the women and babies were paramount and midwifery staff we spoke with felt supported, respected and valued. Community midwives had experienced a difficult time in 2018 due to changes to their core working practices, several changes to managers and the acquisition. Leaders were aware of the challenges and were working closely with staff to help them to feel valued and supported. This was by stable management and improvements to working practices.

The trust had a nominated Freedom to Speak up Guardian who worked trust wide, who encouraged and enabled staff to speak up safely within the workplace. Staff knew who their Freedom to Speak up Guardian was and how to contact them.

The trust had a function within their reporting system which allowed staff to tick a box to highlight their report was categorised as whistleblowing and it went directly and confidentially to the Freedom to Speak up Guardian, which encouraged staff to report and access support.

Medical and midwifery staff we spoke with told us there was excellent multidisciplinary working and were proud of the service they provided. Junior doctors told us they were well supported by their seniors and by midwives on the unit. Midwives we spoke with felt they could challenge decisions made by their medical colleagues and feel listened to.

**Governance**

**The service did act to improve the quality of its services and safeguard high standards of care.** However, the approach was not always robust as the governance structure was not aligned across sites. We saw plans in place to make improvements.

Since the acquisition, services were not yet fully aligned, however leaders told us they had seen improvements and they were working on creating a robust governance structure divisionally and liaising corporately to achieve consistency across the whole trust. We reviewed an action plan which outlined actions to be taken and progress against the key targets. They acknowledged it was a work in progress and they had a lot more work to do as a trust.

There was a programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken.

Staff at Queen’s Hospital Burton held monthly Women and Children’s Clinical Risk Group meetings to discuss the maternity dashboard, risk register, incidents and audits. The meeting was attended by the Head of Maternity, consultants, the Operational Manager for surgery, matrons and senior sisters. We saw minutes of the meetings which showed follow up and actions following issues being raised.

**Management of risk, issues and performance**
The trust had systems for identifying risks, planning to eliminate or reduce them.

The trust operated a corporate risk register, which included the ongoing risks identified for the maternity service. Risks were recorded and managed using the trust's electronic incident reporting system. An up to date risk register was provided following the inspection which showed nine risks directly related to maternity and six related to Queen’s Hospital Burton. During the inspection we found the risk register had not always been maintained as there were old risks which had not been closed. Risk and governance leads for Royal Derby Hospital told us the risk register had been used but old risks had not always been updated and closed.

Service leads said they would review the risk register and close any risks that were no longer valid.

At the time of our inspection there was an obstetric lead for risk, one band 7 midwifery risk lead and two band 6 risk midwives trust wide. Staff told us all incidents were reviewed by matrons daily, if determined as no harm then were closed or escalated for investigation.

At Queens Hospital Burton and Samuel Johnson Community Hospital incidents were investigated by lead consultants. Staff held weekly multidisciplinary wash meetings where incidents were discussed. Action plans and learning were also discussed. If required incidents were escalated to the monthly clinical risk group meetings for discussion and action.

The risk lead consultant told us the service was now using the national standardised Perinatal Mortality Review Tool (PMRT) to support systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death. The lead and staff held round table reviews of all stillbirths to look at the circumstances and to discuss improvements to be made.

The service did not have an automated dashboard. The trust had planned for Burton based service to have the same dashboard as the Derby based service from May 2019. In the meantime, managers were manually extracting figures from the electronic recording system which was open to human error and time consuming. The dashboard was reviewed at the monthly labour ward forum.

The antenatal clinic had staffing issues which had been the case for several months. This had left managers less time to complete management tasks. Leaders were aware of the issues and were working towards interim and longer-term solutions.

Information management

The trust’s systems to collect, analyse and manage information did not support staff in their roles. The trust did have secure electronic systems with security safeguards.

The maternity service collected data around women’s activity and outcomes. Service performance measures were reported and monitored through the maternity dashboard staff completed. However, the service did not have an automated dashboard. An update to an existing system had caused problems with staff being able to produce outcome data. Staff had to rely on the birth register to extract the required figures. The trust had planned for Burton based service to have the same dashboard as the Derby based service from May 2019.

Overall staff had access to the information they needed to undertake their roles effectively. However, guidelines for the Burton sites were not easily available and accessible through the trust’s intranet site. Staff we spoke with could only access the guidelines for Royal Derby Hospital.
Staff had access to the women’s records and diagnostic tests they needed in a timely way. Arrangements to ensure the confidentiality of identifiable data were robust. Across all clinical areas we saw medical records were always secured in a locked trolley or stored in a secure area where staff were working.

**Engagement**

The service engaged well with women, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Managers told us staff were involved in change processes. There were various task and finish groups involving senior midwives, midwives and maternity support workers.

Managers sent out a governance newsletter and emails to staff to update them on any developments. A matron told us if there was a change in policy managers sent out emails to staff, it was discussed at staff handovers and displayed on staff notice boards. We saw in the staff room there was information displayed for staff such as safeguarding team details, how to recognise child sexual abuse and exploitation and a list of staff champions.

Staff we spoke with did not fully understand the plans for the service or the changes which had been implemented since the acquisition. Leaders for the service said that cross site working for managers was a challenge and they continued to improve how this worked, including communication about the service’s developments.

Wards and departments held staff meetings on a regular basis, to share learning and highlight areas for improvement.

The service provided support for staff including a staff wellbeing programme. The service had hosted a health and wellbeing day which staff were enthusiastic about. During the day staff received information on healthy eating, exercise, smoking cessation and could have blood pressure checks. Complimentary therapies were offered such as chair yoga and relaxation.

The service worked with Maternity Voices Partnerships, which was established to listen to women and families to gain feedback the service could use to make improvements. It is a working group of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of maternity care.

Women’s feedback was generally obtained through the NHS Friends and Family test. We saw there were secure boxes on wards where people could post feedback. Wards displayed thank you cards from women and members of the public to share positive feedback with staff and people visiting the ward.

Staff had displayed facts for visitors on display boards in the labour suite at Queen’s Hospital such as the number of water births, inductions and normal deliveries.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

We saw there was a range of information on the trust’s website, which gave women information about all aspects of the women’s journey antenatal, labour and postnatally as well as health promotion and practical advice. It included a video tour which was available with subtitles in a variety of languages.
The service had developed mandatory PROMPT training for staff in partnership with another trust. The programme had made the sessions more interactive and engaging for staff and were very relatable to clinical practice.

Two midwives were completing scanning training to support sonographers and prevent delays for women. Staff saw this as a very positive development for the service as sonographers were hard to recruit.
University Hospitals of Derby and Burton NHS Foundation Trust was formed on 1st July 2018 by the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust. The latter trust acquired the former under its existing registration with the CQC. As such, our legal position is that the acquired trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because this data relates to the same legal entity as the merged trust it is used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity, we expected the trust to be able to demonstrate how they responded to the data to improve services.

Children’s and young people’s services are provided at the Royal Derby Hospital and the Queen’s hospital, Burton. At this inspection, which took place from 5 to 7 February 2019, we looked at services at the Queen’s hospital, Burton and this report relates to children’s and young people’s services at the Queen’s hospital.

Queen’s Hospital Burton

Queen’s Hospital Burton has 39 inpatient paediatric beds:

- Neonatal unit: 14 beds
- Ward 1 (paediatrics): 11 beds
- Ward 1 (paediatric triage assessment unit): six beds
- Ward 2 (paediatrics): eight beds

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Wards 1 and 2 were managed and staffed together and in many ways functioned as one ward. A band six nurse was always allocated to each of the wards.

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. It is provided for contextual purposes and is not used to form part of our judgement.

Burton Hospitals NHS Foundation Trust had 3,234 spells from October 2017 to June 2018.

Emergency spells accounted for 95% (3,085 spells), 4% (130 spells) were day case spells, and the remaining 1% (19 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from October 2017 to June 2018, Burton Hospitals NHS Foundation Trust.
Total number of children’s spells by site, Burton Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen’s Hospital Burton</td>
<td>3,234</td>
</tr>
<tr>
<td>This trust</td>
<td>3,234</td>
</tr>
<tr>
<td>England total</td>
<td>1,125,915</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

University Hospitals of Derby and Burton NHS Foundation Trust

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because this data relates to the same legal entity as the merged trust it is used to form part of our judgement.

University Hospitals of Derby and Burton NHS Foundation Trust had 8,726 spells from October 2017 to September 2018.

Emergency spells accounted for 53% (4,640 spells), 41% (3,614 spells) were day case spells, and the remaining 5% (472 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from October 2017 to September 2018, University Hospitals of Derby and Burton NHS Foundation Trust.
Total number of children’s spells by site, University Hospitals of Derby and Burton NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Derby Hospital</td>
<td>7,488</td>
</tr>
<tr>
<td>Burton Hospital</td>
<td>1,238</td>
</tr>
<tr>
<td>This trust</td>
<td>8,726</td>
</tr>
<tr>
<td>England total</td>
<td>1,125,915</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Managers provided mandatory training in key skills to all staff and made sure everyone completed it. Although compliance data provided by the trust showed completion did not always meet the 90% target set by the trust, particularly in relation to medical staff, the overall completion rate was over 80%.

Mandatory training completion rates

Queen’s Hospital Burton

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all mandatory training.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in children’s services at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>57</td>
<td>57</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>European paediatric advanced life support</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>56</td>
<td>57</td>
<td>98.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>56</td>
<td>57</td>
<td>98.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (collection)</td>
<td>30</td>
<td>31</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>30</td>
<td>31</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>55</td>
<td>57</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>55</td>
<td>57</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory (nursing)</td>
<td>51</td>
<td>53</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>18</td>
<td>19</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (administration)</td>
<td>100</td>
<td>106</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>50</td>
<td>53</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Qualified nursing staff in children’s services at Queen’s Hospital Burton had an overall mandatory training completion rate of 93.8%. The hospital’s training targets were met for 19 of the 23 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for medical staff in children’s services at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion theory (doctors)</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (full evacuation)</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>13</td>
<td>17</td>
<td>76.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Doctors manual handling awareness</td>
<td>13</td>
<td>17</td>
<td>76.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>European paediatric advanced life support</td>
<td>11</td>
<td>15</td>
<td>73.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>11</td>
<td>15</td>
<td>73.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>12</td>
<td>17</td>
<td>70.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>12</td>
<td>17</td>
<td>70.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in children’s services at Queen’s Hospital Burton had an overall mandatory training completion rate of 80.2%. The hospital’s training targets were met for three of the 17 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The senior management team told us the number of divisional audit days had been increased to enable staff to take time out of clinical duties, to ensure they could complete their mandatory training. This would enable the rates of completion to increase. Completion of mandatory training was reviewed at staff’s annual appraisals.

Managers ensured staff completed paediatric life support training. All medical and nursing staff
had completed paediatric basic life support training. In addition, 100% of nursing staff working in children’s services and 73% of paediatric medical staff had completed European paediatric advanced life support training. Theatre staff worked with both adults and children. All nurses and operating department practitioners in theatre completed paediatric basic life support and staff working in recovery completed a paediatric competency pack that included children's airway management.

Staff were not provided with specific training about learning disability or autism. The nursing leadership team told us the emphasis was on asking individual parents and children what was important to them. However, a workshop was held on the Derby site with parents of children with special educational needs and disabilities, and from this a video was produced entitled “Small things make a big difference.” It had been used to raise awareness of staff about the things they could do to improve the experience of children with special educational needs and disabilities in hospital and was starting to be shared across the other hospital sites including the Queen’s hospital.

Safeguarding

Staff understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. We observed good multi-disciplinary working and good liaison with other services such as social care, in relation to child protection.

Safeguarding training completion rates

Queen’s Hospital Burton

Staff at Queen’s Hospital Burton had a mandatory training target of 90% for all safeguarding training modules.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in children’s services at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent awareness</td>
<td>57</td>
<td>57</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>57</td>
<td>57</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>57</td>
<td>57</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>55</td>
<td>57</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>55</td>
<td>57</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>52</td>
<td>57</td>
<td>91.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in children’s services at Queen’s Hospital Burton had an overall safeguarding training compliance rate of 97.4%. The hospital’s safeguarding training targets were met for all six safeguarding training modules for which qualified nursing staff were eligible. A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for medical staff in children’s services at Queen’s Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 4</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff in children’s services at Queen’s Hospital Burton had an overall safeguarding training compliance rate of 78.1%. The hospital’s safeguarding training target was met for one of the seven safeguarding training modules for which medical staff were eligible. However, over 80% of medical staff had completed children’s safeguarding training at level 3.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The safeguarding team recognised the need to ensure staff, working in areas predominantly used by adults and where children were seen, completed safeguarding children training at level 3. This included the operating theatres, adult outpatient departments and radiology. We found key staff in each area had completed this training. The remaining staff had completed safeguarding children training at level 2 and were scheduled to receive level 3 training within the next 12 months when their training was due for renewal.

The safeguarding team had recently increased the availability of children’s safeguarding training and an online computer training package was due to be launched in March 2019 to improve uptake of training.

Awareness of child sexual exploitation was included in safeguarding training. Staff we spoke with showed a good awareness of these issues and were confident they would recognise possible indicators of child sex exploitation. We noted the admission assessment documentation included prompts to ensure these issues were considered. Similarly safeguarding training included awareness of female genital mutilation.

Information about safeguarding children was available on the trust intranet and in the clinical areas. We saw a variety of posters and displays about different aspects of safeguarding children designed for staff and patients.

The trust’s electronic patient record system enabled alerts to be put onto the system, when there were safeguarding concerns for a patient. In this way, staff could immediately identify when existing safeguarding concerns were identified and share information with other appropriate agencies about attendances and concerns.

The trust had a named doctor for child protection and named nurses. Staff reported that the named doctor and nurses were available for advice and provided a high level of support and leadership. A member of the safeguarding team attended daily medical handovers and safeguarding concerns were discussed. Staff told us safeguarding nurses visited or telephoned the wards and children’s outpatient department daily (Monday to Friday), to check for any concerns.

Staff were very clear about their responsibilities in relation to safeguarding children. They were aware of the procedures for reporting a concern and making a safeguarding referral. They told us they received a good level of feedback when they reported a concern and were well supported. For example, a nurse told us how the safeguarding team had supported them when they were required to complete a witness statement and had provided training to improve their knowledge of the requirements. Staff said the safeguarding team were very visible and accessible.

We spoke with a foster carer of a child and they told us staff were very sensitive in their approach, whilst subtly asking questions needed to check on safeguarding issues. They said staff had checked who had parental responsibility and contacted the relevant social services team in
We identified gaps in information about numbers of safeguarding referrals from the paediatric wards for two quarters in the year from April 2017 to March 2018. The safeguarding team told us this was due to the introduction of an electronic referral system by the local authority and difficulties in obtaining copies of the referrals made. This issue was being resolved by raising awareness of staff, of the importance of copying the referrals to the trust safeguarding team or naming the safeguarding team on the referral, as the point for feedback. The team were completing a retrospective audit of the documentation of children who had attended with specific injuries in this time frame, to check the correct referrals were made.

Managers told us safeguarding supervision was available for nurses and a monthly peer review meeting for medical staff was led by the named doctor. Every case was discussed at the meetings that were attended by all grades of medical staff. Feedback was provided and learning points discussed. Nursing staff confirmed they had access to safeguarding supervision on a six monthly basis. Managers told us the frequency of supervision was being increased to quarterly, following the recent appointment of additional safeguarding nurses.

**Cleanliness, infection control and hygiene**

**Staff controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**

There were no reported cases of MRSA or MSSA bacteraemia in children’s and young people’s services at the Queen’s Hospital from January 2018 to December 2018

**CQC Children and Young People’s Survey 2016**

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.93 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Parents we spoke with during the inspection, had no concerns about the cleanliness of the wards and clinical areas. We observed cleaning schedules were available in all areas and staff completed checklists that showed daily cleaning of toys and games in each area was undertaken.

All areas were visibly clean including bed areas, bathrooms, toilets and play areas. We observed that toys were made of materials that were easily cleaned. Domestic staff were present during the inspection and showed a good understanding of the principles of infection prevention and control. Monthly environmental audits were completed to assess the cleanliness of the ward environment. The trust reported 100% compliance in January 2019 for the paediatric wards, we did not see results for the neonatal unit or children’s outpatient department.

We observed staff adhering to good hand hygiene practices. They were ‘bare below the elbows,’ washed their hands or used hand sanitising gel, before and after each patient contact. Parents commented that staff were very good at remembering to wash their hands. Evidence provided by the trust’s infection prevention and control team showed the paediatric wards scored 100% in
their hand hygiene audit in January 2019. We did not see results for the neonatal unit or children’s outpatient department.

We were told the infection prevention and control team completed regular audits of compliance with infection control practices, such as care of cannulas inserted to provide intravenous fluids and medicines. However, the trust did not provide us with the results of these audits.

**Environment and equipment**

*Children’s services were provided in suitable premises, had appropriate equipment and looked after them well. However, the environment with the theatre recovery area was not ideal for children, as they were separated from adults only by a curtain. We also identified an issue with secure exit from the children’s wards, which the trust also identified independently and took action to address.*

The children’s wards and the neonatal unit had secure entry systems. Staff were able to enter using an electronic card entry, while visitors were required to use a telephone at the entrance to each area. This was answered by nursing staff and people’s identity was checked prior to entry. This meant staff had control over people entering the unit. However, the system had a switch that released the door lock near to the exit point on the paediatric wards, allowing people to leave without the knowledge of staff. The trust identified this when we raised a concern about a similar situation in another area and confirmed they were taking action to change the entry system and had placed the risk on the risk register.

The children’s outpatient department did not have a secure entry system; however, the main reception desk was manned when the department was open and all people entering the department were monitored and checked by the receptionist, or other staff, if the receptionist had to leave the reception desk. The department was entered through a gate and in this way people were not able to enter or leave without staff at the reception desk knowing. Parents stayed with their child throughout their time in the outpatient department.

Ward 1 had a six bedded bay and the remainder of the beds were provided in side rooms. Ward 2 consisted single side rooms and one double room. As a result, single rooms were available for those patients with infections and the accommodation was flexible enough to accommodate adolescents or young babies in single rooms if they wished. There was also space for a parent to stay by the bedside if they wished. Ward 1 included a six bedded paediatric assessment unit and the ward also had a treatment and stabilisation room for very sick children. There was piped oxygen and suction to every bed space on the wards and in the assessment unit. The treatment and stabilisation room was fully stocked with emergency equipment and drugs, appropriate for babies, children and adolescents. We noted the door to the room was not secured with a key pad or key operated lock. It was situated by the nurses station, therefore if an unauthorised person accessed it, a member of staff would probably identify it; however, there were sharps and intravenous fluids accessible within the room. We discussed this with staff and the nursing leadership team. They told us that as the resuscitation trolley and other emergency equipment was stored in the room to prevent access by children on the ward and that a key pad lock would delay access to these in an emergency. They agreed to complete a risk assessment of this area to explore whether security could be increased. Following the inspection, the trust confirmed a risk assessment was in place. In addition, a lockable cupboard was awaiting shelving and would be used to store sharps and intravenous fluids.

The floor print of the neonatal unit was on the divisional risk register, because there was a risk of non-compliance with the central newborn network standards, as the layout of the unit reduced the visibility of patients by staff on occasions when the unit was full to capacity. The trust was mitigating the risk by following the network recommendations for staffing on the unit. The senior management team had developed plans for a new neonatal unit and were submitting a capital bid...
for funding.

The paediatric wards and the neonatal unit had facilities to make hot drinks within a parents’ room. Children and babies were not allowed in the room and parents were provided with lidded containers for hot drinks if they wished to bring them into the ward, to reduce the risk of scalds.

The children’s wards and the neonatal unit had the beds and equipment required to keep children and babies safe. Staff told us they had good access to the equipment they needed. Specialised beds for children with complex needs were available when required.

The operating theatres had sufficient paediatric equipment to maintain safety. One theatre was identified and was predominantly used for children’s surgery. Royal College of Anaesthetists (RCA), guidelines for the provision of anaesthesia services (2019) state that, “Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a solution.” At the Queen’s hospital, children shared the same recovery area as adult patients. One bed space was allocated for children. It was decorated with a fairy story mural and the children’s emergency airway trolley was situated by the bed space. Separation was achieved by using bed curtains to screen the space. Compliance with the RCA guidelines was therefore achieved, but it was not ideal. Some adult patients were delayed for several hours in recovery due to ward capacity issues and therefore were fully awake and could be mobile when still in recovery.

All new medical equipment was delivered through the medical engineering department and entered onto an asset management database. A maintenance plan was established for all items and entered on the database; the equipment was labelled with the equipment number and the next service due date.

The trust reported that all clinical areas were visited annually to complete servicing and identify any items not on the inventory. We checked 40 pieces of equipment in the clinical areas and found they were all serviced and tested for electrical safety, in line with requirements.

Each area had a resuscitation trolley and/or an emergency grab bag, with resuscitation equipment and drugs. These were secured in areas away from the general public and had tamper proof tags to identify if any of the equipment had been accessed. Daily checks were kept of the emergency equipment in the paediatric wards, neonatal unit, children’s outpatient units and operating theatres. Child and baby sized equipment was provided. The operating theatres had a paediatric resuscitation grab bag and paediatric emergency drug box. The recovery area had an airway management trolley stocked for children and a paediatric resuscitation trolley. Daily checks were completed of each of these.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Early warning scores were used to identify deteriorating patients and staff took the necessary action when the scores indicated that escalation was needed.

Staff completed a full assessment of each patient when they were admitted. This included sepsis screening and vital signs observations. A paediatric early warning score (PEWS) was used to identify signs of deterioration in patients on the paediatric wards. The senior nursing leadership team told us staff in paediatrics at the Royal Derby hospital used a different early warning score designed for use in the emergency department and they were planning to introduce the use of one tool across the trust. A neonatal early warning score was not used on the neonatal unit.
We reviewed six patient’s observation charts on the paediatric wards and found PEWS was completed with every set of observations. One patient’s observation chart showed their PEWS had increased on a number of occasions indicating their condition was deteriorating and the escalation procedure should be followed. Records showed that the required actions were completed and the child was reviewed promptly by medical staff. The trust did not provide evidence of audits of PEWS.

Staff told us medical staff responded quickly when they escalated a deterioration in a patient’s condition. They told us they would have no hesitation in escalating a concern to a more senior doctor or consultant, if they felt it necessary. They said the consultants were happy to be contacted if they had a concern and would attend if required.

During the inspection, one child had a respiratory arrest and we observed staff responded quickly, calmly and effectively. Within seconds of the alarm being raised, medical and nursing staff were at the bedside and action was taken, with a positive outcome for the patient.

The trust used a national paediatric sepsis screening tool and the ‘Sepsis Six’ care pathway to ensure a systematic approach to the identification and treatment of sepsis. Staff received training when the pathway was introduced and it was incorporated into the induction for new staff. A member of staff on the paediatric wards told us they had responsibility for going through the tool with new members of staff and ensuring they were confident in using it. The trust also had a policy for the management of the neonate following prolonged rupture of membranes in pregnancy and early neonatal infection.

Registered nurses and medical staff in children’s services completed European paediatric life support training, thus ensuring there was always a member of staff on duty with the qualification. The neonatal unit had one intensive care bed and two high dependency unit beds. The paediatric ward did not have any allocated high dependency care beds; however staff had the competencies to care for high dependency children and did so until they could be transferred to a high dependency facility.

A policy for the transfer of the critically ill babies, children and young people, was in place (dated June 2017). It provided clear criteria for patients for transfer to other hospitals and the process to be followed.

The trust had access to a children’s and neonatal intensive care decision support and neonatal transfer service to provide advice and management of children and neonates requiring intensive care. Staff told us the team provided an excellent source of advice and support, identifying the most appropriate facility for the patient and attending to manage the transfer of the patient when necessary. During the inspection, a child initially required continuous positive airway pressure (CPAP), a form of ventilation and later required full ventilation. Staff contacted the service; they provided advice and attended to transfer the patient. A paediatric consultant and anaesthetist stayed with the child until transfer.

Children’s services at Queen’s hospital provided mostly medical care and a small amount of planned surgery. Children requiring an admission or a day case bed were cared for on the paediatric ward. The trust did not provide children’s emergency surgery overnight and children requiring emergency surgery were transferred to the Royal Derby hospital or a neighbouring specialist children’s hospital. However, not all children who required emergency surgery were transferred out overnight, just any complex surgery, or those that required specialist intervention / care.

We followed the pathway of a patient requiring ear nose and throat surgery and also a patient requiring sedation for an investigation. Staff completed pre-operative safety checks prior to the child being transferred for surgery or investigation and checks were repeated as required when the
patient reached the operating theatres. We observed staff adhered to the World Health Organisation checklist for safer surgery.

The trust had developed local safety standards for invasive procedures (LocSSIPs) based on the national safety standards for use in theatres and other areas where invasive procedures were undertaken. These standards were designed to improve safety and reduce harm and were based on best practice. A summary booklet was provided to all staff and staff we spoke with showed a good understanding and awareness of the LocSSIPs.

Staff were able to access the children’s and adolescent mental health service (CAMHS) for advice when children and young people with mental health needs attended. Staff told us that provided they contacted the service before 11am, patients could be seen on the same day. Information about how to contact the service out of hours was provided in a CAMHS information folder kept on the paediatric wards.

CQC Children and Young People’s Survey 2016

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.42 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.39 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nurse staffing

Children’s services had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Queen’s Hospital Burton

The trust reported their staffing numbers by department for qualified nurses in children’s services at Queen’s Hospital Burton below for the period from April 2017 to March 2018 and from November 2017 to October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Paediatric diabetes</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Paediatric clinic</td>
<td>0.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Neonatal unit</td>
<td>19.4</td>
<td>21.1</td>
</tr>
</tbody>
</table>
Within children’s services at Queen’s Hospital Burton, there was an overall nursing staffing level of 85.0% from November 2017 to October 2018, with a deficit of 8.4 WTE nursing staff. This staffing level was lower than the previous period, April 2017 to March 2018, when it was 91.4%.

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

Vacancy rates

Queen’s Hospital Burton

From November 2017 to October 2018, the trust reported a vacancy rate of 11.0% for qualified nursing staff working in children’s services at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

The breakdown by department was as follows:
- Paediatric diabetes: 33.5%
- Paediatric clinic: 16.7%
- Ward 1: 13.5%
- Neonatal unit: 12.7%

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

Turnover rates

Queen’s Hospital Burton

From November 2017 to October 2018, the trust reported a turnover rate of 9.9% for qualified nursing staff working in children’s services at Queen’s Hospital Burton. This was within the trust’s target of a turnover rate between 8% and 12%.

The breakdown by department was as follows:
- Paediatric assessment unit: 38.7%
- Neonatal unit: 22.5%
- Paediatric diabetes: 0.0%
- Ward 1: 0.0%
- Paediatric clinic: 0.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Queen’s Hospital Burton

From November 2017 to October 2018, the trust reported a sickness rate of 5.7% for qualified nursing staff working in children’s services at Queen’s Hospital Burton. This was higher than the trust’s target rate of 3.8%.

The breakdown by department was as follows:
- Neonatal unit: 6.5%
- Ward 1: 5.5%
- Paediatric assessment unit: 5.4%
- Paediatric clinic: 2.7%
- Paediatric diabetes: 1.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Queen’s Hospital Burton

The trust provided bank and agency staff usage data for qualified and unqualified nursing staff in children’s services.

From November 2017 to October 2018, the trust reported that 8.9% of qualified nursing hours in children’s services at Queen’s Hospital Burton were filled by bank staff and 1.4% by agency. In addition, 1.3% of qualified nursing staff hours were not filled by bank or agency staff to cover qualified nursing staff absence.

Over the same period, the trust reported that 3.2% of unqualified nursing staff hours at Queen’s Hospital Burton were filled by bank staff, while no hours for this staff group were filled by agency staff. There were 1.5% of unqualified nursing staff hours that were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Agency</th>
<th>Unfilled</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
<td>Hours</td>
<td>%</td>
</tr>
<tr>
<td>Qualified</td>
<td>9,164.5</td>
<td>8.9%</td>
<td>1,424.0</td>
<td>1.4%</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>1,053.0</td>
<td>3.2%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>10,217.5</td>
<td>7.5%</td>
<td>1,424.0</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

At the time of the inspection, the paediatric wards reported no nursing vacancies. The senior sister and senior nursing team told us they normally achieved the Royal College of Nursing recommendations for nurse staffing in paediatric wards, including a 70:30 registered to unregistered staff ratio. There was a minimum of two registered children’s nurses on duty at all times on the wards. There was access to a senior nurse for advice at all times throughout the 24-hour period.

Staff told us that it was unusual to need to use agency staff on the paediatric wards; when temporary staff were required, the trust’s own bank staff were used or cover was obtained from another paediatric area.

The neonatal unit had a 0.6 whole time equivalent vacancy and four staff on long term leave of absence. They faced challenges in recruiting specialist neonatal nurses and were exploring ways to attract staff to the unit. The senior nursing team told us they were planning to introduce an initial rotation covering the Royal Derby hospital and the Queen’s hospital to improve recruitment for new recruits. In the meantime, agency staff were utilised to cover the unfilled shifts. Staff told us the agency nurses were provided with an induction and there were a limited number of agency staff who attended the unit regularly and therefore were familiar with the unit and procedures. This enabled them to meet the recommended staffing levels.

The trust completed regular audits to check staffing levels met the national standards for staffing.
neonatal units produced by the British Association of Perinatal Medicine. These specify one to one care for intensive care patients, one registered nurse to two patients for high dependency care and one registered nurse to four patients for special care. These standards were met 97% of the time at the Queen's hospital.

Staff on both the paediatric wards and the neonatal unit told us they felt there were generally enough staff on duty to provide the care patients required and staffing levels were never unsafe. Patients told us they felt staffing levels were good and staff were available to provide care and support when needed.

When we visited the children’s outpatient department, a member of staff from the ward was providing support due to the absence of two regular members of staff. The department had core staffing levels, however, at times the number of clinics created minor delays and staff told us staffing levels were “tight.” A member of staff told us the staffing levels were being reviewed following the acquisition. The play specialists covered the outpatient department in addition to the wards; however, staff told us they were not always available to provide input when it was needed due to the pressures on the wards.

Medical staffing

**Children’s services had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

**Queen’s Hospital Burton**

The trust reported their staffing numbers for medical staff in children’s services at Queen’s Hospital Burton below for the period from April 2017 to March 2018 and from November 2017 to October 2018. A breakdown of medical staff numbers by department was not provided.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>14.1</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Within children’s services at Queen’s Hospital Burton, there was an overall medical staffing level of 72.5% from November 2017 to October 2018, with a deficit of 6.9 WTE staff. This staffing level was higher than the earlier period, April 2017 to March 2018, when it was 56.5%.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

**Queen’s Hospital Burton**

From November 2017 to October 2018, the trust reported a vacancy rate of 34.5% for medical staff working in children’s services at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

*(Source: Routine Provider Information Request (RPIR) - Vacancy tab)*

**Turnover rates**

**Queen’s Hospital Burton**
From November 2017 to October 2018, the trust reported a turnover rate of 56.3% for medical staff working in children’s services at Queen’s Hospital Burton. This was higher than the trust’s turnover target of between 8% and 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Queen’s Hospital Burton

From November 2017 to October 2018, the trust reported a sickness rate of 1.9% for medical staff working in children’s services at Queen’s Hospital Burton. This was lower than the trust’s target rate of 3.8%.

(Source: Routine Provider Information Request (RPIR) - Sickness)

Bank and locum staff usage

Queen’s Hospital Burton

The trust provided bank and locum staff usage data for medical staff in children’s services at Queen’s Hospital Burton.

From November 2017 to October 2018, the trust reported that no medical staff hours in children’s services at Queen’s Hospital Burton were filled by bank staff. There was 2.7% of agency staff usage while 40.3 hours (0.1%) were not filled by bank or locum staff to cover staff absence.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>Hours</td>
<td>Hours</td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>0.0</td>
<td>1,425.0</td>
<td>40.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

In September 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 77 Whole Time Equivalent staff working in children’s services at University Hospitals of Derby and Burton NHS Foundation Trust

<table>
<thead>
<tr>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>39% 42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>6% 7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>43% 45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12% 6%</td>
</tr>
</tbody>
</table>
The senior management team and individual medical staff told us there was a full complement of medical staff at the time of the inspection. They were unaware there was a slightly lower proportion of consultants and a slightly higher proportion of junior medical staff than the national average; however, they told us the consultant rota worked well and was manageable.

The service operated a “service week” rota for consultant paediatricians. As a result, a named consultant took overall responsibility and conducted twice daily ward rounds on the paediatric wards and neonatal unit and provided a on call service out of hours. The consultant was on site between the hours of 9am and 2pm at the weekend and was on call outside these times. They completed ward rounds at weekends. This meant a consultant paediatrician was available in the hospital during times of peak activity seven days a week. It also ensured every child admitted to a paediatric ward with an acute medical problem was seen by a consultant within 14 hours of admission.

The paediatric assessment unit based on ward 1 operated 24 hours a day. There was access to a consultant on call out of hours.

There were medical handovers three times in every twenty-four hours with consultant presence at two of the handovers. We observed a medical handover and found there was a robust discussion of each patient and the plan for the patient; safeguarding issues were also discussed.

Middle grade doctors (specialist registrars) and junior doctors, told us their rota was compliant with the UK working time regulations and European working time directive. A registrar covered the paediatric wards and a separate registrar covered neonates out of hours. This provided a good level of cover and meant they did not experience a conflict if an emergency or deteriorating patient situation occurred in both areas. All grades of medical staff told us they received a good level of support from the consultants, who were always available and happy to attend when needed. One doctor said, “The consultants are very hands on; the rota cover is good.”

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Paediatric medical staff used paper based records in contrast to the electronic record used by other staff; although this interrupted the continuity of the record, it did not cause any impact on patient care.
The trust used an electronic health record, on which most of the patients' health records were stored. The exception was the daily medical staff plan and notes for the patient for the current admission, which was paper based and was scanned into the health record retrospectively. If an agency nurse was not allocated a password and therefore was unable to log into the system, they completed their daily records in the medical notes and a permanent member of staff inserted a note into the electronic record stating where the notes could be found.

Staff in the outpatient department told us patient paper records were sent to them a week prior to the patient's appointment and they checked prior to the clinic to ensure all the records needed were available. They confirmed what the trust told us in their provider information return, that records were rarely unavailable and if a paper record could not be found, it was possible for the patient to be seen, as most of the record was now held electronically.

The electronic patient record included alerts to identify when a patient had special needs such as a learning disability, or where there were child protection concerns. This was widely understood by staff and they checked the alerts on the system when patients attended the hospital and used the information to plan and implement the patient’s care.

Nursing records in children's services contained a full assessment of the patient including risk assessments and care plans. We checked eight nursing records. These were up to date and contained the sufficient detail about each patient’s care needs. Observation charts were completed to the frequency identified in the record and were clear. Medical records contained a clear plan for the patient. Staff adhered to professional standards for record keeping. All the records we reviewed were legible and completed in black ink; the date and time of the entry was recorded, along with the name, designation and signature of the person making the entry.

Medical staff completed care summaries that were sent to the patient's GP on their discharge. Most discharge summaries were sent electronically and when it was not possible to send a summary electronically, a paper copy was sent by post. A copy of the discharge letter was given to the parents, to enable this to be given to a medical professional in the event they did not have access to the electronic letter.

**Medicines**

**Staff followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.** We found an example of good practice in relation to medicines awareness, in that safety huddles ('druggles') were held monthly in children's services to improve safety of medicines management.

An electronic medicines system was used to prescribe, order and administer medicines. This enabled pharmacists to check prescriptions and provide prescribing advice promptly. The child’s weight was recorded on the system to enable the appropriate doses of medicines to be given according to the child’s size. Staff were unable to prescribe without recording the patient's weight. Known allergies were recorded and the child was provided with a red wrist band when they had an allergy, to act as an alert to staff when administering medicines. This was in accordance with national guidance on the use of wrist bands to identify patients.

We checked six medicines charts and found they were completed appropriately. Most of the prescriptions for antibiotics contained the necessary details to ensure good prescribing practice was followed, however, the stop or review date for antibiotics was not recorded in two of the six charts we checked.

Patients and parents told us staff always checked the child’s identity by asking their name and date of birth and checking their wrist band before administering medicines. A parent told us staff
checked the last time their child had been given paracetamol by them prior to admission, to ensure the correct gap was left between administration when they were first admitted. We observed staff wore red tabards when administering medicines to discourage interruptions as it is recognised that this can be a contributory factor in medicines errors.

Medicines were stored safely in locked facilities and the temperature of the room and refrigerators used to store medicines were recorded daily. We noted the temperature of the room used to store medicines on the paediatrics wards had registered above the recommended limits on some occasions in the past. Staff had reported this to pharmacy staff and the shelf life of the medicines had been reduced by six months as a precaution. We observed the new expiry dates were clearly identified. It was also reported to the maintenance department and it was identified that air conditioning facilities were required. However, we were told this was a trust wide issue. The risk was identified on the divisional risk register and we were told it was being addressed at a trust level.

Liquid medicines were labelled with their date of opening in line with good practice. Intravenous fluids were stored in individually labelled storage and potassium containing fluids were stored separately. Controlled drugs were stored correctly and daily checks of stock were completed and documented. We checked a sample of controlled drugs and found they corresponded with the ward records. We also checked the expiry date of other medicines and found they were all within their expiry date.

A pharmacist visited the wards most weekdays to provide advice and check medicines prescribed. A junior doctor told us they received good support and advice from the pharmacists. Staff told us the pharmacist also facilitated the timely supply of discharge medicines for the patient to take home. A stock of commonly used discharge medicines was stored on the ward to enable ward staff to provide these for patients when necessary to reduce delays to discharge. The required checks were in place to ensure these were provided safely.

A monthly safety huddle was led by a pharmacist to raise awareness and highlight issues pertinent to the prescribing and administration of medicines in children’s services. This was referred to by staff as a ‘druggle’. The druggle was accompanied by a single page summary of the issues discussed, in a newsletter format. We saw the most recent druggle had included incidents and prescribing issues with learning from them, advice on sodium valproate prescribing in teenage girls, neonatal drug doses and medicines on discharge for example.

Incidents

Patient safety incidents were managed well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Queen’s Hospital Burton

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition as well as data for University Hospitals of Derby and Burton NHS Foundation Trust post-acquisition. It is provided for contextual purposes and it is not used to form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a
never event.

From January to December 2018, Queen’s Hospital Burton reported no incidents classified as never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Queen’s Hospital Burton

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition as well as data for University Hospitals of Derby and Burton NHS Foundation Trust post-acquisition. It is provided for contextual purposes and it is not used to form part of our judgement.

In accordance with the Serious Incident Framework 2015, Queen’s Hospital Burton reported no serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from January to December 2018.

(Source: Strategic Executive Information System (STEIS))

The trust used an electronic incident reporting system, to report and manage incidents. Staff were familiar with using the system and told us they received feedback about incidents they reported. They felt confident to report concerns and incidents.

Band six and seven staff told us they reviewed all incidents and cascaded learning from incidents. Staff told us they received feedback with learning from incidents in a variety of forms. They said they were told about changes to practice as a result of incidents, at handover, by email, in newsletters and in ward meetings. Nursing staff told us that in addition to verbal communication at handover, feedback was also incorporated in the handover summary sheets for staff. Medical staff also reported an open approach to reporting incidents and they received good feedback on learning from incidents. They said learning from incidents was disseminated in their protected teaching sessions.

Staff were able to demonstrate their awareness of learning from a range of incidents in paediatrics at the Queen’s hospital and at other trust hospital sites. For example, they told us about the introduction of safety cannulas to reduce the incidence of needlestick injuries, and the additional measures in place to cap the piped air supply, with new checks on the oxygen supply, as a result of incidents related to the use of air rather than oxygen previously.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a trust policy relating to duty of candour, which outlined actions to be taken when something went wrong.

Medical and nursing staff were aware of the duty of candour and their responsibilities in relation to this. They told us they were always open and honest with patients and apologised to them when things went wrong and applied this to all incidents.

Paediatric morbidity and mortality meetings were held every two months. Minutes indicated good attendance; a full discussion of the cases took place and learning points were identified.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide
immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from November 2017 to November 2018 for children’s services.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Staff were working towards accreditation of their services with external organisations that promoted best practice in the care of babies.

Staff had access to information about best practice in the form of national and local clinical policies and guidelines. Staff told us they accessed clinical guidelines on the trust intranet and we observed results of audits, local and national guidance were displayed widely in the clinical areas. For example, we saw the pre-operative fasting guidelines displayed on the paediatric wards, the East Midlands neonatal operational delivery network care pathway, displayed on the neonatal unit, and the local pathway for hearing loss displayed in a consulting room in the children’s outpatient department.

The Trust held a monthly NICE working group to coordinate the approach to the review, implementation of, and compliance with, NICE guidelines. This enabled the appropriate parties to ensure the review of and implementation of all relevant NICE guidelines, both new and existing, recognising the requirement to evidence compliance in line with best practice.

The trust provided us with evidence of clinical audits completed to assess compliance with national and local guidelines. For example, they completed an audit to explore the role of CXR in the management of children with respiratory infections and compare practice with the British Thoracic Society guideline for the management of community acquired pneumonia in children (2011 update), NICE guideline, Fever in Under 5s: assessment and initial management (NICE 2013) and NICE guideline Bronchiolitis in children, diagnosis and management (NICE 2015). The audit identified that some chest X rays completed were not clinically indicated and the results did not change the management of the child. The results were presented and discussed to encourage changes to practice.

An audit of the management of neonatal jaundice was completed that compared practice with NICE Clinical Guidance [CG98] Jaundice in newborn babies under 28 days. (Updated October 2016) was completed in 2018. Areas of good practice and those for improvement were identified, and an action plan was developed with a plan to re-audit 9n 12 to 24 months.

An audit of the management of babies born to hepatitis B positive mothers compared with national and local guidance was completed. The results were presented in August 2018. However, it was unclear as to whether the audit looked at practice at the Queen’s hospital or the
The neonatal unit were in the final stages of working toward accreditation with BLISS a charity for premature and sick babies. To achieve accreditation neonatal units must demonstrate they have embedded a high quality approach to family-centred care following the Bliss baby charter principles. Staff were expecting a final assessment within the next six months.

The trust were also working towards accreditation with the UNICEF baby friendly initiative.

The trust had access to child and adolescent mental health services (CAMHS) for children and young people who had mental health problems. A folder on the wards provided information for staff including a deliberate self-harm pathway, increased supervision care bundle, and other information, for staff.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences. However, fluids were sometimes withdrawn prior to surgery for longer than necessary for the well-being of the patient.**

Patients on the paediatric wards told us they received enough to eat and drink and a parent commented on the good choice of food appropriate for children, which encouraged their child to eat when otherwise they might be reluctant. Parents of babies said staff went out of their way to ensure they had access to the type of milk they used at home and were familiar with.

The trust had a pre-operative fasting clinical guideline that promoted minimum fasting times prior to surgery. The guideline indicated that patients could drink clear fluids until two hours prior to their surgery. However, we spoke with two children who were recovering from their operations, and their parents; they had both been instructed not to drink for two hours prior to their admission at 7.30am. They went to theatre at 12 midday or later, which meant they were without fluids for 4.5 hours or more. Both children were offered a choice of food and drink when they returned from theatre and were appreciative of the choices they were given.

Facilities were available on the neonatal unit to enable mothers to breast feed or express their breast milk for their baby. The trust encouraged breast feeding and parents told us they had been supported to breast feed; although they felt able to make their own decisions about this.

Staff completed nutritional assessments and developed individual care plans for patients to ensure their nutritional needs were identified and addressed. All patients were weighed on admission and their weight recorded and assessed against national norms.

Patients had access to a dietitian when required. A dietitian attended multi-disciplinary clinics for patients with long term conditions such as diabetes.

Drinks and snacks were available in the main hospital, a short distance from the children’s outpatient department.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate by using suitable assessment tools and gave additional pain relief to ease pain. Staff on the neonatal unit completed audits of pain assessments over two, two-month periods and showed improvements in the second audit following the implementation of actions from the first audit.**
Staff used assessment tools appropriate to the age of the patient to enable them to assess patient’s pain. On the paediatric wards staff used pain scales and a series of sad and happy faces to enable patients to communicate the amount of pain they were experiencing. The neonatal unit used a recognised neonatal pain assessment tool to assess pain in babies on the unit. Patient records we checked showed that patient’s pain was assessed with their vital signs observations.

Children we spoke with said staff kept asking them about their pain and they gave them medicines for their pain. They told us staff came back and checked after they had given the medicine, to make sure it had been effective.

Staff on the neonatal unit completed an audit of pain management in 21 patients from June 2018 to July 2018. They identified that 92% of assessments were completed; however, when babies exhibited signs of pain, their pain score was not always reviewed within an hour. Actions undertaken following the audit focused on raising awareness of the importance of pain assessments. The audit was repeated in October 2018 and November 2018 and found that improvements had occurred in assessing and re-assessing pain.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Although previous performance in national audits were generally in line with or better than the national average, action plans to bring about further improvements were in place. Staff also carried out a range of local audits to assess patient outcomes.

**Paediatric diabetes audit 2015/16**

**Queen’s Hospital Burton**

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time.

The proportion of patients receiving all key care processes annually was 77.6%, which was a positive outlier compared to a national aggregate of 35.5%. The previous year’s score was 23.1%.

The average HbA1c value (adjusted by case-mix) at the hospital was 69.1, which was within the expected range compared to a national aggregate of 68.3. The previous year’s score was also within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 65.0, which showed no clinically significant change compared to the national aggregate of 65.0 and the previous year’s score of 64.5.

(Source: National Paediatric Diabetes Audit 2015/16)

A member of staff told us the team were working to improve patient’s diabetes control as indicated by the HbA1c. One action in relation to this was to increase the availability of outpatient clinic time by putting on additional clinic, to enable closer monitoring of those patients with poorer control of their blood glucose levels.
It was also apparent from our discussions with medical staff, that additional audits to assess outcomes for diabetes care were being undertaken to identify where further quality improvements could be achieved. For example, audits of diabetes ketoacidosis and transitional care for young people moving to adult services. There were also plans in place to manage the implementation of NICE guidance in relation to the use of insulin pumps in qualifying patients.

**Emergency readmission rates within two days of discharge**

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition. We only provided this for contextual purposes and it is not used to form part of our judgement.

The tables below show the percentage of patients (by age group) who were readmitted following an elective admission. They display the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table. The data shows that from May 2017 to April 2018 there were no emergency readmissions after elective admission at this trust among patients in the under one age group while, for the one to 17 age group, no speciality had six or more readmissions.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from May 2017 to April 2018 there was a higher percentage of under ones readmitted following an emergency admission to paediatrics compared to the England average and a similar percentage of patients aged 1-17 years old readmitted following an emergency admission to paediatrics compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Burton Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.1%</td>
<td>1,923</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Burton Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.8%</td>
<td>3,323</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

Notes: These tables show the three treatment specialties at the trust with the highest volumes of readmissions; only those specialties where the trust had 6 or more readmissions recorded are shown in the tables.
No other speciality at this trust had six or more readmissions.

Notes: These tables show the three treatment specialties at the trust with the highest volumes of readmissions; only those specialties where the trust had 6 or more readmissions recorded are shown in the tables.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

Burton Hospitals NHS Foundation Trust

Data for the acquired Burton Hospitals NHS Foundation Trust are included in this analysis for the period up to the date of the acquisition. We only provided this for contextual purposes and it is not used to form part of our judgement.

From June 2017 to May 2018 the trust had no admissions for patients under one year old with a long term condition of asthma or diabetes. The trust had fewer than six multiple admissions for epilepsy within this age group and therefore the analysis has been suppressed in the table.

The trust performed similar to the England average for the percentages of patients aged 1-17 years old who had multiple readmissions for asthma and epilepsy. The trust had fewer than six multiple admissions for diabetes within this age group and therefore the analysis has been suppressed in the table.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years) (June 2017 to May 2018)
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Babies</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>*</td>
<td>32.9%</td>
</tr>
<tr>
<td>1 to 17</td>
<td>29.0%</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>27.4%</td>
<td>9</td>
</tr>
</tbody>
</table>

Notes: To protect patient confidentiality, figures between 1 and 5 and their associated proportions have been suppressed and replaced with “*” (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

The senior management team told us they had examined re-admissions in the under one year age group and identified that a proportion of these were admissions of babies who in the first few weeks after discharge from the post-natal ward. They were therefore focusing on the reasons for re-admission and exploring ways of reducing admission.

National Neonatal Audit Programme

Queen’s Hospital Burton

Data from the pre-acquisition period for Queen’s Hospital Burton NHS Foundation Trust are included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

In the 2017 National Neonatal Audit, Queen’s Hospital Burton’s performance in the four measures relevant to children and young people’s services was as follows:

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5°C-37.5°C?**

  There were 25 eligible cases identified for inclusion, of which 63.1% of babies had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

  This was within the expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

  The hospital did not meet the audit’s recommended standard of 90% for this measure.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

  There were 162 eligible cases identified for inclusion, of which 95.6% of babies had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission.

  This was better than expected when compared to the national aggregate where 90.5% of cases had the first consultation within 24 hours of admission.

  The hospital did not meet the audit’s recommended standard of 100% for this measure.

- **Do all babies <1,501g or a gestational age of <32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)?**

  There were 35 eligible cases identified for inclusion, of which 96.3% of babies with a weight of
<1,501g or a gestational age of <32 weeks at birth received the appropriate ROP screening.

This was within the expected range when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

There were 17 eligible cases identified for inclusion, of which 47.1% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

This was within the expected range when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

*(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

Trust leads identified key actions identified from the audit where practice could be improved. These included maternal steroids, temperature measurement within one hour of birth and follow up at two years of age. In addition, data quality issues were also identified. Actions taken to improve included, data entry training for the neonatal database given at induction. A local audit of temperature measurement was carried out to highlight reasons for poor compliance. Cases where mothers are not given steroids or magnesium sulphate when indicated were discussed with maternity services.

The trust provided us with evidence of the completion of a wide range of audits that had been undertaken to monitor and improve practice. Most of these, showed evidence that action plans were developed to bring about further improvements. It was not always clear whether the audits were undertaken at the Queen’s hospital or at the Royal Derby hospital; however, following the acquisition and the move to integrate governance processes, the senior management team expressed a commitment for learning to be transferred across the trust. The examples given below, were mostly completed by staff at the Queen’s hospital.

A local audit to look at weight loss in babies presenting to the paediatric assessment unit was completed in April 2018 and identified several areas of good practice and also identified areas for improvement.

Medical staff completed an audit of the diagnosis and management of Coeliac disease to assess compliance with the trust guideline and national guidance. It was a retrospective audit of documentation of patients being treated between 2011 and 2017. It identified good practice in most areas and areas for improvement were to encourage attendance at annual follow up appointments and adherence to dietary advice.

An audit of the use of food challenges for food intolerances and allergies was completed during 2018, to assess practice against expert review opinion and to develop a local guideline. This identified that practice closely mirrored expert review opinion. It identified areas that were important to include in the local guideline and additional instructions for inclusion in the appointment letter for parents.

The trust did not participate in the National Maternity and Perinatal Audit, a national audit of the NHS maternity and neonatal service in 2017, as it was unable to submit data during the data
collection period. However, data was collected during 2018 and submitted as per the audit protocol. The results of the 2017 audit were presented at clinical governance meetings to promote discussion about the standards and raise awareness.

The trust provided details on their ongoing programme of clinical audit for children’s services, which demonstrated a commitment to reviewing and monitoring patient care with the emphasis on improving outcomes for patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. However, staff working in adult outpatient departments where children were regularly seen, did not have any children’s training and found it difficult to access courses in caring for children.

Managers ensured staff completed competency assessments relevant to the areas in which they worked, when commencing work in children’s services. Staff told us they were encouraged to develop their skills and they did not feel pressurised to undertake further skills until they were confident they were competent. Two nurses working in different areas within children’s services told us they had received a good induction; they told us they felt well supported and were given the opportunity to develop their skills and competency.

Staff in children’s services and in the operating theatres completed European paediatric life support training. Staff working on the paediatric wards and the neonatal unit had the ability to manage a critically ill child for an extended period when there were delays in retrieval by the children’s transfer service. A paediatrician was available for immediate telephone advice for acute problems and they were on site seven days a week.

Staff in the adult outpatient departments where children were seen, did not have a children’s nursing qualification and had not completed a course in caring for children. We spoke with one nurse who regularly provided care to children in the adult outpatient department and they told us they had a special interest in caring for children. They said they had asked to undertake children’s training but this had not been progressed.

Appraisal rates

The trust set a target of 90% for the completion of non-medical staff appraisals. They noted that the medical staff appraisal target is set at 100% by the General Medical Council for those who are due an appraisal within a year (this does not include staff on long-term sick leave, end of life care leave or a sabbatical of greater than six months).

Trust Wide

From November 2017 to October 2018, 89.5% of required staff within children’s services at the trust received an appraisal. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare scientists</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>88</td>
<td>94</td>
<td>93.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>188</td>
<td>211</td>
<td>89.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. Qualified nurses had an appraisal rate of 90.9% which was just below the 90% target.

**Queen’s Hospital Burton**

From November 2017 to October 2018, 94.5% of required staff within children’s services at Queen’s Hospital Burton received an appraisal. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and clerical</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>19</td>
<td>20</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>40</td>
<td>44</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>91</td>
<td>94.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. In addition, qualified nurses had an appraisal rate of 90.9% which met the 90% target.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff told us they had an annual appraisal and they found them constructive and supportive. They said they discussed their training needs and further development opportunities. A member of staff told us they had completed a nationally recognised level two course related to mental health in education for children and young people. This had enabled them to work more confidently with patients with mental health needs.

**Multidisciplinary working**

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. However, the input of play specialists to the outpatient areas was limited.

**CQC Children and Young People’s Survey 2016 – Q23**

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.58 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
We observed good multi-disciplinary working during the inspection. Staff showed respect for each other and the expertise each brought to the care of patients. They worked collaboratively together for the benefit of patients.

Arrangements were in place to enable patients to access children and adolescent mental health services (CAMHS) when required. Staff told us that if they contacted the service before 11am, the patient could be seen the same day. A doctor told us they felt access to CAMHS was very good and responsive.

Paediatric multi-disciplinary meetings were held monthly and ward rounds included the relevant professionals.

Some outpatient clinics were held jointly with consultants from tertiary centres on a regular basis. For example, surgeons from Nottingham University Hospitals, urologists from Birmingham Children's hospital and cardiologists from Leicester conducted regular clinics with consultants from the Queen's hospital. Diabetes held quarterly clinics with Birmingham Children's hospital. They also held clinics where children had access to dietitians, a clinical psychologist and the diabetes specialist nurses.

The hospital had a transition policy to ensure there was a structured approach to transition between paediatric and adult services and ensure transition to adult services was a positive experience for young people using healthcare services. The trust were undertaking a project to improve the experience of patients and encourage consistency of approach across different specialties. They had developed a model for transition and a project plan to drive the project forward.

Transition clinics were available for children from 16 years to 19 years of age with diabetes. Young people were seen by medical staff from adult and paediatric services at these clinics. Transition clinics were also being established in other specialties. Transition services were flexible according to the pathway and individual patient. Transition could start from 15 years of age and some patients stayed in paediatric services until 22 years of age.

Qualified play specialists covered the paediatric wards and children’s outpatient clinics, although their main focus was on the inpatient wards. 2.4 whole time equivalent play specialists were employed and they provided a service, seven days a week. A play specialist told us they had given a talk to medical staff to explain their role and how they could be better utilised. They told us this had increased the demand for their involvement and told us they were asked to contribute their views and were listened to. Children attending the adult outpatient departments did not have access to play specialists.

Pharmacy supply and clinical services were provided Monday to Friday from 9am to 5pm and weekends from 9am to 12:30pm. There was an on-call pharmacist and access to medication via emergency cupboard available outside of these hours.

Seven-day services

The service was working towards the provision of seven-day services. A paediatric consultant was on site seven days a week. However, a paediatric radiologist was not available on site and specialist advice was obtained from neighbouring hospitals.

Paediatric consultants were present in the hospital seven days a week and completed ward rounds every day. The hospital provided mainly planned surgery. Paediatric surgery was not provided out of hours; children were transferred to Royal Derby hospital or a neighbouring specialist hospital if urgent surgery was required.

Staff told us they had access to diagnostic services such as x-ray, ultrasound and computerised tomography (CT), seven days a week. Magnetic resonance imaging (MRI) was carried out.
weekdays. Medical staff told us the only issue was the lack of a paediatric radiologist at the Queen’s hospital. As a result, they had to access advice from Royal Derby hospital or a neighbouring specialist paediatric hospital. The senior management team told us they were attempting to recruit an additional paediatric radiologist; however, there was a national shortage of radiologists. In addition, access to electroencephalograms (EEGs) was through the Royal Derby hospital, as they did not provide the service at the Queen’s hospital. However, a consultant told us that a pathway was being developed.

Physiotherapists accepted referrals in a range of forms, including telephone referrals, written referrals and email referrals. A paediatric physiotherapist was available Monday to Friday and a respiratory physiotherapist could be called 24 hours a day, seven days a week.

Health Promotion

Health promotion information for children and young people and their parents were available in children’s services. Such information was limited in adult outpatient departments.

Sun protection screen was available by the door to the outside space on the paediatric ward.

We found lots of health promotion information on the paediatric wards, neonatal unit, and children’s outpatient department. Information leaflets such as, “Food and fitness or school-aged children,” sugar smart information, dangers of blind cords and chains for children, and spotting sepsis in children was readily available. We also saw information displayed on the walls about diseases such as meningitis and bronchiolitis, measles immunisations and protecting babies against norovirus.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff were aware of their responsibilities for obtaining consent for treatment and the requirements in relation to obtaining valid consent in children and young people. They completed training in the Mental Capacity Act (2005) with special reference to paediatrics.

Mental Capacity Act and Deprivation of Liberty training completion

Queen’s Hospital Burton

Staff at Queen’s Hospital Burton were eligible for two levels of combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as well as an MCA paediatrics module. The completion target for these courses was 90%. These requirements were inherited from the predecessor trust.

A breakdown of compliance for MCA and DoLS training for the period from November 2017 to October 2018 level for qualified nursing staff in children’s services at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act paediatrics</td>
<td>50</td>
<td>57</td>
<td>87.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>26</td>
<td>33</td>
<td>78.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 90% target was not met by eligible qualified nursing staff in children’s services at Queen’s Hospital Burton for any of the three modules.

A breakdown of compliance for MCA and DoLS training for the period from November 2017 to October 2018 level for medical staff in children’s services at Queen’s Hospital Burton is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>20</td>
<td>24</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>0</td>
<td>6</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met by medical staff in children’s services at Queen’s Hospital Burton for either of the modules. None of the six eligible staff had completed the MCA and DoLS level one training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with were aware of the requirements for obtaining consent for treatments and procedures and the Gillick and Fraser competencies, which apply to assessing the competence of children and young people to consent to treatment.

Children, young people and their parents said treatments were explained to them fully, along with alternative options to enable them to make informed decisions.

Parents told us they were asked to complete consent forms for surgery at the outpatient clinic. They were not asked to re-visit this and confirm their consent on the day of surgery as is best practice. However, they told us they received full explanations and had a good understanding about the procedure, it’s risks and benefits prior to completing the consent form.

The trust were unable to provide any evidence of audits of consent in children’s services.

Medical staff were aware of the Mental Capacity Act (2005) and the implications for young people between 16 and 18 years of age.

Other CQC Survey Data

CQC Children and Young People’s Survey 2016 Data

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

The trust performed about the same as other trusts for four or the five questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. No score was provided for question 54.

CQC Children’s Survey questions, effective domain, University Hospitals of Derby and Burton NHS Foundation Trust
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.04</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.08</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>8.51</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33</td>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>7.03</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 children</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age  
0-15 adults = asked of parents and carers of children up to 15 years of age  
8-11 children = asked of children aged from eight to 11 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We observed staff engaging well with patients and parents in a welcoming and friendly manner, putting them at their ease.

CQC Children and Young People’s Survey 2016

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

The trust performed about the same as other trusts for all 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, compassionate care, University Hospitals of Derby and Burton NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.08</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.07</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Do you feel that your child was well looked after by the hospital staff? | 0-7 adults | 9.21 | About the same as other trusts |
---|---|---|---|
Do you feel that you (the parent/carer) were well looked after by hospital staff? | 0-15 adults | 7.96 | About the same as other trusts |
Was it quiet enough for you to sleep when needed in the hospital? | 8-15 children | 6.09 | About the same as other trusts |
If you had any worries, did a member of staff talk with you about them? | 8-15 children | 8.71 | About the same as other trusts |
Do you feel that the people looking after you were friendly? | 8-15 children | 9.36 | About the same as other trusts |
Overall, how well do you think you were looked after in hospital? | 8-15 children | 9.13 | About the same as other trusts |

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Parents commented on the kindness and compassion of nursing staff. They said they quickly developed good relationships with the children and made things fun. They distracted them well when procedures were undertaken, thus enabling procedures to be undertaken with the minimum anxiety and distress for the child. A parent said staff took time to find out about their child and the things they liked. Another parent said, “The staff are exceptional;” they commented positively on the knowledge of staff and the reassurance they provided. A child told us, “The nurses are very good and very kind.” A parent on the neonatal unit said, “Staff are amazing. They are very approachable and very helpful with breast feeding.”

We followed a child to theatre and observed staff in theatre greeted the child and parent in a friendly manner. The anaesthetist explained there would be a slight delay and the child was kept occupied by staff. We observed the child was chatting and relaxed with staff. Staff distracted the child very well and involved the parent, during insertion of the intravenous cannula and the child did not feel the cannula being inserted. All the checks were carried out in a very patient focused way with the patient and parent at the centre of all interactions. The parent was taken back to ward by the member of staff and was reassured.

We observed a play specialist looking after a child with a learning disability. They engaged with them very well. The child’s parent said they were very confident in the staff on the ward. They attended regularly and they were happy to leave their child on the ward for short periods with staff, which they would normally be reluctant to do.

We observed patients arriving for their outpatient appointments. They were welcomed by staff and greeted in a very friendly way. Some of the patients attended regularly and clearly knew staff well. They showed by their actions that they were pleased to see the staff and were very relaxed with them. One of them commented that the receptionist was not there on their last visit and they were disappointed not to have seen them, but were very happy to see them that day.

Staff maintained patients’ privacy and dignity well. We observed they asked questions sensitively and discreetly and took them to private areas when appropriate. When we arrived on the neonatal unit, a set of parents were facing a very distressing decision and staff were engaged in supporting them and the baby. We were appropriately asked to return later, to allow the parents privacy and to allow staff time to be able to support them without distractions.

Staff encouraged patients and parents to provide feedback on their experience through the
Friends and Family Test (FFT) question, followed by three questions to explain the good aspects of their stay and things that could be improved. Displays at the entrance to the wards and the neonatal unit showed the results of the FFT along with positive and negative comments with actions taken to address areas for improvement. Scores displayed at the time of the inspection showed over 97% of respondents would recommend the ward to their family and friends. The FFT was collected in the children’s outpatient department, however, the number of responses was low and staff told us time restraints made it difficult to encourage patients to complete the survey before they left.

**Emotional support**

*Staff provided emotional support to patients to minimise their distress. Parents praised the support they received from staff.*

**CQC Children and Young People’s Survey 2016**

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

The trust performed about the same as other trusts for the five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, emotional support, University Hospitals of Derby and Burton NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.21</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.25</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.31</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children</td>
<td>9.32</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>67</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 children</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

Parents spoke about the emotional support they received from staff at times when they were anxious or distressed. They told us staff were very understanding and they appreciated the support they received. We observed that many of the thank you cards received on the paediatric wards and the neonatal unit, contained positive feedback from parents about the support they had received from staff. For example, “It’s been a very hard time but you (staff) have got us through it. Thank you for looking after me at the same time as fixing (child’s name).” Another
parent wrote, “During my visit with my son, the staff were perfect, nothing was too much trouble. Being on my own when emotions hit, they cared for me; amazing staff.”

The Queen’s early starters group was a support group for parents of babies who were or had previously been patients on the neonatal unit, that was held monthly and run by staff. This enabled parents to get together with other parents and discuss issues and staff were available for advice. Speakers were invited to the group to talk about issues of interest and concern to new parents of low birthweight babies.

Staff could refer parents to a psychologist at the Royal Derby hospital and the leadership team were meeting with the psychologist to discuss regular input into the unit.

The chaplaincy team provided spiritual and pastoral care and were available to patients, parents and staff. A member of the team visited the ward twice each week to offer support and could be contacted by telephone at other times. There was a Chapel and multi-faith room for people to use if they wanted to pray or simply sit and think or reflect.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Parents were encouraged to be involved in the day to day care of their child as much as they wished.

**CQC Children and Young People’s Survey 2016**

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

The trust performed better than other trusts for four questions and about the same as other trusts for the 16 of the remaining 17 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. No score was provided for question 66.

**CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, University Hospitals of Derby and Burton NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.00</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.73</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.08</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.38</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.81</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Sample Size</td>
<td>Score</td>
<td>Note</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.17</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.84</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.75</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32</td>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.88</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39</td>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>7.99</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.46</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children</td>
<td>8.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>8.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>61</td>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.85</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>62</td>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.72</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>63</td>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>6.57</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>66</td>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 children</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>69</td>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 children</td>
<td>9.94</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>70</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 children</td>
<td>9.45</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>72</td>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 children</td>
<td>8.07</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age  
0-15 adults = asked of parents and carers of children up to 15 years of age  
8-15 children = asked of children aged from eight to 15 years of age  
12-15 children = asked of children aged from 12 to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Parents told us they received good explanations and information about all aspects of their child’s care. One parent said, “We see the doctors twice every day. They are really good; they reassure us and explain everything. We always know what is happening next.” They went on to say their
child was going home that day and staff had provided clear instructions and advice. We heard a member of staff talking to a parent about their child’s discharge and explaining they could ring the ward if they had any concerns after discharge.

Parents of babies on the neonatal unit were encouraged to participate in the care of their child and where appropriate were taught how to administer tube feeds and other daily tasks for their baby. A nurse told us how they liked to involve parents as much as possible. This included involving them in the doctors’ ward round; they started by asking the parent to tell them about their baby. They produced sibling packs for the baby’s siblings and put laminated sheets on the crib with information about what the individual baby responded positively to and things they didn’t like.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people. However, facilities for children seen in the adult outpatient department and the theatre recovery area could be improved.

The trust had agreed guidelines for the referral of paediatric out-patients from primary care. The guidelines were developed by paediatricians (general and community), paediatric subspecialists, and GP children’s leads.

Arrangements were in place to enable patients to access specialist care and treatment at tertiary centres in the surrounding areas and staff at the Queen’s hospital liaised with them and provided joint clinics at the Queen’s hospital in several specialties, for the benefit of patients.

The Royal Derby hospital had a patient and parent group for children with special education needs and disabilities. The nursing leadership team told us of improvements that had taken place to improve the experience of patients when attending the hospital. A workshop was held on the with parents and from this a 15 minute video was produced “Small things make a big difference.” Managers were now starting to share this across the other sites including at the Queen’s hospital. Managers also spoke about changing signposting and sourcing pictorial communication aids following feedback from this group.

The trust had an active Youth forum that met regularly. The adolescent room was developed in response to feedback from the forum. In addition, a review of the children’s menu was undertaken in consultation with patients and the youth forum. This resulted in improving the look and choice on the menu and included more Halal food choices.

**CQC Children and Young People’s Survey 2016**

Data for the acquired Burton Hospitals NHS Foundation Trust is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.

The trust performed better than other trusts for one question and about the same as other trusts for the remaining 16 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.93</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>9.39</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>7.16</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.53</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 children</td>
<td>8.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.73</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38</td>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.04</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40</td>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.74</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 children</td>
<td>5.48</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>57</td>
<td>Did you like the hospital food?</td>
<td>8-15 children</td>
<td>8.04</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>71</td>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 children</td>
<td>8.40</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>73</td>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 children</td>
<td>8.67</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>2</td>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>2.67</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>3</td>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age
12-15 children = asked of children aged from 12 to 15 years of age
The entrance to the paediatric wards was bright, welcoming and attractive and the décor within
the wards continued this theme. The paediatric wards were arranged with predominantly single
rooms to enable flexible use of the bed capacity. A six-bedded bay on ward 1 was used as the
paediatric assessment unit and there was a separate treatment and stabilisation room for the
stabilisation of seriously unwell patients. A large play room was located next to the assessment
unit and this was well equipped with toys, games and electronic media, suitable for a wide age
range, from the under fives to early teens. A second room, off the play room, was being
converted for the use of teenagers and adolescents. A small sensory room was available with
sensory toys and light and sound features. One of the single rooms had been adapted to remove
ligature points and increase its suitability for children at risk from self-harm.

A parents’ room was available on the paediatric wards to enable parents to relax and take some
time away from their child. It was equipped with a microwave, refrigerator, tea and coffee making
facilities and a basket of snacks was provided with an honesty box for parents to pay for items
used.

The neonatal unit had facilities for one intensive care bed, two high dependency beds and eleven
special care beds. In addition, there were two parent’s rooms where parents could stay overnight,
when they were preparing to take their baby home. There were also similar facilities to those of
the paediatric wards for parents to make hot drinks and prepare simple meals.

The children’s outpatient department had a small waiting area and a range of consulting rooms.
The consulting rooms had some toys and distractions for children. There were no facilities for
children with special needs who might require a quiet area to wait; however, staff said they would
try to use an empty consulting room if necessary; although staff told us they sometimes waited
outside the department and staff would ring them when they were due to be called in.

Some children were seen in adult outpatient departments. This was mainly in the fracture clinic,
ear, nose and throat (ENT) clinic and ophthalmology clinic. The environment in the ENT clinic,
(including the consulting rooms) was not adapted for children and we were told there were no
dedicated clinics for children. There were no toys or distraction for children. Children’s
appointments were intermingled with adult appointments in the clinics. There was a central
waiting area outside the ENT clinic that had a gated play area for small children; however, we
observed children sitting amongst adults in the main waiting area. There were chairs within the
ENT clinic for patients waiting to be called, although no facilities in this area for children. A
member of staff in children’s outpatient told us that ENT had approached them about holding
clinics for children in the children’s outpatient department, however, they did not have the
capacity required for this or the equipment.

The fracture clinic had a waiting area for children with books and toys that were easy to clean.
Staff told us children with a learning disability or other additional needs would be prioritised, so
they did not have to wait for significant periods. The radiology department had a bright and
attractive children’s play area for small children. However, there was no separate area for
children to wait. Staff identified a small room where children with special needs could wait in a
quiet environment. One of the x-ray rooms that was allocated for children had murals on the walls
and lead aprons that were patterned with children friendly pictures. The magnetic resonance
imaging (MRI) department and CT scanning area had a quiet waiting area for sedated children
and parents were able to stay with their children during MRI and CT scans if they wished. The
MRI equipment had a mirror to allow parents and children to maintain eye contact during the
procedure. Children could choose music to listen to during the scan and they were given a button
to press if they became distressed during the scan.
There was no separate operating theatre recovery area for children. A bed space within the main recovery area was allocated for children and separation of adults and children was achieved by use of curtains drawn around the bed space. We were told the recovery area was often very full and some adult patients were in the area for several hours, due to a lack of bed capacity in the adult surgical wards. The Royal College of Anaesthetists, “Guidelines for the Provision of Paediatric Anaesthesia Services” (2019) state that, “Children should be separated from, and not managed directly alongside adults throughout the patient pathway, including reception and recovery areas. Where complete physical separation is not possible, the use of screens or curtains, whilst not ideal, may provide a solution.” The trust was therefore meeting the guidelines although the circumstances were not ideal.

Meeting people’s individual needs

Staff took account of patients’ individual needs. Staff took a very person centred approach to the provision of care and treated everyone as an individual.

The trust used an electronic flagging system which alerted the Learning Disability Liaison Team of patients diagnosed with a learning disability upon admission to the emergency department. Learning disabilities nurses were employed by the mental health trust and were seconded to the trust. The Learning Disability Liaison Team were notified of all admissions via the electronic flagging system. (source: PIR)

The alert system also enabled staff to identify patients with other additional needs and also, any safeguarding concerns.

When children had additional needs, staff told us they assessed each child’s needs individually on admission to ensure their needs were met and that staff were aware of what was important to them. Staff said had come to know some patients well as they had frequent admissions due to their complex needs. They used communication aids such as pictures and symbols and some patients used computers to communicate. A member of staff emphasised the importance of not appearing to be patronising and being sensitive to the wishes of the individual patient.

Staff said they offered a single room whenever possible, for children with a learning disability or behavioural needs; however, some children preferred to be with others and staff responded accordingly. All the single rooms had space for a parent to stay by the bedside if they wished. There was also space for this in the six bedded bays although it was more limited. Staff had access to two special needs beds to provide additional support and prevent patients from falling or hurting limbs on metal framed beds. Staff told us they assessed their suitability for the child and spoke with parents before using them.

Theatre staff told us they offered children going to theatre, the opportunity to visit the operating theatre on a Sunday, to see the anaesthetic room and recovery prior to surgery, as they recognised children could be anxious about the unknown. However, they said few children took up the opportunity. The ward and operating theatre staff tried to make the trip to the operating theatre as positive as possible. They had a small battery operated (and remote controlled) car that children could use to drive themselves to theatre if they wished. One child told us they had used the car to go to theatre and their parent told us they had enjoyed this, as it was a new experience for them. The parent told us there were a variety of things to keep them occupied in the anaesthetic room, which were age appropriate and distracted them prior to the anaesthetic taking effect. One child told us there was a picture on the ceiling and they had to find the hidden frog. Children on the wards told us they had been offered a variety of activities, although one child commented they could not see the televisions in the bay due to the position of their bed in the six bedded bay.

Interpreting and translation services were available and provided through third party providers.
This was in the form of face to face or telephone interpreting. Staff told us they occasionally used other staff when interpretation was needed urgently. Sign language interpreters were also available and this could be provided on site or through video links. We observed staff checking that an interpreter was booked for a patient undergoing an MRI scan and a member of staff asking the ward clerk to book an interpreter for an expected admission to the ward.

We spoke with a parent of a child for whom English was not their first language. They told us they were very happy with the way care and treatment was provided and told us staff were sensitive to their cultural needs. They commented that every type of food was available, including Halal food and they were aware of the multi-faith room.

The chaplaincy department provided spiritual, pastoral and religious care to people of all beliefs and of none. It was available to all patients, relatives and staff, and was a 24/7 service across all sites. Referrals to the chaplaincy team could be made by ward staff, specialist teams such as the palliative care team or bereavement midwives, chaplaincy volunteers, families of patients, local faith group leaders or from the patient themselves. Chaplaincy volunteers were trained in pastoral listening skills and were allocated to a specific ward to visit patients and identify anyone who would like further chaplaincy support. Other needs were met through memorial services, baby funerals, and providing space for quiet reflection. There was weekly holy communion provided and weekly prayers for Muslims. Chaplains were also involved in spiritual care awareness training for staff. (source: PIR)

Patients with mental health conditions were admitted to the ward and staff showed us the assessment and pathways that had been developed in conjunction with the child and adolescent mental health service (CAMHS) and which were used to guide their assessment and care of these patients. Staff had received training in relation to CAMHS. Staff told us these patients were usually cared for in a single room with one to one support when their parent or guardian was not present. When necessary a mental health nurse was obtained to provide care for the patient. The CAMHS team were responsive to referrals to their service.

**Access and flow**

**People could access the service when they needed it. There were appropriate systems in place for the referral and assessment of urgent and emergency patients and the accommodation of patients for planned surgery.**

Children were admitted to the paediatric assessment unit either by referral from their GP or from the emergency department. From here, patients could be admitted to the ward or observed on the unit for up to four hours or discharged home. The children’s wards also admitted a small proportion of children for planned surgery.

GPs had access to immediate telephone advice from paediatric medical staff and if patients did not require immediate admission, GPs could refer patients to a weekly rapid access clinic where they were seen by a paediatric consultant.

The service met the standards for review of all patients admitted to the paediatric wards and neonatal unit by a consultant paediatrician within 14 hours of admission and to be seen by a middle grade doctor on the paediatric rota within four hours of admission.

**Neonatal Critical Care Bed Occupancy**

**Burton Hospitals NHS Foundation Trust**

Data for the acquired Burton Hospitals NHS Foundation Trust pre-acquisition is included in this analysis. We only provided this for contextual purposes and it is not used to form part of our judgement.
From November 2017 to June 2018, neonatal bed occupancy rates at Burton Hospitals NHS Foundation Trust were consistently lower than the England average.

### Neonatal critical care bed occupancy rates, Burton Hospitals NHS Foundation Trust.

![Graph showing neonatal critical care bed occupancy rates at Burton Hospitals NHS Foundation Trust.](chart)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

**University Hospitals of Derby and Burton NHS Foundation Trust**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in this analysis as well as data for Queen’s Hospital Burton from the date of acquisition in July 2018. Because this data relates to the same legal entity as the merged trust it is used to form part of our judgement.

From November 2017 to March 2018, neonatal bed occupancy rates at University Hospitals of Derby and Burton NHS Foundation Trust were consistently lower than the England average. However, in the subsequent seven months, April to October 2018, the rates increased to similar to the England average.

In the latest period, October 2018 neonatal critical care bed occupancy at the trust was 74.1% compared to an England average of 73.8%.

### Neonatal critical care bed occupancy rates, University Hospitals of Derby and Burton NHS Foundation Trust.

![Graph showing neonatal critical care bed occupancy rates at University Hospitals of Derby and Burton NHS Foundation Trust.](chart)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
In relation to bed occupancy, the Queen’s hospital neonatal unit was not always fully utilised and staff told us they were working together with the Royal Derby hospital to improve bed occupancy and care for babies as close to their home as possible. The recent acquisition facilitated this process and staff told us they were working together to agree a pathway for transfer of babies. However, babies that had been transferred to specialist hospitals and were ready to return to the neonatal unit, were sometimes delayed, due to the capacity of the transportation and retrieval service, as the priority was on transferring critically ill babies and children to intensive care facilities.

Children using the children’s outpatient service were referred by their GP or a consultant following admission to the wards. An electronic booking system was used to book outpatient appointments. Staff told us this had some limitations and they were discussing moving the booking of appointments back to the children’s service, however, this was not in line with the overall direction for booking. When the electronic booking system was used, it was not possible to book consecutive appointments for siblings, or to ensure a patient with special needs was given an appointment at a time when the wait would be reduced.

There was a clear process for staff to follow when patients were not brought or did not attend, their outpatient appointment. Information was provided to the consultant as to the number of times the appointment had been missed. The doctor decided on the action to be taken and whether a patient should be discharged or offered another appointment. Attempts would be made by staff to contact the patient by letter or by liaising with a health visitor. If the patient did not attend at the third appointment this would trigger a referral to the safeguarding team. Staff we spoke with were clear about the procedure.

The senior management team were aware that the percentage of patients who were not brought to their outpatient appointment was higher than the national average. However, they told us of action they had taken to reduce this rate. This included taking a snapshot of patients who did not attend and this identified some patients who had regular appointments. Staff texted reminders and rang parents to remind them of the appointment and check they were coming. It enabled them to re-schedule appointments when necessary. The senior management team told us they had been successful in reducing the rate of patients not attending their appointments at the Royal Derby hospital from 11% to 7% and were transferring the learning to the Queen’s hospital.

**Learning from complaints and concerns**

Managers treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The timescale for response did not always meet the trust target, however the average response time was 27.3 days against the target of 25 days.

**Summary of complaints**

**Trust level**

From November 2017 to October 2018 the trust received 33 complaints about children’s services. For the 32 complaints that had been closed at the time of data submission, the trust took an average of 32.7 working days to investigate and close these complaints. This was not in line with their complaints policy, which states complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The one complaint that had not yet been closed had been open for 135 days at the time of data submission. This was also not in line with the policy statement above.

The breakdown by subject can be seen in the table below.
<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>14</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>6</td>
</tr>
<tr>
<td>Patient care</td>
<td>4</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
</tr>
<tr>
<td>Communication</td>
<td>2</td>
</tr>
<tr>
<td>Trust administration/policies/procedures including patient record management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

**Queen's Hospital Burton**

From November 2017 to October 2018 the trust received three complaints about children’s services at Queen’s Hospital Burton. All three were already closed at the time of data submission.

The trust took an average of 27.3 working days to investigate and close these three complaints. The complaints policy states that complaints should be responded to within 25 working days, or 40 days for more complex complaints.

The breakdown by subject can be seen in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

Staff told us they received feedback about complaints and learning from complaints and we were told all incidents and complaints were reviewed by the senior management team on a weekly basis.

Staff were aware of complaints and feedback they had received. For example, a nurse told me of the three complaints made within the previous year. In relation to the complaint regarding communication with a parent, the handover sheet was changed to provide more specific information. We were also told that soft closure bins were obtained for the wards to reduce noise levels.

Displays to show feedback received and action taken were found on the wards and neonatal unit in the form of “You said, we did,” and these showed changes implemented as a result of feedback from patient and parent surveys.

**Number of compliments made to the trust**

**Trust level**

From October 2017 to September 2018 the trust received 25 compliments about children’s services. The trust did not provide a breakdown by subject for compliments received.
Queen’s Hospital Burton

From October 2017 to September 2018 the trust received 11 compliments about children’s services at Queen’s Hospital Burton. The trust did not provide a breakdown by subject for compliments received.

The breakdown by location can be seen in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wards 01 and 02</td>
<td>8</td>
</tr>
<tr>
<td>Paediatric outpatients</td>
<td>2</td>
</tr>
<tr>
<td>Neonatal Unit</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We observed numerous compliments and thank you cards in all areas of children’s services.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Children’s and young people’s services sat within the Women’s and Children’s division. The senior management structure for children’s services was reviewed following the acquisition and a management structure for children’s services was created, to bring together the services across the new trust. This was led by a general manager, clinical director and lead nurse with support from matrons. Some of the team were in interim posts and others were new to the Queen’s hospital, having previously had responsibility for services at the Royal Derby Hospital. As a result, we found that whilst the team had a good grasp of the challenges at the Queen’s hospital, they had had limited time to address the issues raised. However, they expressed a commitment to transferring learning across all sites and working with staff to bring them together. We found a sense of common purpose and a willingness to learn from each other.

The senior management team told us that management meetings for women and children’s services such as performance management meetings, gave the same amount of time to discussion of children’s services as to women’s services. They pointed out that large volumes of children were seen at both sites and it was a sizeable service. They felt they were able to raise issues and they would be given the same priority as other services.

The senior management team recognised their responsibility for taking an overview of services for children and young people, wherever they were cared for within the hospital, including those cared for in predominantly adult services. They held children’s standards meetings monthly at the Queen’s hospital to bring together staff from all areas where children attended. Representatives attended from each of the areas. The meetings discussed the risk register, incidents, complaints and challenges. Positive and negative news from each of the areas was shared. The risk lead for children’s services across the trust came to the meetings to ensure joint working between the hospitals.

Staff told us their matron was visible and supportive. A nurse told us, “Support is outstanding at the trust from the whole of the senior nursing team.” The matron’s office was at the entrance to the children’s outpatient department which was next to the children’s wards, placing them at the centre of activity and facilitating their ability to keep in touch with activities in these areas. Staff in
the neonatal unit also told us matron visited their wards regularly and was abreast of the day to
day issues and challenges on the unit.

Band 7 staff had a good overview of their areas and showed good leadership and management
skills. They were knowledgeable about the performance of their ward in relation to quality and
management indicators. They were proactive in identifying and resolving issues and staff said
they were approachable and fair. Band 7 staff said they were able to escalate issues and they felt
listened to and their opinions valued as did other staff.

Vision and Strategy

**Managers had a vision for what they wanted to achieve. They had a plan for the immediate
future and were developing plans for the longer term to bring together the service and
move forward, with involvement from staff, patients and stakeholders.**

Prior to the acquisition, a full business case and patients benefits case were produced which set
a direction for the new trust. We were told the trust were now in the process of building on this
plan aiming to produce a long-term overarching strategy by March 2019.

The trust’s strategy was supported by five annual plans, structured around:

- Putting patients first (Quality),
- Right First Time (Transformation and Service Delivery),
- Investing our Resources Wisely (Financial),
- Developing our People (Staff) and
- Ensuring Value through Partnerships.

This was abbreviated to PRIDE. Staff were aware of the acronym and what it stood for.

The paediatric wards and neonatal unit had developed visions for their own services with the
involvement of staff and patients, that were displayed on the walls of the areas. For example, the
paediatric wards’ vision was, “To deliver a safe and effective local service for our children and
their families in a caring and friendly environment. To be the hospital our children and their
families come to first and return to again because we make a difference.”

The trust provided us with a copy of the business plan for children’s services for 2018/2019 with
an overview of the priorities up to 2021. However, this was developed before the acquisition and
focused on services at the Royal Derby hospital. The senior management team told us it
reflected the same priorities for the Queen’s hospital and there were several examples within it of
working with the Queen’s hospital to improve services.

The trust did not provide any longer-term strategy or business plan for children’s services
following the acquisition which occurred in July 2018. The senior management team voiced the
importance of bringing the services together and achieving consistency across the trust in terms
of clinical pathways and processes. This was reflected by clinical staff, one of whom said, “It is
early days yet in terms of integration. There are some small differences, but some guidelines
have been agreed and we are having a dialogue with each other.” Similar thoughts were reflected
by other staff.

Culture

**Managers across the trust promoted a positive culture that supported and valued staff,
creating a sense of common purpose based on shared values.**

We found staff were open and listened to the views of others, valuing their input. There was a
sense of working together to provide the best care possible for patients and concern for each
other’s welfare. All the staff we spoke with told us how supportive the culture was and how the
teams pulled together to overcome difficulties.

Staff were proud to work in the trust and proud of the achievements of the service. They were enthusiastic about the future and all voiced a commitment to working together to continuously improve the quality of care and treatment provided. They told us they felt the team working was good and there was always someone to support them when they needed it.

We saw a de-briefing was immediately organised following a distressing incident on the neonatal unit and staff said it was good to be able to have time to reflect on what had happened, the care provided and discuss how they felt. They told us counselling was available for staff through the occupational health department if they required it and they also told us of wellbeing days for staff when they could access massages and the trust provided us with information about their wellness week for staff at the Derby site.

**Governance**

*Managers took a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.*

The chief nurse was identified as the executive lead for children’s services. Prior to the acquisition each trust board received an annual safeguarding children report. We reviewed the report for Burton hospital for 2017/18 and found it provided a good picture of the position in relation to safeguarding children and elements of good practice. The service also had a safeguarding action plan for 2018/19 that included actions to improve children’s and adult safeguarding.

There was a clear governance structure for the newly formed trust that included committees for patient safety, patient experience and clinical audit. Staff told us the governance structure within children’s services was being reviewed to align the groups at the individual hospitals. There was a bi-monthly clinical governance meeting across the trust and governance meetings at each site that reported to the trust wide group. There was a paediatric risk group at each site and the paediatric risk lead ensured information was shared across sites. The paediatric risk group reported to the business unit meeting and through this to the divisional clinical governance committee. Learning was shared through newsletters and direct feedback through matrons and the management team.

Although the new governance structure was still in the process of being implemented, the risk meetings for children’s services at the Queen’s hospital had been in place for some considerable time and were well established. Incidents and complaints were reviewed at these meetings and learning identified. The risk register was also reviewed. In addition, the senior team told us they had weekly meetings to discuss new incident, complaints and risks, although these were not minuted.

A paediatric and neonatal dashboard was produced and monitored monthly. The quality indicators reported on in the dashboard included serious incidents, complaints, medicines errors, CAMHS patient numbers, patient experience and staffing indicators. It also included ward assurance measures for the paediatric wards and neonatal unit. Ward assurance measures included patient safety indicators, pain assessment, patient observations, care planning, discharge and liaison with health visitors. The indicators were audited monthly by a member of staff from another ward or clinical area, to ensure independence. The senior sisters in each area showed us their most recent performance in relation to each indicator and we saw they were displayed on the quality board at the entrance to the wards. Compliance with each indicator was high and we noted there was an improving picture. For example, on the neonatal unit the scores for prescription of oxygen and liaison with health visitors had shown improvements over the last six months.

Matrons reviewed each areas performance in the quality indicators and met with the senior sisters to discuss areas where they were performing well and areas for improvement. They said this was
included in the matron’s report to the business unit. However, the route for discussion at clinical governance meetings was not well developed. Ward performance in the form of compliance with the ward assurance measures was not discussed at the trust board or trust wide governance meetings.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust provided a copy of a monthly performance report for women’s and children’s services at the Queen’s hospital; this gave performance against key indicators such as referral to treatment times, cancelled outpatient appointments, emergency re-admissions, friend and family test results, and complaints response times; however, they did not provide information broken down for children’s services. As a result, issues affecting solely children’s services might be masked by good performance in the division as a whole. Processes were in place to review and escalate these performance indicators within the division and at trust level.

Monthly clinical audit meetings were held that were open to all staff. We saw evidence of staff being encouraged to complete clinical audits in relation to issues they were interested in for the benefit of patients as well as audits to monitor performance against national and local priorities. For example, a play specialist told us they were completing an audit to look at whether more MRI scans could be completed without the need for sedation in children by using play specialists to prepare the patients and provide ongoing support and reassurance.

A systematic programme of clinical audits to monitor practice against national guidance and compare outcomes of care and treatment with other trusts was in place for the current year.

There were regular meetings within children’s service to review risks on the risk register and identify new risks. Most of the risks we identified during the inspection, were known to the senior management team and were on the risk register. We discussed some of the key risks on the risk register and were satisfied that steps were being taken to mitigate the risks and escalate the issues where appropriate. For example, the footprint of the neonatal unit limited visibility of babies when the unit was full and steps were taken to ensure staffing levels were adequate to enable observation. The senior management team had made an unsuccessful bid for funds for a new neonatal unit and were therefore progressing this through a bid for capital funds. When we identified risks the trust had not previously identified, they acted immediately to address the risks and place the risks on the risk register.

The trust had an emergency planning policy and there was major incident plan for the Queen’s hospital. Staff understood their roles and responsibilities in relation to a major incident. There were also business continuity plans for each site. Staff on both the paediatric wards and the neonatal unit were accustomed to receiving emergency patients that required stabilisation and subsequent transfer to specialist hospitals. They therefore were able to deal with these situations calmly and were aware of the support and advice available.

Information Management

The trust collected data to support its activities; however, systems to extract and separate data about children’s services from that of other patients were not well developed. This made it difficult to obtain accurate information and assess performance specific to children’s services. Patient records were managed safely using secure electronic systems with security safeguards and ensuring paper records were stored securely.
Staff told us they experienced challenges because the Queen’s hospital used a different patient administration and record system to that of Royal Derby hospital. The two systems functioned independently and were configured differently, making transfer and amalgamation of information difficult. For example, when a patient moved from one site to another.

The senior management team told us they also had difficulties in extracting paediatric data from the system, for example, data about paediatric patients’ attendances in the ED. Systems were configured around directorates and divisions and this made it difficult to identify issues or performance specific to children’s services.

Most of the patient records in children’s services were electronic and staff had access to computers in the clinical areas to enable them to view the attendances, results of investigations, medicines and ongoing record of care. However, paediatric medical staff recorded information on paper records and they were scanned into the electronic record on discharge. This meant there was not a multi-disciplinary record in one place. However, staff had access to the full record, albeit in a separate format, following scanning. Surgical doctors completed their records of the current admission in the electronic record. We were unable to identify a reason why the paediatric doctors kept separate records during an admission.

Staff were very aware of the importance of maintaining confidentiality and all paper records with patient identifiable information were stored securely. We did not see any instances of information at outpatient clinics or on the wards being open to unauthorised access.

**Engagement**

Managers engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Children, young people and their parents were actively encouraged to give their views about the service and contribute to the improvement of the service. Comments and suggestions boxes were available in the clinical areas and the feedback forms for the friends and family test also included open questions about the patient’s experience and what could be improved.

Displays on the walls of the paediatric wards and neonatal unit, gave examples of how patient feedback had been used and the action taken as a result. Examples included the snack baskets for parents, soft closing bins, to reduce noise and including parents in ward round discussions.

A youth forum was held monthly and had a good attendance. The creation of an adolescent room was the result of feedback from members of the group and they were involved in choosing the décor and facilities in the room.

The trust had a forum for children and parents of children with special educational needs and disabilities. Managers told us members of the forum were involved in the “15 steps challenge” initiative. This is an approach to quality improvement that focuses on ward or service ‘walkarounds’ using a ‘15 steps challenge’ team that includes patients, carers, and staff. The team members consider their first impressions from the perspective of a service user, recording how it appears; looks; sounds; smells and how accessible it is. We were told the outcomes of the initiative included a review of signage and disabled access. They also looked at pictorial communication aids and increased the availability of these.

Staff we spoke with, spoke about some uncertainty in relation to the acquisition. One person said, “Everything is up in the air because of the merger, but we are starting to look at joint policies.” However, almost all the staff were very positive about the acquisition and the possibilities created by being part of a larger organisation. Several of the staff we spoke with had worked at the trust for a considerable number of years and they felt it was a good place to work and there was a sense of shared ownership.
The national staff survey 2017 reported a staff engagement score of 3.78 for Burton hospitals NHS foundation which was in line with the national average.

**Learning, continuous improvement and innovation**

Managers were committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Staff in all areas of children’s services received a good level of information about incidents and learning from incidents; there was a strong safety culture. Staff were also encouraged to question practice and look at possibilities for improvement.

Following the acquisition, managers and staff were working to develop trust wide policies and procedures to ensure a consistent approach across services provided in different locations. Information received following our inspection assured us discussions were in place with nominated people within the directorates to ensure all polices were brought up to date as soon as was practicable. In addition, the trust’s document management policy had been updated to provide greater clarity on definitions of guidelines, standard operating procedures (SOPs) and location of non-clinical guidelines, SOPs and forms.

Cross site working was being established for some specialist nurses. For example, in diabetes and epilepsy and opportunities for further integration were being explored. Consideration was being given to rotation of newly qualified nurses to both hospitals to provide wider experience and encourage staff to consider working at the Queen’s hospital site.

Band six nurses from the paediatric wards rotated to cover shifts in the emergency department, to improve access of children and young people to a paediatric nurse. We were told it had made a big difference to patients’ experience and it supported emergency department staff to provide improved flow of patients. The increased networking between the departments improved staff’s understanding of the constraints in each area.

The senior management team demonstrated an initiative they had undertaken to reduce admission and readmissions to hospital and signpost parents to the most appropriate service and source of advice. An app for mobile phones had been developed, to provide support and advice to parents and carers about common childhood illnesses and signpost parents appropriately. It linked with the trust guidelines and had been developed with other stakeholders. The app was being publicised in the local media including local radio.

The trust was successful in reducing the number of patients who did not attend their outpatient appointments at Royal Derby hospital and were planning to cascade the learning from the initiative to the children’s outpatient clinics at the Queen’s hospital. Some actions had already been implemented at the Queen’s hospital to remind parents of appointments.

The trust provided us with information about other innovations that had been introduced in children’s services at the Royal Derby hospital and the senior management team told us they were committed to transferring learning to services at the Queen’s hospital.
End of life care

Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1st July 2018 following the acquisition by Derby Teaching Hospitals NHS Foundation Trust of Burton Hospitals NHS Foundation Trust. The former trust acquired the latter under its existing registration with the CQC. As such, our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

We have included data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust. Because it relates to the same legal entity as the merged trust we have used this to form part of our judgement.

Where we have included data from the acquired Burton Hospitals NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity, we expected the trust to be able to demonstrate how they responded to the data to improve services.

The trust provides end of life care at two sites – Royal Derby Hospital and Queen’s Hospital Burton. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services.

The trust had 2,407 deaths from August 2017 to July 2018.

(Source: Hospital Episode Statistics)

End of life care is delivered through the trust’s department of palliative medicine with distinct teams on each acute hospital site.

Queens Burton Campus

There is a hospital palliative care team comprising 1.2 WTE palliative medicine consultants, 2.4 WTE clinical nurse specialists and Macmillan therapists providing six-day specialist palliative care services to hospital in-patient beds, outpatient support and weekly support to Sir Robert Peel and Samuel Johnson community hospitals. Additionally, there is a 0.8 WTE end of life facilitator who leads on the implementation best practice and training and education.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

There was no palliative care ward at Queens Burton Hospital. Patients requiring palliative or end of life care were nursed throughout the hospital.

The provision of end of life care services to patients was not the sole responsibility of the hospital palliative care team (HPCT). It was provided by general nurses and doctors who work on the wards throughout the hospital.

The hospital palliative care team (HPCT) provided face to face support Monday to Saturday from 08:30 to 4:30. Outside of these hours, there was a telephone advice line held by inpatient trust staff for specialist advice.
Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 90% or 95% for the completion of most mandatory training modules. The exceptions were:

- Local induction, safeguarding, preventing radicalisation and medicines management, where the target was 85%.
- Resuscitation training modules, where the target was 75%.

These training targets were inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided this service.

Queen’s Hospital Burton

The trust did not provide any mandatory training data for qualified nurses in end of life care at Queen’s Hospital Burton.

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Palliative and end of life care was part of the division for medicine at the trust. Mandatory training rates for medical and nursing staff were reported within the individual directorates.

The trust used an electronic monitoring system to manage staff mandatory training. Staff told us they were responsible for making sure that they were up to date with all their training and could access their training records online. Staff were sent reminder emails when their training was due to expire. End of life care was not part of the trust’s mandatory training programme.

Staff told us they completed their mandatory training which was a mixture of face-to-face training and electronic learning packages. The majority of staff said they believed they were experienced and confident delivering end of life care for their patients and supporting their families but could not recall any specific end of life care training, but felt they had many years ‘experiential learning.’

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 85% for completion of all safeguarding training modules. This target was inherited from Derby Teaching Hospitals NHS Foundation Trust, which previously provided these services.

Queen’s Hospital Burton

The trust did not provide any mandatory training data for qualified nurses in end of life care at
Queen’s Hospital Burton.
Safeguarding training rates for medical and nursing staff were reported within the individual directorates. Staff who provided end of life care said they had received training in safeguarding children and vulnerable adults. Safeguarding training was part of the trust’s mandatory training programme.

There were up-to-date safeguarding policies and procedures in place, which were accessible to staff through the trust’s intranet site. Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise.

Nursing staff understood how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns. None of the staff we spoke with could recall any recent safeguarding incidents relating to end of life care.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

End of life and palliative care patients were nursed throughout the wards at Queens Hospital Burton.

The mortuary waiting and viewing room was visibly clean and had been newly refurbished in 2018.

The trust had ‘A notice of Infectious disease form’. Ward staff completed one of these for each patient that died, to either advise the mortuary that the patient had an infectious disease or they did not. This minimised the risk of cross infection. The bottom section of the form detached and was given by the mortuary to the collecting undertaker. This part of the form stated if the deceased was suitable for embalming and or viewing.

Ward and clinic areas, we visited appeared clean and there was evidence of cleaning regimes displayed and were visible to the public.

We saw infection prevention and control (IPC) policies and procedures in place that were readily available to staff on the hospital intranet. Infection prevention and control was included in the trust’s mandatory training programme.

Hand cleansing gels were available and used in all the areas we visited. We observed staff using hand gels to clean their hands at regular intervals.

In the clinical areas we visited the nursing staff could describe good infection control and hygiene practises before, during and after patient contact. This demonstrated that staff were able to practise good standards of hygiene and minimise risk to patients from cross infection. All staff were observed to be bare below the elbows and complied with good hand hygiene principles (hand washing or gelling) in accordance with the World Health Organisation (WHO) five moments for hand hygiene. Staff had access to personal protective equipment (PPE) and we observed staff using and disposing of this appropriately.

Staff were knowledgeable about what precautions to take if they did have a patient with an infectious or contagious disease who died whilst in the ward area. There was also a trust policy for staff to follow when performing last offices (the process involved in preparing a body for transfer to the mortuary) and staff told us if they had any specific concerns, they would contact mortuary staff or the infection prevention and control team for advice.
Clinical staff had responsibilities for regularly cleaning equipment. Staff had access to wipes to decontaminate equipment. All equipment was visibly clean.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

The mortuary had swipe card access and closed-circuit television (CCTV) surveillance to maintain security. The mortuary waiting and viewing rooms provided facilities for relatives such as comfortable seating and information booklets about bereavement, the trust’s bereavement service and organ donation programme.

The trust had two concealment trollies (specialist trollies for removing deceased patients from the ward to the mortuary). Porters told us the concealment trollies were not suitable as although they were electrified for raising and lowering, the trollies did not raise high enough to reach the top shelves of the fridges in the mortuary, this meant the deceased had to be transferred to the fridges using other means. Porters had raised this with their managers.

The trust used the T34 McKinley syringe pumps for patients who required continuous infusion of medication to control their symptoms and these met the current requirements of the Medicines and Healthcare Regulatory Agency (MHRA) for end of life care patients who required continuous symptom management. This meant that patients were protected from harm when a syringe pump was used to administer a continuous infusion of medication because the syringe pumps used were tamperproof and had the recommended alarm features. Staff told us they did not have a store of their own syringe pumps, however if they required one for a patient, the staff from the medical equipment library were quick to provide them with one. Out of hours, there was a system in place for them to access the equipment library to collect a syringe pump. Syringe pumps were maintained and used in accordance with professional recommendation.

Clinical waste and domestic waste bins were emptied by the cleaning staff on the ward area and disposed of through the trust’s waste disposal procedures. Staff adhered to correct principle for managing and disposing of sharps. Sharps bins were correctly assembled and were not overfilled (all bins were observed to be below three quarters filled).

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**

We attended an early morning handover and saw that at the beginning of each shift incoming staff were updated on the events of the previous shift and key information was shared. During handovers, staff were made aware of any patients who were at risk, for example, those at risk of falls or those who were confused.

The trust used a nationally recognised early warning score assessment tool for recording the observations of patients admitted to the hospital. Early warning scores were developed to enable early recognition of a deteriorating patient. End of life care patients were assessed for how regularly observations were required and this was documented in their notes. In all the patient records we reviewed, we saw that patients who still had their early warning scores calculated and dependant on their individual plan of care and escalation management, appropriate action was taken.

The trust used the AMBER care bundle system. This is a model which provides a systematic approach to management and care of hospital patients who are facing an uncertain recovery and
who are at risk of dying in the next one to two months. We saw care nursing care records where
the AMBER care bundle was used to assist in the planning and delivery of patient care.

On all the wards we visited, we saw that intentional rounding was being undertaken. Intentional
rounding is an organised process where nurses carry out regular checks with individual patients at
set times, normally hourly. During these checks, the nurses undertake scheduled or required
tasks. For example, observations with patients; addressing patients’ pain, positioning and personal
care needs; assessing and attending to the patient’s comfort; and checking the environment for
any risks to the patient’s comfort or safety. Dependent on the individual patient’s level of risk,
these checks were conducted between one to four hourly intervals. Intentional rounding ensures
that if patients have increased needs this is identified for example, mouth care, need for change to
medication (especially if on syringe driver or if they need one).

The hospital palliative care team (HPCT) met each morning to discuss their caseloads and new
referrals made to the team. They used this meeting to discuss any challenges faced for the
patients on their caseload as well as any urgent reviews which were required. Staff told us the
usual referral system for seeking the hospital palliative care team input was by completing an
electronic referral form. However, if they had any urgent referrals or requests, they would contact
the team through a pager system and would discuss directly with the team.

There was a dedicated advice line at the local hospice for professionals to call out of hours and at
the weekend. There was a separate advice line for members of the public. This was a way of
responding to any patient risk.

**Nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to
keep people safe from avoidable harm and to provide the right care and treatment.

**Overall staffing rates**

The trust did not provide any staffing numbers for qualified nurses in end of life care at Queen’s
Hospital Burton.

Nursing staffing rates were reported within the individual directorates. There were no dedicated
end-of-life care beds at the trust. Patients requiring end of life care were nursed on general
wards, throughout the hospital. Nursing staff told us they could provide end of life care and would
always prioritise those patients in the last hours or days of life.

The hospital palliative care team (HPCT) consisted of 2.4 whole time equivalent (WTE) clinical
nurse specialists and Macmillan therapists providing a six-day specialist palliative care service to
hospital in-patient beds, outpatient support and weekly support to Sir Robert Peel and Samuel
Johnson community hospitals. Additionally, there was a 0.8 WTE end of life facilitator who led on
the implementation best practice and training and education. This allowed the team to provide
cover six days a week between 08:30 and 4:30 Monday to Saturday. Information received
following our inspection showed the service would be providing a seven day service from June 2019.

There were no specific handovers from the HPCT to the nursing and medical staff, however, we
saw that staff from the HPCT had written in individual patient records and had communicated with
the named nurse for the patient. We did however attend general ward handovers and found
incoming staff were updated on the events of the previous shift and key information was shared.

**Vacancy rates**
The trust did not provide any vacancy data for qualified nurses in end of life care at Queen’s Hospital Burton. Vacancy rates for nursing staff were reported within the individual directorates.

**Turnover rates**

The trust did not provide any turnover data for qualified nurses in end of life care at Queen’s Hospital Burton. Turnover rates for nursing staff were reported within the individual directorates.

**Sickness rates**

The trust did not provide any sickness data for qualified nurses in end of life care at Queen’s Hospital Burton. Sickness rates for nursing staff were reported within the individual directorates.

**Bank and agency staff usage**

Bank and agency staff usage levels were reported within the individual directorates.

**Medical staffing**

**Planned vs actual**

The trust reported their medical staffing numbers for end of life care for March and October 2018 as below.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>October 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
<td>Fill rate</td>
<td>Actual staff (WTEs)</td>
</tr>
<tr>
<td>Queen’s Hospital Burton</td>
<td>1.2</td>
<td>1.0</td>
<td>-</td>
<td>1.2</td>
</tr>
</tbody>
</table>

The hospital palliative care team (HPCT) consisted of 1.2 whole time equivalent (WTE) palliative medicine consultants.

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 33.3% at Queen’s Hospital Burton. The trust had a target vacancy rate of 6%.

Vacancy rates were reported within the individual directorates.

Staff generally felt end of life care patients, especially those who had been recognised as in their last days of life were prioritised where possible, and most wards told us they had enough staff to enable them to do this.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were a combination of electronic and paper records. These were separated into medical and nursing care records. Health care professionals wrote in both medical and nursing records, which were stored in cabinets in each patient bay or at the nurses’ station. These were
not locked but were always visible to the nurses. Nursing records, assessments and care plans were kept at the bedside.

We reviewed the medical and nursing notes of 11 patients who were receiving end of life care. Notes were accurate, complete, legible and up to date. We saw risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.

All the records we viewed included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the hospital palliative care team information and advice was clearly recorded so that staff could easily access the guidance given.

The end of life care medical documentation contained detailed discussion and decision making with the patient and/or family and outlined the professionals involved in the care. The document also provided guidance and flowcharts for clinicians on symptom control such as management of pain, nausea, agitation and breathlessness. The end of life medical documentation was used in conjunction with the end of life nursing documentation. This was a specialised care plan which was on pink paper so that it was easily recognisable. It addressed five fundamental questions about the patient’s needs each day; their deteriorating condition; symptoms associated with dying; nutritional needs; physical needs; and capacity and consent. In addition, the document included an evaluation chart which was completed every two hours when checks were made on the patient’s comfort, symptoms and any concerns or questions raised by the patient or family.

At the time of our inspection, the trust was in the process of transferring all patient records to an electronic system. There appeared to be some confusion amongst staff as to what paperwork was completed electronically and what paperwork was still completed on paper. On one of the wards we visited, the sister told us that “Half the doctors complete the paperwork records and half the doctors complete the paperwork electronically.” None of the staff we spoke to knew of a date when records would become completely paperless.

In the bereavement office, we reviewed the documentation for a certification after a patient had died and observed the completed medical certificate of cause of death (MCCD) which had been scanned into the electronic record of the deceased. The MCCD enables the deceased’s family to register the death. We found the certificate had been issued within 14 days of death and burial or cremation forms had been signed in accordance with the Births and Deaths Registration Act 1953.

For patients who were being discharged home, discharge summaries were completed and a copy given to patients prior to them leaving the ward. A copy of the letter was also sent to the GP electronically or by fax. We did not see any discharge letters during our inspection.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

The trust used syringe driver pumps for patients who required a continuous infusion of medication to control their symptoms. All the syringe pumps we inspected met the current NHS patient safety guidance, which recommends the use of syringe pumps that have specific alarm features and are tamperproof.

The trust had a protocol called ‘The five priorities for end of life care.’ The protocol was for the last 48 hours of life and provided guidelines for staff on actions to take such as anticipatory prescribing.
We saw that anticipatory medicines for patients were prescribed for the five key symptoms in the dying phase. These symptoms are pain, agitation, excessive respiratory secretions, nausea and vomiting, and breathlessness. This was in line with best practice. By prescribing medicines, ‘just in case’, before the patient has any symptoms, this allowed patients to receive effective symptom control in a timely manner. We saw patients who had been given anticipatory medicines were reviewed in a timely way to ensure the medicines were effective.

There were appropriate systems for the safe custody and checking of controlled drugs and syringe pumps. We saw on the wards we visited that all medicines were stored safely and the record keeping was in line with the trust’s policy. We found controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013.

There was one member of the hospital palliative care team (HPCT) who was a non-medical prescriber. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional’s field of expertise. Another one of the HPCT nurses we spoke with said she would shortly be undertaken her non-medical prescribing course. Information received following our inspection showed by September 2019, three out of four members of the HPCT would have prescribing qualifications.

Staff told us all medications were explained to the patient and their relatives on discharge from the hospital. Medication information was included on the discharge summary for patients, and GPs received an electronic copy of immediately on the patient’s discharge. Where discharge involved district nurses, this was discussed verbally with them prior to discharge.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

The service had no never events reported for patients’ receiving end of life care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From January 2018 to December 2018, the trust reported no incidents classified as never events within end of life care.

Breakdown of serious incidents reported to STEIS

Burton Hospitals NHS Foundation Trust

Data from the pre-acquisition period for University Hospitals of Derby and Burton NHS Foundation Trust is included in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care at Queen’s Hospital Burton which met the reporting criteria set by NHS England from December 2017 to November 2018.

The hospital palliative care team (HPCT) were familiar with the process for reporting incidents,
near misses and accidents using the trust electronic incident reporting system. The HPCT understood their responsibilities to raise concerns and report incidents and near misses. Any serious incidents would be investigated using root cause analysis and where necessary further training would be arranged.

Mortality and morbidity meetings took place monthly. This supported the trusts learning from the deaths review process.

All staff we spoke with had a good understanding of Duty of Candour. Staff talked of being open and honest when things went wrong. Staff were not able to give example of where Duty of Candour had been applied, as they could not remember a time when an incident had occurred requiring a response under Duty of Candour. Senior leaders were aware of Duty of Candour process and the requirement to send formal apology letters to patient and families when a patient had encountered moderate or above level of harm.

**Safety thermometer**

The NHS safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline, is intended to focus attention on patient harms and their elimination, for example, at the nurse’s handover or during ward rounds. The NHS safety thermometer helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide.

Safety thermometer information was reported within the individual directorates.

Safety information and performance was displayed in the ward areas including hand hygiene, infection control and patient feedback.

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**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

End of life care at Queen’s Hospital Burton mostly followed the National Institute for Health and Care Excellence (NICE) Quality Standards relating to best practice in end of life care for adults. However, the hospital did not comply with Statement 10 of those standards:

People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night’ as, the hospital palliative care team did not provide a seven-day face-to-face service.

Following the withdrawal of the Liverpool Care Pathway, the trust had developed and implemented individualised care plans for patients on the end of life care pathway. The individualised care plans recognised the five priorities for end of life care as set out by the Leadership Alliance for the Care of Dying People (2014). Staff were using the trust’s end of life-individualised care plans consistently where patients had been identified as end of life to ensure they received evidence based end of life care.

The trust was using the AMBER care bundle throughout the hospital wards to support the identification of patients with an uncertain recovery. This approach encourages staff, patients and
families to continue with treatment in the hope of a recovery; while talking openly about people’s wishes and putting plans in place should the worst happen.

The trust audited patients preferred place of care or death for end of life care patients. Between March and September 2018, a sample of 66 patient notes were reviewed. Results showed 96% of patients had their preferred place of care identified. Of these, 85% achieved their preference. Results demonstrated a year on year improvement in the number of patients achieving their preferred place of care; 68% in 2016 and 80% in 2017.

The trust audited hospital palliative care response times between January 1 2018 and June 30 2018, recording 915 patients were referred to the hospital palliative care team (HPCT) during this time. Within this sample. 100% of patients were triaged within 4 hours. Once triaged 75% of patients were seen by the palliative care team within 24 hours, with 8% being assessed as not requiring a face to face visit by HPCT. 12% were seen within 2 days and 4% in 3 days.

Since our last inspection, the trust had implemented the use of a computerised electronic referral system. The system enabled the referral of palliative and end of life care patients to the (HPCT) from the nursing and medical staff on the wards. Referrals to the HPCT were mostly made this way, however, the HPCT told us that some staff phoned through their referrals and some staff referred patients both electronically and by phone.

The trust had implemented the use of a ‘Red flag’ system. This is an electronic system which enabled the tracking and location of all end of life care patients. This meant the identification of known patients, their location within the hospital and their specific needs were identified on a regular basis.

The service had an extensive audit programme which included audits on the use of the AMBER Care Bundle. There had been considerable improvement in the use of the Amber care bundle since 2017. The 2018 audit 30 patients supported by ACB compared to 2017: only 1 patient supported by ACB. The amount of time supported on the ACB ranged from 0 – 15 days the average length of days was 3 days and the median length of days was 2 days

**Nutrition and hydration**

*Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences, but did not have a vegan menu.*

We reviewed 11 sets of nursing records for patients in the last days of life and found patients were screened for their risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify patients who are malnourished, at risk of malnutrition and to ensure those who were nutritionally at risk were identified accordingly. Where interventions were required we saw these documented on the patient’s daily record. For example we saw an entry from the dietician on one of the wards we inspected, where a patient required extra nutritional supplements; this was because there was a reduction in the patient’s appetite which was a recognised aspect of their illness. Patients were encouraged to eat and drink as and when they could and for as long as they were able to in their last days of life. Families were also encouraged to support and help their relatives to eat.

We looked at the menu on each ward we visited. The menu was on an iPad which the ward housekeeper used when advising patients of their meal choices. The menu had a main section and one for cultural meals which included kosher, halal and vegetarian options. However, we could not find a vegan section. Staff told us, if a patient requested a vegan meal, they would
contact the kitchen for a vegan meal to be made or a nutritionist would visit the patient on the ward to discuss a bespoke menu. Vegans are classified as the protected characteristic of ‘Belief’ under the Equality Act 2010 and therefore must be treated equally.

Patients receiving end of life care could also order from the children’s menu, this was because there were some end of life care patients preferred the children’s menu choices.

The patient’s relatives we spoke with said the food was good or satisfactory and that there were plenty of drinks available.

Where patients were unable to eat due to their ill health, we saw that care plans were in place for staff to monitor their food and nutrition. A green tray service was used to signify those patients who needed assistance with eating and nutrition.

Pain relief

We saw the core standards for pain management services were being met in all the medical notes we reviewed. The core standards for pain management in England are a comprehensive index of recommendations and standards for pain management patient outcomes.

We saw evidence of patients regularly being assessed for pain and given medication in a timely fashion. For example, we saw an end of life care patient on a ward we inspected, had undergone an assessment of their pain level which resulted in having their medication changed to control this. We saw patients had been prescribed pain relief medication as well as when required (PRN) so that breakthrough pain could be managed. Breakthrough pain can occur in between regular, planned pain relief. Staff confirmed syringe pumps were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief.

The trust used the Pain Assessment in Advanced Dementia (PAINAD) to aid communication for patients with a dementia, sensory loss or had communication needs and are judged to potentially be in pain. The PAINAD assessment tool is designed to be used with both nonverbal and verbal patients.

Patient Outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Appraisal rates

The trust set a target of 90% for the completion of non-medical staff appraisals. They noted that the medical staff appraisal target is set at 100% by the General Medical Council for those who are due an appraisal within a year (this does not include staff on long-term sick leave or a sabbatical of greater than six months).

Trust Wide

From November 2017 to October 2018, 83.3% of staff within end of life care at the trust received an appraisal.
The breakdown by staff group can be seen in the table below:

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<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
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</thead>
<tbody>
<tr>
<td>Medical staff - hospital</td>
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<td>6</td>
<td>100.0%</td>
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<tr>
<td>Administrative and clerical staff</td>
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<td>10</td>
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<tr>
<td>Qualified nurses</td>
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<td>52</td>
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<td>Additional clinical services staff</td>
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<tr>
<td>Additional professional, scientific and technical staff</td>
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<tr>
<td>Healthcare scientists</td>
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<td>3</td>
<td>33.3%</td>
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<td>Estates and ancillary staff</td>
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<td>0.0%</td>
<td>90%</td>
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<tr>
<td>Total</td>
<td>80</td>
<td>96</td>
<td>83.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staff had a 100% appraisal rate, meeting the target set by the General Medical Council. However, qualified nurses had an appraisal rate of 88.5% which was just below the 90% target.

**Queen’s Hospital Burton**

From November 2017 to October 2018, 100% of required staff within end of life care at Queen’s Hospital Burton received an appraisal. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff - hospital</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appraisal rates were reported within the individual directorates.

Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. All qualified nursing, medical and health care support workers we spoke to, confirmed they had received a meaningful appraisal within the past year.

Each ward except for the emergency department and the intensive care unit (ICU) had one or two end of life care champions who had additional responsibilities in relation to end of life care. They supported staff and attended meetings to update the ward of any issues or changes relating to end of life care. We spoke with staff who had this responsibility and found they were passionate about their role.

There was a 0.8 WTE end of life facilitator who leads on the implementation best practice and training and education.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All staff we spoke with on the wards (both nursing and medical staff) commented on the positive relationship they had with the hospital palliative care team (HPCT). They told us even if the HPCT
could not review a patient at the time, they were able to get advice over the phone for care and treatment of patients who were end of life or palliative care. During our inspection, we regularly observed members of the HPCT on the ward areas reviewing patients and engaging with staff members about patients they had reviewed.

All members of the multidisciplinary team worked and interacted well with each other to enable a coordinated approach to the way in which care was delivered. We saw evidence of regular input from dietitians, occupational therapists, physiotherapists, HPCT, social care workers and discharge coordinators involved in the care and treatment of end of life and palliative care patients. We saw evidence of good MDT working when patients required fast track discharges to be arranged. Fast track discharge is a process implemented for patients identified to be within the last days of life and who had a preferred place of care or death outside of the hospital. Members of the MDT, including staff members from the pharmacy department worked to ensure all aspects of a safe discharge to come together in a timely process to ensure the needs of the patient were met. We saw evidence of this process being implemented during our inspection.

**Seven-day services**

The hospital palliative care team (HPCT) worked Monday to Saturday from 08:30 to 4:30. Outside of these hours, there was a telephone advice line held by inpatient trust staff for specialist advice. The trust recognised they were not providing a HPCT seven days a week. However, they told us there were plans for this to commence and had already submitted a business case in January 2019. Information received following our inspection showed recruitment had taken place and the service would be providing a seven day service from August 2019.

End of life care was provided by general nurses and medical staff on the wards throughout the hospital seven days a week and 24 hours a day.

The chaplaincy service provided pastoral and spiritual support and was contactable out of hours. The mortuary provided a 24-hour, seven day a week service to the trust and to the coroners office.

Bereavement services were open Monday to Fridays from 08:30 until 4:30pm except Bank Holidays.

An out of hours viewing service was provided by the mortuary for cases at the discretion and availability of the staff on duty

**Health promotion**

Staff supported patients who were end of life or receiving palliative care to maintain healthy choices and healthy lifestyles. Information about healthy diets was given to all patients. There were specialist nurses and other allied health professionals to support patients. For example, occupational therapists and dietitians were involved in promoting healthy lifestyles for patients.

On the wards we saw that nutrition and hydration posters were clearly visible for patients and displayed information on how to undertake a healthy diet.

**Consent, Mental Capacity Act and DOLs**

Mental Capacity Act and Deprivation of Liberty training completion

Queen’s Hospital Burton

Page 528
The trust did not provide any mandatory training data for qualified nurses in end of life care at Queen’s Hospital Burton.

We did not see any end of life or palliative care patients deprived of their liberty during this inspection.

Mental capacity assessments were included as part of the last days of life care plan for end of life care patients. Patients and relatives told us that staff did not provide any care without first asking their permission. Signed consent forms were evident in most of the patient records we examined. Nursing and medical staff told us they had received training on the Mental Capacity Act and how to complete mental capacity assessments. Doctors completed the mental capacity assessments, even though nurses and allied health professionals were also trained to do so by the trust.

Do not resuscitate orders were stored in the front of the patients’ notes. The forms had a red edging so were easily identifiable and accessible.

During our inspection, we looked at 15 ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) orders across the hospital, and found there were inconsistencies in how these were completed. We found that out of 15 DNACPR orders, 11 were not completed correctly (74%). We found staff had not always followed trust policy when they completed DNACPR orders and DNACPR orders were not completed accurately for several reasons. These included;

- lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and or their families and care givers.
- DNACPR orders that were not signed by the senior clinician as well as lack of discussion with the patient and community.
- DNACPR orders dated 2015 that had not been reviewed or updated.

Staff did not always understand or adhere to the principles of the Mental Capacity Act 2005, on one ward we saw two ‘Do Not Attempt Cardio Pulmonary Resuscitation’ orders in place. Both of these stated the reason for not discussing the form with the patient was they ‘Lacked Capacity’, however, we could not find a mental capacity assessment for either patient. We escalated this to the ward manager. When we returned to the ward later the same day, both the mental capacity assessments were completed but were not completed accurately. For example, in one case the section which stated in capital letters ‘You must provide sufficient evidence to explain your answers had been left blank. In the other case, and in the same section, the doctor completing the mental capacity assessment had written “see above”. The above section had “DNACPR” written in it and nothing else.

The nurse in charge of the ward escalated both cases again to a senior doctor whilst we were there. We asked the senior doctor if they had received training in undertaking mental capacity assessments, they advised us that it was mandatory training for all doctors and that the training was repeated annually.

On the same ward, we saw a DNACPR order for a patient that had been completed when the patient was very ill two months previously and not expected to live. The patient had since recovered and was much better and at the time of our inspection and was now receiving active treatment. We noticed the DNACPR order had ‘Cancelled’ written across it. We discussed the DNACPR order with the patient, who told us they were not aware that the DNACPR had been cancelled. There was no entry into the medical notes to explain the reason for cancelling the DNACPR order.
On another ward, we looked at a DNACPR order in the front of a patient's notes, the DNACPR order had four diagonal lines across the length of the page from one corner to the other. We asked the ward sister what that meant and they confirmed with the doctor that it had been cancelled. We looked in the medical notes but could not find any evidence of a discussion with the patient or family concerning the cancelling of the DNACPR order.

On a separate ward, we saw a DNACPR. The reason given for the DNACPR order was “Brain tumour”. The form stated the patient “Has capacity”, however, the DNACPR order specified the decision not to resuscitate the patient had been discussed with the patient’s family, but not the patient. This meant the principles of The Mental Capacity legislation had not been followed.

On the same ward we saw a DNACPR which stated, “Has community DNACPR dated 10/12/2018 which states “Lacks capacity”. We spoke to the ward sister concerning this, they advised they did not know if the doctors had investigated this. We could not find an entry into the medical notes to state that. This meant there was no evidence the patient was not capacitated and the principle of ‘fluctuating capacity’ which is part of The Mental Capacity Act had not been considered.

The trust did not at the time of our inspection audit the mental capacity assessments. This meant that any training needs might not be identified on a formal basis and any changes in legislation or guidance on best practice might not be identified and implemented.

During our inspection, we escalated these issues to chief executive officer, the chief nurse and the medical director. After our inspection the trust advised they had implemented some immediate actions to mitigate the incorrect completion of both mental capacity assessments and DNACPR orders. The trust advised that

- A consultant had visited the wards on the day of escalation and reviewed all mental capacity and DNACPR orders forms.
- The deputy medical director for quality and safety attended medical handover the following morning to highlight issues raised and actions required.
- A ‘what good looks’ dummy mental capacity assessment and DNACPR order were created and circulated to all medical staff the following day.
- Regular spot checks were undertaken by lead staff following the inspection.

The senior leaders confirmed there was a comprehensive longer-term action plan in place prior to the inspection because the trust had already identified concerns in this area of practice. This action plan had been further strengthened.

We returned to the hospital three weeks later and looked at a further 15 ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) orders across four wards. We found a significant improvement with 11 out of 15 DNACPR orders completed correctly. Of those not completed correctly, two had no mental capacity assessments where the patients had been deemed to lack capacity and two had mental capacity assessments completed greater than five days after the DNACPR order had been completed, this meant they were invalid as mental capacity assessments must be completed at the time a decision is required and not retrospectively.

The trust completed audits to identify standard completion of DNACPR forms. Both in August 2018 and November 2018 a total of 34 forms were audited. The form included two pages, separated on completion, with the bottom page (a carbon copy) sent to the resuscitation trainers to review. The resuscitation trainers received 100-150 forms every month. To collate the most up to date medical record, all in patient areas were visited, the audit was conducted with notes in situ on wards and a sample of those who were present were audited.
The August 2018 audit identified that DNACRP forms were filed mostly at the back of the patient record, the November 2018 audit found all DNACPR forms audited were filed correctly at the front of patient records.

The August 2018 audit recognised a presumption that mental capacity assessment was not required for DNACPR's which were completed in the community as this decision was not made in the Trust. The November 2018 audit found this presumption remained.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), that staff spoke about the patients they cared for with compassion, dignity and respect. Without exception we also observed patients being treated with compassion, dignity and respect by all staff, including the transfer of the deceased patient to the mortuary. We spoke with the relatives of four patients who were receiving end of life care. The relatives described the care and support as excellent and said they felt well informed by the staff.

The trust had a bereavement service and we saw staff providing support for relatives, following the death of a patient. We saw staff supported patients to access private relative’s rooms, which were available on most wards, to facilitate sensitive conversations could be undertaken. We saw staff supporting relative to visit when they chose and normal visiting times were waived for relatives of patients who were at their end of life.

We saw the chaplain assisting nursing staff to ensure that care and treatment was provided to patients with due regard to their religious persuasion.

The mortuary porters told us they always treated the deceased with the greatest of respect when transferring them from the ward to the mortuary and could describe the process of collecting the deceased from the ward. For example, they would advise the nursing staff they had arrived, the porters would leave the concealment trolley on the landing outside of the ward until the curtains could be drawn around the patient’s beds on the ward. This was to promote dignity and privacy.

Porters told us that ward staff treated the deceased with dignity and respect before they were transferred to the mortuary. Nurses undertook what is known as ‘Last offices’, this is the procedure performed by nurses to the deceased shortly after death has been confirmed and is the process where the deceased is prepared for transfer to the mortuary.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Family members we spoke with told us they felt involved in the care delivered. We saw staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient’s notes.
We saw staff providing guidance literature for patients and their relatives. This included a booklet about end of life care and what they might expect to happen. There were also patient and relative information leaflets around the last days of life care plan and the processes involved in caring for patients at the end of life.

Nurses from the hospital palliative care team (HPCT) spent time with patients and their families to provide reassurance and support and answer any difficult questions they may have in relation to the treatment being received. The team acknowledged the importance of supporting not only the patient but their relatives and friends throughout the dying process.

The chaplaincy service was aware of all those patients who required end of life care as the chaplain attended the hospital palliative care weekly multidisciplinary (MDT) meeting where all palliative and end of life care patients were discussed. The chaplain provided emotional support to patients, families, loved ones and staff. The chaplaincy service provided a 24-hour seven day a week on call service for patients in the hospital, as well as their relatives and loved ones and aimed to see people within the hour.

Communion was held at the patient’s bedside by the chaplain if patients were too ill to attend the chapel. The chaplain told us they conducted last rites and blessed the deceased in the mortuary as required.

The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress. There were several thank you cards in the multi-faith chapel thanking the staff for their support during times of bereavement.

Although not licensed to conduct weddings for end of life care patients, the chaplaincy team could facilitate weddings with a community registrar within four hours of a referral for an end of life care patient and their partner. We spoke with one patient and their partner, who said the chaplain had arranged an “emergency wedding” within two hours late on a Friday evening a few months ago, when it was thought the patient only had a few hours to live.

Volunteers were used to escort patients to religious services in the hospital or sit with end of life care patients as required.

The chaplaincy worked with local faith leaders to ensure deceased patients were cared for following their cultural and religious requirements.

Chaplaincy, bereavement and mortuary staff demonstrated empathy for the relatives, loved ones and friends of the deceased, thereby showing a holistic approach and the skills needed to provide for the emotional needs of those left behind.

The viewing of deceased patients was carried out in a dedicated area in the mortuary divided into a waiting room and a viewing room, both of which were appropriately decorated.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Staff were aware of patients who were end of life or in need of palliative care and were reliant on having their relatives and loved ones close to them, and how involved the families and friends of patients when planning and providing care. They ensured that those close to the patients were present when advising of any updates to the patient.
All the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.

We saw staff discuss care issues with patients and relatives where possible and these were generally, clearly documented in patient’s notes. An example of this was on one of the wards we inspected, we saw a doctor explain to a patient and their relatives some of the side effects of their medication. This was done concisely and in plain English.

Staff ensured that sensitive communication took place between staff and the dying person in an atmosphere of dignity and respect.

Mortuary staff understood where religious needs required a prompt burial and worked to facilitate this. The bereavement also office understood how certain religions required patients were buried as soon as possible after death. In such circumstances, they tried to ensure that all the relevant paperwork was completed as soon as possible to issue the death certificate and release the body within the appropriate time.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.

The hospital palliative care team (HPCT) provided two outpatients clinics to offer treatment for patients being cared for by the team.

The bereavement office provided a responsive service to bereaved families and provided further advice as required. For example, the service had written a booklet entitled ‘Because We Care’ for bereaved families and loved ones. The booklet had a section on ‘Practical necessities’ and explained in plain English ‘What to do first’. ‘The booklet explained the process if the Coroner and or if a post-mortem examination was required. Information was provided on tissue donation, arranging a funeral, the grieving process and where families could obtain further help and counselling if required. The bereavement office undertook and annual survey and this was included in the booklet as a tear-out page. As well as a paper booklet, the booklet was available on the trust website and was suitable for downloading.

The Bereavement service had devised a ‘Tell us once’ service, which meant the bereaved only had to tell the bereavement service once of any relevant information. Through this service, the staff assisted with issues such as patients’ passports, state benefits and liaised with funeral directors.

Staff provided ‘comfort packs’ for families of patients if they had to stay in hospital unexpectedly to be with relatives who were approaching the end of their lives. These included items such as toothpaste, toothbrush, comb, soap and other essentials. Staff would support families by having open visiting and the use of a camp bed, should family members wish to stay overnight. However, due to the design and size of the side rooms, this could mean the space was very cramped. Staff said they made regular drinks for families and one housekeeper told us, she always gave breakfast to relatives if they had stayed overnight.

The trust had no dedicated end of life beds in the hospital. Nursing staff told us where possible and if appropriate patients receiving end of life care were nursed in side wards to afford them and their relatives more privacy and dignity, however patients with infection prevention and control risks took priority.
The nurses from the HPCT sent sympathy cards to bereaved relatives of patients for whom they had cared for and made follow up telephone calls to families to offer any further support that they could.

**Meeting people’s individual needs**

**The service took account of patients’ individual needs.**

The trust had a chaplaincy service, to support patients’ and relatives’ individual spiritual and emotional needs. The service had links and access to local faith leaders for patients of different religious beliefs, including Christians, Muslims, Sikhs and Buddhists, as well as providing support to non-religious patients.

The chaplaincy team, which included volunteers, regularly visited significant ward areas such as the emergency department and the intensive care unit and visited all those patients who had been placed on the individualised end of life care plans. Within the chapel, there were prayer mats and washing facilities for Muslim prayer. There were reading materials for other faiths such as Sikhs and Buddhists, as well as non-faith material.

Interpreters were available when required for patients whose first language was not English.

Staff described of how they made ‘reasonable adjustments’ for patients with learning disabilities or those living with dementia. For example, one member of ward staff explained how they had ensured a patient with a learning disability was cared for in a side room so their care giver could stay with them. The trust had three learning disability toolkits for end of life care patients who were living with a learning disability or dementia. Although not specifically for palliative and end of life care patients, the toolkits comprised of several different laminated cards with animated pictures on and the word they meant. For example, Grief, was shown as a person looking sad and funeral, showed several sad people at a cemetery. The toolkit was kept in the medical library and could be accessed by staff during normal working hours.

The trust was in the process of building a bereavement garden, for the purpose of inviting relatives back three times per year to plant bulbs and flowers. A sculpture had been commissioned for the garden.

The “Birds Model”, in place at the Royal Derby Hospital site, comprises recognising dying forms endorsed by the patient’s consultant, when staff identified when a patient was potentially in the last hours/days of life. The form allowed staff to consider a person’s views and preference for care, whilst regularly reviewing and responding to change in plan of care. This model was to be rolled out to the Queens Hospital Burton site this year once education had commenced.

**Access and flow**

**People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.**

Records showed evidence of patients being reviewed by the HPCT within 12 hours, some of which were seen within eight hours. Patients who required ongoing support by the HPCT were usually seen on a regular basis (every two to three days) unless the condition of the patient required more regular input. Staff on the wards were extremely positive about the input they received from the team.

Referrals were undertaken to the HPCT electronically, by phone or using both systems. If referrals were received by phone, normally in urgent cases, all information was logged by the specialist
nurse on to the electronic system. For example, we saw an urgent case that had been referred and logged by a member of the HPCT during our inspection.

Where a patient had a rapidly deteriorating condition and may be entering a terminal phase, an application could be made on their behalf and with consent for the NHS to fund their care (Fast Track Pathway for NHS Continuing Health Care funding). The purpose of this pathway was to expedite care provision in the setting of the patient’s choice. However, staff told us that some discharges were delayed by the lack of provision of equipment such as a hospital bed, which were ordered by the district nursing service, or the lack of a care package in the community or nursing home bed. This could happen especially at weekends or out of hours.

Nursing staff told us fast track discharges usually took up to 48 hours to arrange but in some cases, this could take longer. Fast track discharge is a process implemented for patients identified to be within the last days of life and who had a preferred place of death outside of the hospital.

The trust had Rapid discharge home to die pathway. Patient discharge in these circumstances was facilitated by the HPCT clinical nurse specialists.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff.

Summary of complaints

Trust level

From October 2017 to September 2018 there were no complaints for end of life care for The Queens Hospital Burton.

Number of compliments made to the trust

From October 2017 to September 2018 there were four compliments within end of life care.

The breakdown by site is shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens Hospital Burton</td>
<td>4</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

The trust had an up-to-date complaints policy. The policy was available for staff to access on the trust intranet. The policy and procedure provided guidance and standards for the handling of complaints.

Information on how to raise a concern or make a complaint was available in the wards we visited. Patients and relatives told us they would feel comfortable raising a complaint with ward or the Patient Advice and Liaison Service (PALS).

Staff told us that if a patient or relative had concerns about care being delivered they would try and address the issue at the time to resolve the concerns as quickly as possible. None of the staff could remember a complaint about the service.
**Is the service well-led?**

**Leadership**

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care

At the time of our inspection, Queens Hospital Burton had undergone a recent acquisition with a neighbouring trust six months previously, this meant that all priorities for ensuring sustainable, compassionate, inclusive and effective leadership and succession planning were currently being reviewed to amalgamate into a trust wide strategy.

Staff confirmed there were regular formal information relaying processes including messages from the chief executive and board of directors. Staff were aware of the leadership structures and told us they received good local leadership and support from their immediate line managers. Staff described local leaders as visible and approachable. Staff were clear about their roles and the roles of others within end of life care services. Managers spoke confidently about staff they managed, both their professionalism and commitment to the job.

Ward staff felt senior management were approachable and supportive. They could name the HPCT nurses and could give us examples of cases where they had felt involved with improving patient care for patients who were at the end of life.

The service was in the process of integrating into the acquiring trust at the time of our inspection, staff were therefore in the process of becoming familiar with the new organisation as a whole.

There was a non-executive director (NED) for end of life care at board level. Non-executive directors work alongside other non-executives and executive directors as an equal member of the board. They share responsibility with the other directors for the decisions made by the board and for the success of the organisation in leading the local improvement of healthcare services. This meant the provider had a designated person at board level to champion the strategic direction of end of life care within the organisation.

The trust had a service improvement lead for end of life care.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Due to the recent acquisition by a neighbouring trust, the service was in the process of apprising its end of life care strategy.

At the time of our inspection, the trust had an end of life five-year care strategy which had commenced in 2016, the strategy document included the development of end of life care pathways in line with guidance and recommendations from the National Gold Standards Framework in End of Life Care.

The end of life care strategy had vision, values and a strategy which had been developed using a structured planning process in collaboration with staff at the trust and secondary care in the community. The service was clear on what it wanted to achieve and had workable plans to turn it
into action developed with involvement from staff. However, the management of the end of life care strategy was not well embedded across the trust. Of the 11-ward staff we spoke with, two knew what the strategy was and where it could be accessed.

We asked three different members of staff to find the end of life care strategy on the staff intranet. None of the staff were able to do so. However, staff were aware of their responsibilities and their role in the delivery of good end of life care and the documentation required to deliver good evidence based care

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Nursing and medical staff spoke positively and passionately about the service they provided for end of life and palliative care patients. Staff were committed to providing and ensuring patients received a good end of life care experience. Without exception, all staff were dedicated to ensuring patients received end of life care in the way and where they wished. Nurses told us that end of life care was always considered a high priority for them. They also spoke with pride about the importance of helping individuals achieve a comfortable and pain free death.

Staff reported positive working relationships, and we observed that staff were respectful towards each other. All staff said they felt confident to raise concerns with their managers.

The trust had a nominated freedom to speak up guardian (FTSUG) who encouraged and enabled staff to speak up safely within the workplace.

There were systems in place to ensure that staff affected by the experience of caring for patient at end of life were supported. There were opportunities for formal debriefings as well as informal support.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

At the time of our inspection, Queens Hospital Burton had undergone a recent acquisition with a neighbouring trust six months previously, this meant that all priorities for ensuring sustainable, inclusive and effective governance were currently being reviewed.

Governance for end of life care was part of the integrated governance structure, within the specialist and ambulatory care medicine division. There were clear lines of accountability including a structure for cascading information to the senior management team and back down to staff delivering care.

The trust were central members of the Derbyshire alliance for end of life care, which is a toolkit designed collaboratively by professionals who work across Derbyshire for end of life care to help teams plan and deliver care for people in their last months, weeks and days of life.

New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. All the staff involved with the provision of end of life care, could demonstrate they received regular communication from the board, heads of service and team leaders. This meant there were clear lines of accountability including a structure for cascading information to the senior
management team and back down to staff delivering care, and that staff could keep up to date with current practice and national guidance.

There was an extensive number of policies and procedures available each stating the roles and responsibilities of staff within the organisation. Staff could access these documents through the intranet. All the documents we reviewed were up to date and relevant to service delivery, but were in the process of being reviewed, due to the recent acquisition.

**Management of risk, issues and performance**

*The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.*

Governance arrangements were in place for risk management and staff told us that they received feedback after incidents had been investigated. Staff also felt confident that incidents led to learning and changes being made.

The service operated its own risk register, which included the ongoing risks identified for end of life care services. Risks were recorded and managed using the trust’s electronic incident reporting system.

Mortality meetings took place monthly, where staff discussed patient deaths within end of life care. The meetings identified the circumstances of the patient the diagnosis and prognosis the initial and follow-up care and treatment they had received and the circumstances of the death.

The end of life care team supported the Trust winter plan, the department of Palliative Medicine contributed through operational management. The Hospital Palliative Care Team supported bed management by identifying appropriate patients and transferring them during out of hours periods to available beds in the Nightingale Macmillan Unit.

During the seasonal pressures, the delivered training by the end of life care team continues, with no sessions being cancelled. The Trust have identified their commitment to end of life care over the previous three winters, as staff were released from clinical duties to attend this training.

**Information management**

*The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.*

Trust policies and procedures were available for all staff and accessible via the trust intranet, information about end of life and palliative care patients were discussed, at the daily huddle and on-board rounds.

Referrals to the HPCT were undertaken on an electronic system, or if urgent, by phone. The trust had recently implemented the use a new electronic system which enabled the tracking and location of all end of life care patients. This meant the identification of known patients and their specific needs were identified daily.

GP’s made referrals for palliative and end of life care patients using either an electronic referral system, by letter or fax

There were sufficient computer terminals on the wards to enable staff to access the trust’s intranet and external internet information. There were some computer terminals on wheels (COWS) which enabled nurses to sit with their patients in the bays whilst updating electronic records. We
observed one nurse sitting talking to a palliative care patient whilst working on the COW terminal and sharing a chat and cup of coffee with the patient. This meant that nurses could spend more time with their patients.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Patient representatives took part in the end of life care steering group meetings, which allowed senior staff to hear first-hand feedback on the experiences of patients, relatives and care givers.

The service undertook an annual bereavement survey and identified areas of improvement needed where the responses were negative. Information from the bereavement services questionnaire was discussed during end of life steering and operational group meetings and used to reinforce positive action and improve services.

End of life and palliative care was provided on general wards throughout the hospital. All wards we visited had at least one end of life care champion who had received additional training in end of life and palliative care. They acted as a local source of information and advice for any other staff members caring for end of life or palliative care patients.

The trust was involved in the wider community and were members of the Derbyshire wide strategy group and was also a member of the Derbyshire Alliance for end of life care; this group co-ordinates education across the county and the Derbyshire end of life toolkit.

The chief executive wrote a weekly e-mail to staff on a Friday called ‘Exceptional care together.’

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust had precured the Sage and Time project. This is a national program aimed at training staff to have difficult conversations. This had been especially beneficial, at the Royal Derby Hospital site, for overseas nurses who had found the program useful as it also offered cultural guidance for talking to patients and their families. This was part of essential to role training and was due to commence at Queens Hospital Burton in May 2019.

At the time of our inspection, the trust was trialling the use of red ‘dignity pegs’. These were pegs placed on the curtains when they were closed around the patient’s bed alongside a no entry sign, when treatment or care was being undertaken. This was to encourage staff to stop and think and not just enter when the curtains were drawn.

The mortuary manager had purchased several DVD’s with music associated with the Amazon rain forest and whale songs for the viewing room, to give an atmosphere of calm for the relatives viewing their deceased loved one.

The trust employed a 0.8 whole time equivalent (WTE) end of life facilitator who led on the implementation best practice and training and education.

Although not formally a part of the NHSE Transforming End of Life Care in Acute Hospitals programme, the Trust have aligned to this model to underpin service improvement and training, and have worked to implement the key enablers, beginning with the AMBER care bundle in 2013.
Since this time the Trust have implemented an approach to all key enablers except EPaCCS. EPaCCS remains a part of the Trust work plan however this is being undertaken in partnership with the Derbyshire wide Alliance for End of Life Care.
University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1\textsuperscript{st} July 2018 following the acquisition by Derby Teaching Hospitals NHS Foundation Trust of Burton Hospitals NHS Foundation Trust. The former acquired the latter under its existing registration with the CQC. Our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data relate to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

There were 901,332 first and follow appointments from October 2017 to September 2018. It was the 20\textsuperscript{th} largest provider nationally.

Of the 1,126,788 appointments handled by the trust over the same period, approximately 10\% were at Queens Hospital Burton, and 3.7\% were trust wide appointments which were held at either Royal Derby Hospital or Queens Hospital Burton. Royal Derby Hospital hosted 72\% of the appointments and the rest took place at community hospitals.

We inspected outpatient services at Queens Hospital Burton, which included outpatients A and B in the main building (medical outpatients), eye casualty, ophthalmology, ENT, ENT casualty oncology, gynaecology, diabetes clinic, and fracture clinic. We also inspected outpatient services at Samuel Johnson and Sir Robert Peel hospitals at Lichfield and Tamworth, respectively, which ran a range of outpatient clinics. Samuel Johnson hospital provided specialised lucentis injection and UVB treatment.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Our last inspection of Queens Hospital Burton in 2015 stated that:

- The trust must review policies and procedures for planning and booking outpatient clinics to ensure that waiting times for appointments are minimised and patients are not subject to long delays in waiting for appointments. Waiting times in outpatient clinics should be routinely monitored.

- The trust must ensure managers are sighted on issues affecting the responsiveness of outpatient services and risks are identified and actioned.

Our last inspections, in 2015, of Samuel Johnson community hospital Lichfield and Sir Robert Peel hospitals said that, for both hospitals, the trust should:

- Routinely monitor the time patients wait for their appointment in out-patients to ensure services are responsive to peoples' needs and identify any issues and/or associated risks.
**Type of appointments**

The chart below shows the percentage breakdown of the type of outpatient appointments from October 2017 to September 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at University Hospitals of Derby and Burton NHS Foundation Trust from October 2017 to September 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

From October 2017 to September 2018, there were proportionately more hospital and patient cancellations at Queens Hospital Burton than other hospitals in the trust. However, the amount of did not attends (DNAs) was slightly lower than Royal Derby Hospital and lower than the England average.

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**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*A Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

Outpatient services managed and monitored mandatory training effectively. Mandatory training covered a range of relevant subjects including equality and diversity, adverse incident reporting, conflict resolution, infection control, information governance, immediate life support, basic life support and paediatric life support.

The trust met its own target of 90% training completion rate between April and October 2018 for qualified nursing staff at Samuel Johnson and Sir Robert Peel hospitals. At Queens Hospital Burton the service met the target for most subjects, and 22 qualified nurses had advanced life support training. However, outpatients did not meet the target for Mental Capacity Act and Deprivation of Liberty Safeguards level one, blood handling and administration, or blood transfusion theory. Compliance rates were 88.8%, 75% and 0% respectively.

No medical staff mandatory training data was provided by the trust for outpatients at Queens Hospital Burton. Following our inspection, we requested details of medical staff mandatory training and level of safeguarding compliance figures for Queens Hospital Burton, the trust provided data for Royal Derby Hospital only.
Safeguarding

The executive nurse director had overall responsibility for safeguarding vulnerable persons across the trust supported by a safeguarding lead and team of named nurses. The trust had policies in place for safeguarding children and adults with clear guidance to support staff with safeguarding concerns. The safeguarding children policy also included female genital mutilation, child sexual exploitation and modern slavery.

Safety and safeguarding policies were effectively communicated to staff. Staff explained clearly the cases they had referred and the action they had taken. They gave us specific examples such as how they acted to safeguard a patient at risk of self harm. They were knowledgeable about safeguarding alerts and could describe the different categories of abuse. They were frequently supported by the safeguarding team.

The trust recognised that although staff took appropriate action, they could improve the quality of referrals. Staff took prompt action and were able to refer directly to the local authority. However, this bypassed the safeguarding team. When the safeguarding team audited some of the referrals, they found that in a third of cases best practice had not been applied. Since then, Burton hospital had strengthened its capacity for safeguarding supervision.

Staff received appropriate safeguarding training. Outpatient services in Queens Hospital Burton met their targets for level three training for nurses who treated children, and for level two adult safeguarding training.

Staff told us that safeguarding was given the highest priority. All the staff we interviewed were knowledgeable about how to identify any vulnerable children or adults in outpatients. The trust flagged safeguarded patients in their electronic record system, so staff had a knowledge of these patients before they arrived in clinic.

All nurses in outpatients who had level three training covered child sexual exploitation and female genital mutilation policies (FGM). However, they told us they had not yet made any referrals for concerns of this nature.

Where a patient was assessed to be at risk of suicide or self-harm, arrangements were put in place to enable them to remain safe. Staff had telephone access to the mental health team based on-site in the Emergency Department. Staff also told us they would contact the patient’s GP for support and gave us an example of when had done this.

Safeguarding training completion rates

Qualified nursing staff at Queens Hospital Burton, Sir Robert Peel and Samuel Johnson hospitals all met the trust target of 90% of staff trained in safeguarding courses from April 2018 to October 2018, with 100% of eligible staff completing child protection level three.

A breakdown of compliance for safeguarding training courses from April 2018 to October 2018 for qualified nursing staff in outpatients at Queens Hospital Burton is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 3</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>373</td>
<td>376</td>
<td>99.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>367</td>
<td>376</td>
<td>97.6%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>366</td>
<td>376</td>
<td>97.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
No medical staff safeguarding training data was provided by the trust for outpatients at Queens Hospital Burton.

**Cleanliness, infection control and hygiene**

Appropriate precautions were taken when seeing people with suspected communicable diseases in line with the trust’s infection prevention and control policies and guidelines.

The extent to which standards of hygiene were maintained differed across outpatient services. Services such as gynaecology and ophthalmology had cleaning schedules for clinical areas. However, there were areas where cleaning was less formalised. For example, in ENT the children’s play equipment was deep cleaned monthly but there was no official rota for daily cleaning. Staff told us this was done as and when healthcare assistants had time.

Hand hygiene did not appear to be routinely audited in all services. Outpatients A and B did not do this and told us it was due to difficulties in monitoring.

Most clinical environments within outpatients were clean and accessible. We saw nursing staff using the sanitiser gel before and after patient contact. In addition, personal protective equipment was available to staff in all areas and we observed it was used appropriately.

Following our inspection, we asked the trust for the results of any recent infection prevention and control (IPC) audits carried out in Outpatients services. We received the results of one environment audit carried out in December 2018 in Outpatients A and B. Results showed a compliance score of 96%. Areas of non-compliance were identified, and we saw where appropriate action had been taken as a result of the audit.

Most areas followed trust procedures for storing waste. However, we observed that in cardiology there was nowhere to store waste and it was bagged up and collected from the corridor.

**Environment and equipment**

Resuscitation equipment was readily available and staff we asked knew where to find it. We checked resuscitation trolleys in ENT, ophthalmology, maxillo-facial, and oncology services at Queens Hospital Burton, Samuel Johnson and Sir Robert Peel hospitals. Appropriate paediatric resuscitation equipment was provided everywhere children and young people were seen.

The maintenance and use of equipment kept people safe. We checked blood pressure monitors, bariatric weighing scales, urinalysis machine and intravenous pumps at Queens Hospital Burton and a range of equipment at Samuel Johnson and Sir Robert Peel hospitals. They were all within their service date and had been safety tested. Staff were given training in the use of equipment.

The layout of some Outpatient clinics did not promote safe care. In cardiology, corridors were narrow for bed access as a result, mobile machines for example an echocardiogram had to be brought to the patient. Equipment such as electric charging points for blood pressure monitors was kept in the corridor area due to lack of space. The floor was carpeted which staff told us they had raised as an infection control risk. Scrubs (sanitary clothing worn by health care professionals) and linen bins were kept in the corridor. Bagged waste was left in the corridor for collection by porters, which added to the clutter.
Outpatients A and B also lacked space. It had narrow corridors and small waiting areas. Environmental risk assessments had been carried out at all hospitals and senior managers had oversight of the issues posed by these environments.

The procedure room in gynaecology was very small and there was no separate area to store non-consumables. Medicines and equipment required for various procedures had to stay in a small adjacent clinical area. The room overheated in summer and pharmacy had mitigated the risk to medicines by reducing expiry dates by six months.

Some clinics offered services for both adults and children in the same facilities and clinic sessions, there were few areas specifically for children and they shared the same waiting areas as adults. Where play areas were provided, we saw a children’s room in fracture clinic where small children could go if they were distressed. Staff had access to play specialist advice for children if needed.

Computer access was limited for staff in some areas. Computer equipment was shared between clinics, for example in outpatients A and B at Burton and cardiology. This led to some staff printing off manual patient records and delayed the printing of patient labels.

**Assessing and responding to patient risk**

Managing individual patient risk was inconsistent across the hospitals and clinics we visited. In some specialties in outpatients A and B at Queens Hospital Burton no individual risk documentation was completed for outpatients. For example, staff did not routinely carry out a falls risk assessment unless the patient had a fall. However, other specialties such as ophthalmology took a proactive approach and for example, checked the blood sugar levels of diabetic patients on arrival.

In some clinics there was an absence of daily huddle or formal meeting to start the day. This limited the transfer of knowledge about events or incidents or about the needs of individual patients.

There was a trust wide approach to managing deteriorating patients. The national early warning score (NEWS) was used to identify deteriorating patients in accordance with National Institute for Health and Care Excellence (NICE) guidance (CG) 50: ‘Acutely ill adults in hospital: recognising and responding to deterioration’ (2007). Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate, pain, and the monitoring of a patient’s clinical condition. There were clear instructions to follow when patients’ scores indicated deterioration.

However, the approach to managing the deteriorating adult or child outpatient was inconsistent and, in some cases, informal. In outpatients A and B and other clinics at Queens Hospital Burton staff, were unable to explain an escalation policy or confirm that they had seen one. They told us they would have taken a patient to a side room, done observations and alerted a consultant. Other specialties would have put out a crash call, but they were not all aware of the trust guidance on proactive management of patients at risk. However, Samuel Johnson and Sir Robert Peel hospitals staff described their deteriorating patient policy to us clearly and how they would access support.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. There was an up to date trust policy that incorporated a sepsis pathway. A sepsis tool enabled staff to detect the deteriorating patient and record when they had not followed the plan and used alternative treatments. The trust sepsis nurse specialist ensured continuity and compliance with NICE guidelines.
There were no registered children’s nurses in outpatients at Burton, access to support from paediatric nurses was sourced through the paediatric wards. A registered children’s nurse at Samuel Johnson hospital gave advice on children, paediatric care and play.

Safety standards for invasive procedures helped to control risk to patients. Services used National Safety Standards for Invasive Procedures (NatSSIPs) guidelines and World Health Organisation (WHO) checklist documentation, for example, in ambulatory gynaecology clinics. However, managers told us they did not plan to develop Local Safety Standards (LocSSIPs) or assess the need for these against all invasive procedures carried out. NatSSIPs cover all invasive procedures including those performed outside of operating departments.

Clear processes were in place to admit patients who were clinically unwell. The consultant they were seeing would arranged for them to be admitted to a ward. However, the oncology service reported that sometimes there was a long wait for a bed and the absence of doctors in the oncology service after 5pm was a recognised risk.

All staff had received sepsis awareness training.

Staff at Queens Hospital Burton had access to a mental health crisis team which was based in the Emergency Department (ED).

Specialties acted to avoid harm to outpatients who were waiting in a backlog of follow up appointments. For example, clinicians in ophthalmology risk assessed patient’s clinical needs and prioritised appointments on that basis. The service provided additional appointments to meet this need through clinics in the evening and at weekends.

### Nurse staffing

The total number of whole time equivalent staff across outpatient services in Queens Hospital Burton was 45.6 staff in October 2018. There are no national standards for staffing in outpatient services.

In outpatient areas A and B in Burton, services depended on bank staff to staff clinics. From November 2017 to October 2018, Queens Hospital Burton reported a bank and agency usage rate of 26 in outpatients for qualified nursing. This meant that more senior qualified nurses had to repeatedly invest time in training and familiarising different staff on clinic specialities.

From November 2017 to October 2018, the trust reported a vacancy rate of 7.6%, a turnover rate of 12% and a sickness rate of 6.7% in outpatients at Queens Hospital Burton. The turnover rate was comparatively high but the service did not have a strategy to address this. When we inspected outpatients A and B staff told us there was a high level of long-term sickness. There was no strategy for long-term sickness in QHB outpatients A&B. Management of long term sickness was guided by; trust policies on sickness management; close advice and guidance from the Occupational Health team and the departmental target on sickness rates. This was further supported by a review of general staffing and clinical skill mix that was underway as part of a trust wide review.

Actual staffing numbers for Outpatients A and B for the time of our inspection are shown below. We were not aware how this compared to planned staffing levels.

<table>
<thead>
<tr>
<th>Date</th>
<th>No. of Qualified</th>
<th>No. of Unqualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/19 (am)</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>12/2/19 (pm)</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13/2/19 (am)</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>13/2/19 (pm)</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Numbers of permanent versus bank qualified nurses for Outpatients A and B are shown in the table below.

<table>
<thead>
<tr>
<th>Date</th>
<th>No. of Permanent RN</th>
<th>No. of Bank RN</th>
<th>No. of Permanent HSW</th>
<th>No. of Bank HSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/19 (am)</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>12/2/19 (pm)</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>13/2/19 (am)</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>13/2/19 (pm)</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

Clinical nurse specialists were employed in a variety of outpatient settings within the trust and worked both in isolation and as part of the multidisciplinary team to provide high quality, safe, patient-centred, timely and cost-effective care. Practitioners provided tailored care depending upon patient’s level of need. They also provided education and support for patients to manage their symptoms, particularly patients with long term conditions and multiple morbidities.

**Medical staffing**

The trust has reported their staffing numbers for outpatients at Queens Hospital Burton below for the period April 2018 to October 2018. No planned staffing figures were reported.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post – October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Staff Haematology QHB</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Med Staff Oncology QHB</td>
<td>2.2</td>
<td>3</td>
</tr>
<tr>
<td>Med Staff Ophthalmology QHB</td>
<td>10.9</td>
<td>11</td>
</tr>
<tr>
<td>Grand Total</td>
<td>16.1</td>
<td>17</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Medical staffing and skill mix were planned and reviewed to ensure that outpatients received safe care and treatment. The trust recruited as soon as possible to any medical vacancies. If planned and actual staffing levels did not match, clinicians had a cooperative ethos of working together to cover any rota gaps.

Information received following our inspection for medical staff vacancies, turnover, sickness and locum/agency as of December 2018 is shown in the table below:
Records

Records were not always stored securely. The trust was introducing an electronic patient records system. Where this was already in place, records were kept securely. There were lockable cabinets for paper records in the diabetes clinic. However, in certain specialties such as ENT, this had not yet happened and piles of records could be left on tables in patient areas with a blank sheet on top to hide the patient's name. This was not as secure as locking patient files away.

Nursing staff in Outpatients A all shared one computer at the waiting area desk. We observed staff unable to access records as one nurse who was treating a patient had locked the screen. There was a lack of IT access to display patient alerts. Paperless records for outpatients appointments only contained stickers and blank history sheets.

Where records were paper-based, systems were in place for ensuring medical records availability for clinics. As of November 2018, no patients were seen as outpatients without the full medical record being available. The trust told us in their provider information return that records were rarely unavailable as much of the record was now held electronically. If a paper record could not be found or did not arrive in time, the patient was seen on information held within the system.

Electronic patient records were updated following the patient’s appointment. Paper records were scanned into the system and linked to the patient record and pathway.

Medicines

Medicines related stationery was stored securely. For example, in outpatients A and B consultants had to sign for prescription pads and each page on the pad was numbered. When pads were not in use they were locked away in a cupboard. An electronic prescribing system, already in place at the Royal Derby Hospital was due to be rolled out across both sites.
Medicines were stored securely. The oncology and gynaecology services stored controlled medicines appropriately in a locked cupboard. Medicines cupboards were checked regularly by pharmacy staff. All the medicines we checked were within their expiry date. In outpatients A and B, we saw cupboards containing medicines were secure.

Chemotherapy medicines were provided direct from a supplier and were patient specific. This sometimes meant medicines might be wasted if a patient was not well enough for treatment. Medicines fridges we checked were within the range of 2 and 8 degrees centigrade and we saw where staff had performed daily checks. However, in Outpatients A clean utility we observed the temperature monitoring chart for February 2019 had exceeded 25 degrees on 5 successive days. The signed chart showed no action had been taken or no-one informed. When the temperature rose to 28 degrees during the summer of 2018, the only action noted on the chart was ‘door open, fan on’.

**Incidents**

An incident and serious incident management policy and process was in place to provide a means of identifying and reducing the risks to which the organisation, its patients and staff, contractors, volunteers and members of the public might be exposed, and maintain the reputation of the trust. The procedure provided staff with clear guidance on how to respond to, report, manage and investigate incidents, including Internal Safety Alerts (ISA) and serious incidents requiring investigation (SIs).

From December 2017 to November 2018, the trust reported no incidents classified as never events for outpatients. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in outpatients which met the reporting criteria set by NHS England from December 2017 to November 2018. The SI related to a patient fall. We reviewed the route cause analysis (RCA) (investigation) for this incident and saw where the SI had been reviewed and investigated appropriately with all relevant staff. However, we were not assured learning from this SI had been shared with the wider team. The RCA stated the outcome of this investigation would be discussed at the January staff meeting. Meeting minutes for January 2019 that we reviewed did not show where a discussion had taken place.

Staff in all of the hospitals understood their responsibilities to raise concerns and record safety incidents. They reported clinical incidents report through the electronic reporting system. All staff were trained in this and encouraged to report clinical incidents and they were reviewed daily. Feedback was given to the individual who reported the incident.

The service took action when it learned from incidents. Staff gave us an example of changes and training which had taken place after a disposable tonometer incident in ophthalmology, along with a new standard operating procedure to prevent the incident from happening again.

However, processes around sharing learning from incidents were inconsistent. No nursing staff we spoke with were familiar with a screening issue incident recorded between December 2017 and November 2018. As a result, they could not give us any further information or provide evidence or examples of learning. Staff we spoke with could not tell us about incidents which had happened outside of their clinics, elsewhere in the trust, or explain any generic learning from an incident which extended to all clinics.

Clinical incidents and safeguarding events were reviewed at monthly senior sisters and departmental meetings (Outpatients A&B) where all clinical incidents were discussed. However, in outpatients A and B staff told us there was no team meeting and the nursing sister briefed them individually.

**Safety thermometer**
We did not see a publicly displayed quality or safety thermometer dashboard which demonstrated a clinic’s safety performance over time, including key measures and benchmarks on for example, cleanliness.

**Is the service effective?**

**Evidence-based care and treatment**

Patient care treatment and support was based on the best available evidence. We saw evidence that nurses and doctors followed good practice across the board and were given specific examples in diabetes, ophthalmology, and oncology such as National Institute of Care Excellence (NICE) guidance on glaucoma and insulin pumps, NATSSIPs and WHO checklists.

Specialties participated in national audits relevant to them. For example, the rheumatology services audited early arthritis. Audits were discussed at a monthly meeting, for example the human papilloma audit in gynaecology which was part of a research trial.

Technology and equipment was used to enhance care in some services. The ophthalmology team had bought new equipment for fluorescein angiography work which photographed the back of the eye in a very detailed way. This provided a better understanding of the state of blood vessels in the retina and enabled a more exact diagnosis. The use of virtual clinics to examine pressure tests in glaucoma patients increased the numbers of patients who could be reviewed by consultants.

Consultants organised a comprehensive assessment of the physical, mental and social needs of vulnerable outpatients, and referred outpatients with symptoms of depression for a mental health assessment if this had not already been done.

Protocols/proformas were in place in clinics to guide staff on processes to follow. For example, in Ophthalmology at Samuel Johnson Community Hospital (SJCH) we saw a standard/protocol for the phasing Clinic. A Phasing is measurement of the intraocular eye pressure done over a specific time period usually eight hours.

An outpatient Phasing audit, to determine whether phasing was a useful tool to aid the diagnosis in the treatment of glaucoma patients, was carried out on patients referred to the Ophthalmology department at SJCH. Data was collated over a period of 12 months (January to December 2018) during which time a total of 76 patients had accessed the service. Data regarding the 76 patients was then forwarded to the trust clinical audit department for analysis and inclusion in the report. At the time of our inspection data from the audit was in the process of being analysed in order that areas for improvement could be identified and actions agreed.

**Nutrition and hydration**

We observed staff giving vulnerable patients drinks when a clinic was delayed 45 minutes. In the infrequent case of a long delay, staff told us they would arrange drinks and sandwiches for patients. There were water fountains in outpatient areas.

Drinks and snack machines were available for patients at Burton, Samuel Johnson and Sir Robert Peel hospitals.

**Pain relief**

Pain was not assessed in a systematic way. Clinics advised patients on pain relief but did not dispense any medication for this purpose. Nurses sometimes assessed pain before a procedure.
Patient outcomes

Services conducted surveys and audits to gain an understanding of patient outcomes. In gynaecology a monthly audit meeting reviewed colposcopy patient survey feedback and a human papilloma virus audit which was part of a research trial.

In surgery an audit had been carried out on delays in outpatient clinics. Results for November 2018 to February 2019 showed:

<table>
<thead>
<tr>
<th>Length of time of delay</th>
<th>No of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 60 minutes</td>
<td>11</td>
</tr>
<tr>
<td>60 minutes</td>
<td>20</td>
</tr>
<tr>
<td>Between 30 minutes and 60 minutes</td>
<td>41</td>
</tr>
<tr>
<td>30 minutes or less</td>
<td>19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Long Waits i.e. 60 minutes or more</th>
<th>No of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>5</td>
</tr>
<tr>
<td>Plastics</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>5</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
</tr>
<tr>
<td>Vascular</td>
<td>0</td>
</tr>
</tbody>
</table>

The audit identified frequency of reason for delay as follows:

<table>
<thead>
<tr>
<th>Frequency of Reason</th>
<th>No of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex patients</td>
<td>48</td>
</tr>
<tr>
<td>Consultant arrived late</td>
<td>8</td>
</tr>
<tr>
<td>Overbooked clinic</td>
<td>19</td>
</tr>
<tr>
<td>Audiology delays</td>
<td>2</td>
</tr>
<tr>
<td>Consultant called to theatre</td>
<td>1</td>
</tr>
<tr>
<td>Consultant called away to ED</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

A therapist in oncology therapy services were conducting an audit when we inspected because occupational therapists and physiotherapists were no longer involved in the assessment of patients. This would highlight any impact on patients.

From 01 October 2017 to 30 September 2018, the follow-up to new rate for Burton Hospital was higher than the England average. The hospitals had processes in place to review the follow up rate on an ongoing basis. Patients were managed from a follow up queue, they were appointed within the required time frames. If capacity was not available within the set timeframe this was escalated to the operational teams. In the 12 months preceding this inspection the trust reported no lost to follow up patients at Queens Hospital Burton.

Competent staff

All staff except qualified nurses at Queens Hospital Burton met the target for appraisal rates between April 2018 and October 2018. Appraisals for qualified nurses were 84% compliant, missing the trust target of 90%. Information received following our inspection showed a significant increase in appraisal rates at 95%.
At Sir Robert Peel hospital, appraisals were done in April May and June each year and when we visited they had 100% compliance. The nursing sister reviewed progress towards objectives in December. Staff had the opportunity to shadow clinical specialties and observe practices such as how to take blood samples from children and procedure in theatres to give patients a better explanation.

Access to skills development was variable. Some qualified nurses expressed a wish to do advanced courses in their specialist area but were not released. Others, for example in fracture clinic were encouraged to develop skills in areas which interested them such as tissue viability.

Staff in outpatients A and B told us that training opportunities such as principles of team leading, disability training, vulnerable adults and dementia were available and paid for, but they had to be completed in their own time. However, staff told us there was no specific training on learning disabilities. Senior managers told us there was training on offer to all members of staff and was fully articulated on the trust’s intranet. This was led by the trust’s liaison nurse for learning disabilities.

When we inspected staff were receiving training on a new electronic prescribing system which was being introduced.

Development opportunities existed for some nursing leaders to gain or reinforce the skills they needed to do the job. Nursing sisters at Sir Robert Peel hospital told us they could attend leadership masterclasses.

**Multidisciplinary working**

Outpatients services had multidisciplinary approaches in certain specialties and developed new teams where appropriate. In cardiology, cardiothoracic surgeons met weekly to review echocardiograms and angiograms. Oncology staff worked well with the hospital wide peripheral inserted central catheter (PICC) line team who placed lines for patients to avoid multiple cannulations. A PICC is a form of intravenous access device that can be used for a prolonged period of time.

There was a coordinated approach to diabetes care. An insulin pump clinic for type 1 diabetes which followed the relevant NICE criteria was run jointly by a nurse and a consultant and included input from a dietitian. The podiatrist in the diabetes clinic also worked with a dietitian to deliver treatment holistically to diabetic patients.

The service used specialist nurses in clinic. For example, nurses ran a specialist glaucoma clinic in ophthalmology. They had also developed a nurse led eye injection service for diabetic oedema which increased the capacity from nine to fifteen patients per clinic. This was being introduced when we inspected. In oncology, nurse led venesection telephone clinic and haematology daycase clinics were in place. In ENT two nurses had increased clinic capacity by doing ear micro suction clinics each week. There were nurse led dermatology clinics across the hospitals, nurse clinics assisted dermatology patients treated with Roaccutane with monthly blood tests. Nurse led clinics were also available in rheumatology at Samuel Johnson hospital.

**Seven-day services**

Services were not routinely offered to patients seven days a week. In Burton hospital, specialities such as ophthalmology held clinics at the weekend if they needed to clear a backlog. Eye casualty was open from 9 am to 5 pm Monday to Friday and on Saturday from 8 am to 1 pm, with the Royal
Derby hospital on call outside of these hours. All other clinics at Queens Hospital Burton were open on weekdays during normal working hours.

Sir Robert Peel and Samuel Johnson Community Hospitals held some clinics which started at 7 am (Lichfield) and ended at 7 pm (Tamworth) and there was one Saturday clinic (at Lichfield). This gave patients of working age the opportunity to come to clinic without taking time off work.

Chemotherapy patients had access to an on-call doctor 24 hours a day, seven days a week, and particularly appreciated this service.

**Health promotion**

Clinics used notice boards to display information on nutrition, diet, exercise and a range of issues relating to health promotion.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2018 to October 2018, Mental Capacity Act (MCA) and deprivation of liberty (DoLS) training was completed by 89.1% of staff in outpatients at Queens Hospital Burton.

Staff understood consent processes and we observed staff consenting patients appropriately. Written consent forms were started in outpatients before surgery and were checked as part of the World Health Organisation (WHO) surgical checklist procedure.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

**Is the service caring?**

**Compassionate care**

Patients told us staff were kind, friendly and polite. We observed staff treating patients in a compassionate and caring manner.

Many of the services including outpatients at Samuel Johnson and Sir Robert Peel Community Hospitals as well as Queens Hospital Burton had very good feedback from patients and a number of specialities had 100% response to the question ‘would you recommend the service to your family and friends’. The results of these Friends and Family tests were displayed on noticeboards in public areas. However, the response rates in some clinics was quite low.

Patients told us that staff explained their care and treatment to them. We observed staff talking to patients in plain English and ensuring they understood what was happening. Staff also recognised when patients needed additional support.

Staff showed us quiet rooms where patients who were frightened or confused could wait. Staff members we spoke with displayed a compassionate and understanding attitude to patients with mental health, learning disability or dementia diagnoses. In conjunction with the consultants, staff prioritised appointments for patients who were poorly, frail or living with dementia, learning disabilities or poor mental health.

The layout of reception and waiting areas was not always conducive to providing privacy for patients. We observed in outpatients A and B at Burton that seating was very close to the
reception desks and patients were sometimes unable to talk to the receptionist without being overheard.

Privacy was also compromised in the orthopaedic area used by fracture clinic in Burton. This was because the area was a series of curtained off cubicles. This meant that conversations between doctor or nurse and patient could be overheard.

In many areas, chaperoning was not actively promoted by the service. Although the trust had a chaperoning policy, this focused on providing chaperones for intimate examinations despite chaperoning being an important consideration for any lone patient. They put the onus on the patient to request a chaperone. Staff told us they did not receive chaperone training. Many did not offer a chaperone but waited until the patient requested one, and then they would provide one. However, there was no promotion of this to patients; we did not see posters on walls informing patients they could ask for a chaperone, for example.

**Emotional support**

Patients told us they were given verbal or written information about their condition. For example, in the fracture clinic, patients we spoke with received written information about plastered limbs, and what to expect while they were recovering. In cardiology we saw a wide variety of British Heart Foundation booklets and leaflets available to patients.

Most patients we spoke with felt involved in decisions about their care. They told us that doctors and nurses explained their treatment options to them. At Sir Robert Peel and Samuel Johnson Community Hospitals, staff obtained patient information from the intranet and leaflets, some in-house.

Staff reacted well when patients needed additional support. They would prioritise frail or unwell patients. If a patient was living with dementia, staff would ask the consultant to bring their appointment forward and ask a relative if there was anything specific that would help the patient. If a patient needed to be seen by a mental health professional, they would find a private room and arrange for a staff member to wait with them.

Within the oncology service, a charity provided sessions for cancer patients on topics such as skin care: predominantly patients having chemotherapy and mostly women with breast cancer. Feedback from patients was very positive. The chemotherapy unit was planning to host more sessions of interest to men living with prostate cancer or patients with colorectal cancer.

**Understanding and involvement of patients and those close to them**

Patients told us their appointment letter was easy to understand and gave clear contact details. They were given appropriate information about their condition.

Most patients we spoke with explained that they were encouraged to be part of the decision making process about their care.

Patients who received life changing diagnoses were given appropriate emotional support. However, some oncology staff wanted more involvement from patients in service development and more involvement from patient support groups.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The new trust was in the early stages of mapping the newly combined outpatient service to the
needs of the local population. There was a strategic shift to planning services to be closer to where patients lived and to use technology to tailor services for individual outpatients and prevent unnecessary car journeys.

The trust was building capacity for local continuity of care. Historically some patients had been obliged to travel to Birmingham for some types of elective care. The trust was creating local services such as spinal surgery and injections in the Sir Robert Peel Community Hospital in Tamworth, so there was continuity of care for back surgery and back pain patients.

Services reviewed capacity on an ongoing basis and audits informed service planning. At Sir Robert Peel Community Hospital staff carried out a phlebotomy audit to establish whether the right number of clinics were planned for the right day to meet patient need. In cardiology at Queens Hospital Burton, staff were auditing referrals to check patients were being referred to the right level of doctor.

The services responded to unmet need where possible. For example, the service had increased dermatology provision when activity in a neighbouring NHS trust had ceased.

Play areas were provided for children in clinics where children were mixed in with adults. For example, there were play facilities in the ENT waiting area. The service held a colouring competition for children and allowed them to play in the main waiting area as long as possible before their appointment. The service was planning to carry out a care review for children and young people.

Outpatient services at the former University Hospitals Burton had reduced the did not attend (DNA) rate between our last inspection in 2015 and February 2018. This was the result of a text and phone call campaign to remind patients about appointments. However, between February and September 2018, DNAs had increased from 2% to 5%.

Patients told us they were not necessarily offered a choice of appointment dates. The service had introduced partial booking, however, which enabled some patients to choose their own appointment times if they were familiar with IT, or if the GP did it for them.

The quality of the patient environment varied. For example, we saw some patient waiting areas such as the ophthalmology and oncology areas which were spacious, bright and fit for purpose. However, many of the areas in outpatients A and B were cramped and not very light. Toilets and water fountains were provided in all areas.

Meeting people’s individual needs

The service was starting to identify patients preferred communication method systematically. It aimed to meet the Accessible Information Standard and seconded a staff member to progress the project. Where possible staff asked patients asked how they want to be communicated with.

The trust had no electronic system to flag outpatients with learning disabilities unless their notes showed this from a previous visit. We were told that these patients were not flagged on the electronic record system because the information would come from GP level and the data quality needed to be verified. Although not all staff received learning disabilities training, they had access to a learning disabilities liaison nurse who was on site for three days a week.

Following our inspection, we received an Accessible Information Standard update from the trust. The information summarised progress to date and next steps in order to meet the requirements of the Accessible Information Standard (AIS). Since the last update, the AIS Implementation Group continued to meet on a biweekly basis to progress implementation of the standard. Actions taken
in recent months had continued to focus on the implementation of outpatient letters in four alternative accessible formats: ‘EasyRead’ which is a version of the letter that breaks down lengthy instructions and provides pictures and symbols to aid the patient’s understanding, Braille, large print and MP3 audio (through email).

Staff had adapted communication methods to ensure that patients understood. They had picture boards to use with patients with learning disabilities. Letters were automatically sent in a larger print size to ophthalmology patients. If staff knew that a patient would not be able to read a text message appointment reminder, they would telephone them. Staff told us that letters could be sent out in languages other than English. Some patient information was available in other languages, for example British Heart Foundation leaflets and smoking cessation information in Urdu and Hindi.

Reasonable adjustments were made in clinics to meet patient’s individual needs. Staff used the face to face interpreter system when appropriate, and this included sign language interpreting. The ophthalmology service had a talk communication system of braille with an automated voice. Staff in the ENT clinic wrote their questions down for patients to ensure they understood. Wheelchairs were readily accessible from the main entrance of the hospital to help patients with mobility difficulties.

Services were delivered and coordinated to be accessible and responsive to people with complex needs. For example, the fracture clinic identified the specific needs of some patients before clinic. They prepared the clinic the day before and stickers were used to indicate where a patient may require additional support. For example, an umbrella for safeguarding, a ‘Forget me not’ for dementia and black and white stickers for prisoners. They would also prioritise people with learning disabilities but would not necessarily know about this beforehand.

Depending on the consultant and issue, staff tried to coordinate appointments so that patients did not have to make multiple visits and the appointments IT system facilitated this because staff could see if there were other appointments within a few days.

Patient transport arrangements did not always meet people’s needs. Staff told us that sometimes—older people with mobility issues were kept waiting for transport after their appointment, some until the early evening. Leaders told us that they reported these incidents to local commissioners who oversaw the contractual arrangements with transport providers. Arrangements were subject to review within a few months.

Support for bariatric patients was inconsistent. We saw bariatric chairs in some waiting areas and clinical rooms, for example cardiology but not others. We saw a limited amount of other bariatric equipment.

Although in oncology in Burton had a computer alert for patients living with dementia or with special needs, this was not the case for most services. In general, staff had no prior knowledge of a patient living with dementia or learning difficulties if it was a first appointment. We saw evidence that there were dementia champions in some clinics. Staff told us they had no specific training on learning disabilities but used their experience.

**Access and flow**

In most cases outpatients had timely access to initial assessment, test results, diagnosis and treatment.

Referral to treatment (percentage within 18 weeks) — non-admitted pathways
From November 2017 to October 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been similar to the England overall performance. The latest figures for October 2018, showed 90.6% of this group of patients were treated within 18 weeks versus the England average of 86.9%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, University Hospitals of Derby and Burton NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

University Hospitals of Derby and Burton NHS Foundation Trust & Derby Teaching Hospitals NHS Foundation Trust

14 specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>93.1%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>100.0%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>92.3%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>91.8%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>92.0%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>97.3%</td>
<td>95.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>93.5%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.9%</td>
<td>79.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.3%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Other</td>
<td>91.5%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>92.3%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.5%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>85.9%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>92.3%</td>
<td>86.6%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average for non-admitted pathways RTT (percentage...
within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
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</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>76.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>79.2%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>75.4%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>81.1%</td>
<td>88.6%</td>
</tr>
</tbody>
</table>

**Burton Hospitals NHS Foundation Trust**

15 specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

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<tr>
<td>Cardiology</td>
<td>97.6%</td>
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<tr>
<td>Cardiothoracic surgery</td>
<td>100.0%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.6%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>95.2%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>83.9%</td>
<td>83.0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>92.1%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>97.2%</td>
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</tr>
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<td>Ophthalmology</td>
<td>97.9%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>86.2%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Other</td>
<td>96.7%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>98.0%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>92.9%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>96.9%</td>
<td>86.6%</td>
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Three specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

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<tbody>
<tr>
<td>General medicine</td>
<td>86.6%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>74.0%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>64.3%</td>
<td>86.4%</td>
</tr>
</tbody>
</table>

Data from the acquired Burton Hospitals NHS Foundation Trust from November 2017 to June 2018 is included in our analyses for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

(Source: NHS England)

Performance was comparatively good. Out of 18 specialties, 15 were above the England average for incomplete pathways RTT (percentage within 18 weeks).

Services in the former Burton Hospitals NHS Foundation Trust performed slightly better than Derby for equivalent specialities. Leaders told us this was because they had more capacity. When we inspected there were no patients waiting over 26 weeks for definitive treatment in the former University Hospitals Burton group.
Information received following our inspection, dated January 2019, showed performance was improving for non-admitted pathways with; 93.6% compliance at Queens Hospital Burton, 95% at Samuel Johnson Community Hospital and 93% at Sir Robert Peel Community Hospital.

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From November 2017 to October 2018 the trust’s referral to treatment time (RTT) for incomplete pathways has been consistently better the England overall performance. The latest figures for October 2018, showed 91.0% of this group of patients were treated within 18 weeks versus the England average of 86.6%.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, University Hospitals of Derby and Burton NHS Foundation Trust.**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty**

University Hospitals of Derby and Burton NHS Foundation Trust & Derby Teaching Hospitals NHS Foundation Trust

14 specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

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(Source: NHS England)

Information received following our inspection, dated January 2019, showed performance was improving for incomplete pathways with; 91.6% compliance at Queens Hospital Burton, 93% at Samuel Johnson Community Hospital and 94% at Sir Robert Peel Community Hospital.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), University Hospitals of Derby and Burton NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), University Hospitals of Derby and Burton NHS Foundation Trust

The trust is performing similar to the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing similar to the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, University Hospitals of Derby and Burton NHS Foundation Trust

Nine specialties did not achieve the national standard of 92% from November 2017 to October 2018. These were gastroenterology, general surgery, ophthalmology, oral surgery, plastic surgery, trauma and orthopaedic, general medicine, rheumatology and thoracic medicine. The trauma and orthopaedics and general medicine specialties were very close to achieving the standard, they both treated 91.9% of patients within 18 weeks. Urology had achieved standard over the same period as a result of improvement planning.

Clinics aimed to perform better but specialties had medical staffing gaps they were recruiting to, such as dermatology, gastroenterology, rheumatology at Samuel Johnson. Services at Samuel Johnson hospital ensured they saw patients in a timely way. Dermatology and respiratory specialties were recruiting for replacement consultants and an additional clinic was provided by registrars in rheumatology.

People with the most urgent needs had their care prioritised. The trust met the standard for two-week cancer waits. If there was a backlog of appointments in a specialty, clinicians risk assessed patients from the point of clinical need to ensure they were seen in a timely way.
Data for cancer wait times, while referring to trust-wide performance rather than focusing on the hospitals formerly in the acquired trust, indicated that most patients had timely access to treatment. The following comments refer to the newly merged trust. Between the third quarter of 2017/18 and second quarter of 2018/19, the trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.

Over the same time period, the trust performed at a level similar to the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis (decision to treat). The trust also had similar performance to the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral, although performance declined slightly at the end the second quarter of 2018/19.

**Did not attend rate**

From 01 October 2017 to 30 September 2018, the 'did not attend' rate for Burton Hospital was lower than the England average.

Following our inspection, the trust provided their January 2019 RTT programme board performance report. The report showed an improving picture at Queens Hospital Burton as follows:

**Incomplete Position (Target 92%; Trajectory 90.3%)**

- 89.82% (1,065 pathways from compliance; 236 pathways from trajectory)
  - Derby: 89.27% (1,075 pathways from compliance; 525 pathways from trajectory)
  - Burton: 92.06% (-10 pathways from compliance)
- 48,762 total number of pathways
  - Derby: 32,331
  - Burton: 16,431
- 190 patients waiting over 40 weeks
  - Derby: 167
  - Burton: 23
- 15 patients waiting over 52 weeks
  - Derby: 15
  - Burton: 0

Since our last inspection, the service had improved the environment and signage for some outpatients. It had introduced a new clinic booking template to ensure that patients had sufficient clinic time and had considerably reduced overbooking. Clinics were built around patient needs. For outpatients A and B, staff audited clinic delays and in clinic wait time for patients. As a result, outpatients were not kept waiting long once they had arrived in clinic. Patients we spoke with in clinics in all three hospitals told us that a long delay was rare.

Clinics reviewed capacity and demand. For example, the venesection clinic in oncology was reviewing this when we inspected, and ENT had just reviewed its clinic template.

To manage the increase in demand in Rheumatology the department had implemented a number of measures to try and keep up with the level of demand. For example:
• Business case approved to recruit two specialist nurses to manage increased follow-ups, allowing consultants to focus on new patients. The trust recruited to these posts at the beginning of September 2018 however, one of the post holders had now withdrawn.

• Business case approved to recruit a specialty doctor to deliver both new and follow up clinics. This post was filled in December 2018.

• Consultants delivering extra clinics in the week and also on Saturdays

• Specialist osteoporosis nurse delivering more clinics under consultant supervision to help with the backlog

• Appointed a consultant rheumatologist who started in August 2018.

Ophthalmology reviewed referrals to check whether they all needed to be seen by a consultant or could be seen by a high street optician. Similarly, in audiology, some patients could be seen by an audiologist rather than a consultant.

The service planned and monitored clinic utilisation using a spreadsheet they devised in house. This ensured that all consulting rooms and facilities were well used and maximised clinic capacity.

Clinics across the hospitals had a clear set of rules for patients to access outpatient services. The trust had a recently revised patient access policy which was based on national guidelines.

Clinics used a white board by reception to inform patients of any delays, though how proactively this was used varied. Samuel Johnson and Sir Robert Peel Community Hospitals informed outpatients of any delays on a notice board and the receptionist also told the patient. They monitored wait times and any clinics where this happened regularly were reviewed and revised.

At Queens Hospital Burton we found inconsistent use of the white boards. Not all white boards were used. Patients were only informed of delays, they were not informed if the clinic was on time.

The rapid access chest clinic was not meeting its own target. It aimed to see patients within two weeks. When we inspected, most patients were seen within three weeks. The service was analysing the reasons why and reviewing the appropriateness of referrals.

Access to care and treatment appointments at a suitable time varied. Clinics were available from 9am to 5pm at Queens Hospital Burton unless there were extra clinics to reduce backlogs. At Sir Robert Peel and Samuel Johnson Community Hospitals some clinics started at 7am (Lichfield) and ended at 7pm (Tamworth) and there was one Saturday clinic (at Lichfield). This gave outpatients of working age the opportunity to come to clinic without taking time off.

Some delays impeded patient flow. In oncology, nurses told us that waiting for result from blood tests delayed outpatients but that they were planning to start a fast track blood test service for haematology and oncology patients.

An outpatient efficiency programme was in place to minimise the length of time people had to wait for care, treatment, or advice. Actions for 2018/19 included for example, a text reminder service and a cancellation reduction project looking at the implementation of partial booking.

A patient access policy was in place that focussed on patients. It aimed to promote timely access to care, while also fully respecting patient choice regarding time and place of treatment. The policy had been produced collaboratively with local health communities and set out the standards for the trust, referrers and patients by which access to services was managed. The policy also gave trust staff clear direction and expectations on all aspects of patient access in line with patient rights as set out in the NHS Constitution and Accessible Information Standard.
Learning from complaints and concerns

Summary of complaints

A comparatively low number of complaints came from outpatients. In the last full financial year before the acquisition (April 2017 to March 2018), the Patient Advice and Liaison Service (PALs) service told us there were sixteen formal complaints about outpatient services at the hospitals. Fourteen concerned Queen’s Hospital Burton, and Samuel Johnson and Sir Robert Peel Community Hospitals received one formal complaint each. This was 6.7% of the total for the trust. The most common causes of complaints were errors or delays in diagnosis and issues around communication and information.

More recent information from April 2018 to February 2019 showed nine complaints. Three were from medical outpatients, four from surgical outpatients and one each concerned paediatric services and Sir Robert Peel Community Hospital outpatient services. These complaints were across a range of themes and showed no obvious trends. The PALS service reported a good working relationship with outpatient services.

The trust met its own targets for investigation of complaints. It took an average of 28.0 days to investigate and close these complaints. This was in line with their complaints policy, which stated complaints should be completed within 25 days, or 40 days for more complex complaints.

There was a clear process around the investigation and management of complaints. A senior sister told us that most complaints were managed through PALS (Patient Advice and Liaison Service). She followed up by ringing staff or patients if necessary. PALS displayed information in clinics inviting patients to contact them. The outpatients assistant general manager oversaw monthly reports produced by PALS and escalated any issues to the chief operating officer (COO).

The extent to which services were willing to learn from patient complaints and feedback varied. While some patients were pleased with services others told us they were not being listened to. Some staff we spoke to in outpatients A and B appeared to see complaints as a threat rather than a source of learning. Although outpatient leaders told us they aimed to resolve informal complaints quickly, the service did not appear to learn from them.

Number of compliments made to the trust

From October 2017 to September 2018 there were 44 compliments directed towards outpatients at Queens Hospital Burton. Patients we spoke with were pleased with the care at Samuel Johnson and Sir Robert Peel Hospitals.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leadership of outpatient services was shared across divisions at Queens Hospital Burton. Some services such as ophthalmology, fracture clinic, urology, general surgery and the breast unit reported to service managers and clinical and nursing leads within specialties and divisions.

Outpatient services such as gastroenterology, care of the elderly, rheumatology, ENT, respiratory and gynaecology reported within the Director of Operations division and were led by the head of patient access for administration purposes but otherwise reported through speciality nursing and clinical lines.
The service had taken steps to strengthen leadership in outpatients since our 2015 inspection. The head of patient access led administrative and clerical staff in outpatients A and B and chaired the patient access group. The deputy head of patient access worked on projects to improve efficiency in outpatient A and B clinics and audits and monitoring of clinic performance.

Whilst nursing leaders in outpatients A and B understood the challenges to quality and sustainability, they did not always understand the actions they could take to address them. The absence of team meetings at operational level in outpatients A and B meant that incidents, complaints and policies were not discussed collectively or knowledge about incidents elsewhere in the trust shared.

Nursing leaders recognised that there were workforce challenges such as staffing, succession and turnover at Queens Hospital Burton. However, the service lacked a nursing leadership strategy or development programme, including succession planning. Outpatients A and B depended on a ‘flexible workforce’ in terms of bank staff and had no specific plans to prepare qualified nurses for roles with higher levels of responsibility, although it recognised the ageing workforce as a risk.

The outpatients service had scope to strengthen its board level representation within the trust. There was no non-executive director to champion the interests of outpatients, although the divisional director with lead responsibility for referral to treatment or the patient access manager would present any relevant reports to trust level.

**Vision and strategy**

The trust was in the early stages of strategic development for outpatients. It had several workstreams of transformation to ascertain how and where to deliver services best across all its hospitals including the Royal Derby Hospital, Sir Robert Peel and Samuel Johnson Community Hospitals and Queens Hospital Burton. The strategy was very much patient focussed and included for example;

- Single entrance at BHFT
- Single outpatient phone number
- Email correspondence available between patient, GP and hospital
- Non-GP referrers able to book appointments electronically
- Home/community-based care available for Long Term conditions
- Self-check in
- Patient central to reviewing and improving services
- Home/community-based care developed further
- One-stop- clinics available
- Outpatient standards agreed
- Every specialty has available services in the community hospitals
- Clinical Apps available to support patients and GP’s.
- Maximum of 5 people in a queue.

The strategy was to be aligned to local plans in the wider health and social care economy in Derbyshire and Staffordshire. This included working with partners such as a neighbouring community NHS trust and local commissioners to determine the best outpatient solution for local people. The strategy included strategic reviews of certain services such as gynaecology and...
ophthalmology and assessing the feasibility of delivering some outpatient services more locally, and building capacity in certain specialties in Tamworth, Lichfield and Burton. The trust had started to do spinal surgery and injection care locally in Samuel Johnson Community Hospital. Building capacity for elective care was also important to avoid patients having to travel to Birmingham.

In addition, strategic development included a review of the estate, in view of the ageing condition of parts of Queens Hospital Burton, and how technology could enable new types of clinic. A ‘Patient Knows Best’ portal was under development at the time of our inspection.

Although service managers understood the concepts well, outpatients nursing staff did not express an understanding of the vision and strategy but were familiar with the values. Prior to the acquisition, Queens Hospital Burton had a quality improvement strategy 2016 to 2019, with the quality priorities of consistently safe, consistently effective and a positive patient experience. This was underpinned by the PRIDE values – Passion, Respect, Innovation, Determination and Excellence. Staff we spoke with at Queens Hospital Burton had little knowledge of the quality improvement strategy.

Since the acquisition, strategic development for outpatients had not reached the stage where the hospital could monitor or report on delivery of outcomes for local people. However, senior nurses and service managers told us they had attended patient experience groups and listening events and there were opportunities to be involved in developing plans for the new trust.

Culture

Culture was variable depending on location and specialty. Front line staff in some specialties at Queens Hospital Burton such as ophthalmology and fracture clinic expressed enthusiasm and pride in the organisation and told us they were given learning opportunities. Staff at Sir Robert Peel and Samuel Johnson Community Hospitals told us they were proud of the service and the ‘way we work’.

In outpatients A and B and other specialties staff told us that although they were proud of their service and how caring staff were, there were problems with understaffing and dependence on bank nurses, and sometimes certain specialties were totally staffed by bank staff. This meant that there were fewer nurses with an in-depth specialty knowledge and that permanent nurses repeatedly gave different people the same specialist training. Some staff told us they felt that there were insufficient staff to support each doctor in clinic.

Not all nursing staff were provided with opportunities for career development. At Queens Hospital Burton we heard how some nurses were denied learning opportunities and were not given a clear reason. However other nurses had access to skills development.

Staff wellbeing indicators showed a variable culture across the services. Retention at Samuel Johnson Community Hospital was very good but this was not the case for all the outpatient services. Turnover was relatively high at Queens Hospital Burton; from November 2017 to October 2018, the trust reported a turnover rate of 12.0% in outpatients. The service did not have a plan to address this.

Governance

Structures, processes and systems of accountability to support the delivery of the strategy and sustainable services were not always reviewed and improved. Governance at operational level was inconsistent. In outpatients A and B we found that there was no daily team brief and staff meetings were infrequent. There was no team meeting in fracture clinic. At Samuel Johnson there were monthly team meetings, where staff received feedback on incidents.
However, where meetings had been held, minutes we reviewed showed consideration had been given to various processes across outpatients including for example, a review of previous actions, an operations division update, staffing update and governance.

The deputy head of patient access chaired a monthly outpatients management group which reviewed a monthly performance report for outpatients A and B. Other specialties reported to meetings within their divisions. These meetings linked to divisional clinical meetings and nursing masterclasses.

At Sir Robert Peel Community Hospital there were monthly ‘confirm and challenge’ meetings with the matron and human resource department, surgical and medical senior sister meetings and monthly staff meetings.

The trust recognised that a number of policies need updating and was strengthening its mechanisms for making sure staff understood policies. We found that staff understanding of policies varied. The trust had a range of policies which applied to outpatients including a chaperoning policy, decontamination policy, resuscitation policy and a policy on suspected sepsis. In Sir Robert Peel and Samuel Johnson Community Hospitals, staff signed to indicate that they had read and understood a policy, but this system was not in place at Queens Hospital Burton.

**Management of risk, issues and performance**

Not all risks to outpatient services were addressed effectively. Leaders in outpatients A and B described their top strategic risks as the ageing outpatient building stock for some specialties and the ageing workforce. Some work was under way to improve the clinical accommodation to mitigate the building stock risk. A new building was in progress and some specialties had bid for space there. However, despite the stated need to recruit and encourage younger nurses, this was not reflected in a workforce plan or a strategic approach to succession planning. Long and short term sickness was a major risk, but the service lacked a plan to deal with it.

Each specialty had its own operational risk register and could identify risks to their service. For example, the cardiology service listed the carpeted floor and lack of appropriate waste storage are their key risks.

Information received following our inspection outlined the top three risks that had been identified for outpatients services These included; loss of income and potential fines from the Information Commissioner’s Office (ICO) for failure to meet deadlines, due to changes in law around the processing of subject access requests, the deletion of health records in the electronic patient record system and the risk of loss of patient data due to the poor state of repair for patient records leading to loose pages. We saw risks had been appropriately rated and controls were in place to mitigate risks.

Effective processes were in place to manage waiting list (referral to treatment) performance. At specialty level, leaders monitored the availability of clinic space, performance for new patients and follow ups and access to diagnostics. Specialities reviewed patient backlogs at weekly meetings in specialties and developed action plans to improve performance. This included making the most of existing capacity and planning additional clinics where needed. There was a trust wide outpatient dashboard which covered all specialties. Leaders reported to a weekly RTT (referral to treatment) governance meeting, and to a monthly trust wide RTT programme board. This ensured that leaders monitored performance closely and took corrective action where needed.

An 18-week RTT programme board, chaired by the director of operations, met monthly to review progress with RTT across the trust. We reviewed minutes of three meetings and saw where
appropriate consideration had been given to for example, 52-week breaches, diagnostic waiting times and RTT exceptions. In addition, individual business unit gave updates on their performance. Minutes showed where actions had been and/or were due to be taken.

**Information management**

The view of performance covered waiting list performance (referral to treatment measures), quality, activity and finance. We did not see evidence that this integrated patient’s views.

The service had clear and robust performance measures for waiting list (referral to treatment) performance and had an agreed policy relating to patient access.

The service had a five-year digital strategy for outpatients but when we inspected, it lacked the technology to show that clinics were running to time on a daily or weekly basis and was dependent upon manual auditing processes. Systems logged patient arrival and departure time but did not record when they were actually seen by the doctor. Access to computer terminals was an issue in some areas.

Electronic patient records were not fully implemented. Whilst implementation was ahead of schedule, staff told us full implementation was constrained by the lack of non-clinical trainers and lack of access to terminals.

Not everybody had access to electronic referral information. Where services were provided by a contractor, for example the podiatrist in the diabetic clinic, they did not have access to electronic referrals through the hospital intranet system. Staff had escalated this risk to management.

**Engagement**

Staff were informed about the acquisition through listening events. Specialty leaders told us about a Burton and Derby listening event for audiology where people spoke about what the acquisition could bring them. Senior oncology nurses told us they had attended patient experience groups and listening events. Engagement for unqualified or less senior staff was limited.

Staff were not consistently asked for their views at operational level. At Burton we found little evidence that staff were asked for their suggestions for improvements to have a positive impact on patient care.

Some clinics asked patients for their views but this was not consistent. Gynaecology surveyed patients about colposcopy. The diabetes clinic and oncology clinics were responsive to patient suggestions. There was an information board where patients could suggest what sort of information was displayed. In other services there were no outpatient surveys which asked open questions and the main method for feedback was the Friends and Family Test. There were no ‘you said we did’ displays on noticeboards.

Some examples existed of individual initiatives by staff creating information for patients in response to their feedback. In ENT a nurse developed a booklet to inform patients about ENT and micro suction and hearing tests, and what to expect while in clinic. This aimed to improve communication with patients around ENT casualty in clinic wait times.

**Learning, continuous improvement and innovation**

The joint surgery service at Sir Robert Peel Community Hospital planned to transfer pre-operative assessments including occupational therapy and physiotherapy from Queens Hospital Burton. This would save patients two hours of travel time.
At Sir Robert Peel Community Hospital patients with back pain used to have to drive to Derby to see a consultant and feedback identified this was a problem. The hospital set up a back-pain clinic at Sir Robert Peel Community Hospital.

Cardiology at Queens Hospital Burton received a gold standard recognition in a 24th November 2018 local paper article.
Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on the 1st July 2018 following the acquisition by Derby Teaching Hospitals NHS Foundation Trust of Burton Hospitals NHS Foundation Trust. The former acquired the latter under its existing registration with the CQC. Our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust is included in our analyses where appropriate. Because these data relate to the same legal entity as the merged trust they are used to form part of our judgement.

Data from the acquired Burton Hospitals NHS Foundation Trust is included in our analysis for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

University Hospitals of Derby and Burton NHS Foundation Trust has three community hospitals; Samuel Johnson Community Hospital, Sir Robert Peel Community Hospital and London Road Community Hospital. We did not inspect London Road Community Hospital at this time.

Samuel Johnson Community Hospital in Lichfield belonged to Burton Hospitals NHS Foundation Trust prior to the acquisition. The hospital provides day case surgery, renal dialysis and rehabilitation services. The hospital has 52 inpatient beds located across two wards:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna ward</td>
<td>Rehabilitation</td>
<td>26</td>
</tr>
<tr>
<td>Darwin ward</td>
<td>Rehabilitation</td>
<td>26</td>
</tr>
</tbody>
</table>

Sir Robert Peel Community Hospital in Tamworth also belonged to Burton Hospitals NHS Foundation Trust prior to the acquisition. The hospital provides day surgery for non-complex procedures, rehabilitation, care of older people and general medical care. The hospital hosts an endoscopy unit. The hospital has 39 inpatient beds located across two wards:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philip ward</td>
<td>Rehabilitation</td>
<td>24</td>
</tr>
<tr>
<td>Pre-operative assessments</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>Surgical day cases</td>
<td>-</td>
<td>15</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

The trust’s community inpatient wards and units are supported by consultants and general practitioners. Staff work collaboratively with general practitioners and a local mental health trust to provide physiotherapy, occupational therapy and mental health services at the Tamworth and Lichfield sites.)
Percentage of patients that are children

The trust reported no patients attending their community inpatient services within the last 12 months that were children aged 17 years or under. This was because the inpatient services cared for adults only.

Is the service safe?

Mandatory training

Mandatory Training completion

The trust set a mandatory training target of 90% for completion of mandatory training modules for staff at Samuel Johnson and Sir Robert Peel Community Hospitals.

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff told us that they had usually mandatory training scheduled into the rota and that the ward sisters ensured that staff were able to complete this.

Samuel Johnson Community Hospital

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (admin)</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion competency (coll)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood transfusion theory (nursing)</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The trust had an overall training completion rate of 98.0% for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital. The 90% mandatory training target was met for all 16 mandatory training modules for which qualified nursing staff were eligible.

The trust’s mandatory training data show no medical staff as eligible for any mandatory training for the period from November 2017 to October 2018 at Samuel Johnson Community Hospital.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified allied health professionals in community inpatients at Samuel Johnson Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse incident reporting</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s mandatory training data show that all four allied health professionals at Samuel Johnson Community Hospital had competed all 14 mandatory training modules for which they were eligible.

**Sir Robert Peel Community Hospital**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in community inpatients at Sir Robert Peel Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training module</td>
<td>Number trained</td>
<td>Number eligible</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met Yes / No</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>Information governance</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 96.2% for qualified allied health professionals in community inpatients at Sir Robert Peel Community Hospital. The trust’s mandatory training targets were met for 12 of the 14 mandatory training modules for which qualified nursing staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There was a trust-wide policy in place and staff knew how to access this. Staff we spoke with demonstrated they understood their responsibilities and adhered to trust safeguarding policies and procedures. Staff could give examples of safeguarding concerns they had raised and we observed that safeguarding was discussed at the daily handover meetings where all staff attended.

Staff knew how to contact the safeguarding team for advice and how to access a flowchart with information on how to manage a safeguarding concern and make a referral.

Safeguarding training completion

The trust set a mandatory training target of 90% for completion of safeguarding training modules for staff at Samuel Johnson and Sir Robert Peel Community Hospitals.

Samuel Johnson Community Hospital

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

All 35 qualified nursing staff in community inpatients at Samuel Johnson Community Hospital had completed the five mandatory training modules for which they were eligible.

The trust’s mandatory training data show no medical staff as eligible for any mandatory training for the period from November 2017 to October 2018 at Sir Robert Peel Community Hospital.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified allied health professionals in community inpatients at Samuel Johnson Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Basic safeguarding adults | 1 | 2 | 50.0% | 90% | No

The trust had an overall training completion rate of 70.0% for qualified allied health professionals in community inpatients at Samuel Johnson Community Hospital. The 90% training completion target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible. However, it should be noted that there were only two eligible qualified allied health professionals eligible for each of these modules.

**Sir Robert Peel Community Hospital**

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in community inpatients at Sir Robert Peel Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 1</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 90.0% for qualified nursing staff in community inpatients at Sir Robert Peel Community Hospital. The 90% training completion target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible.

However, immediately after our inspection the Trust provided us with more up to date information which showed that there was a completion rate for medical and non-medical staff combined as follows:

- 97% for Child protection level 1
- 95% for Child protection level 2
- 97% for Safeguarding Adults level 1
- 96% for Safeguarding Adults level 2

The trust’s safeguarding training data show no medical staff working as eligible for any safeguarding training at Sir Robert Peel Community Hospital.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified allied health professionals in community inpatients at Sir Robert Peel Community Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
All four qualified allied health professionals in community inpatients at Sir Robert Peel Community Hospital had completed the five mandatory training modules for which they were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to community inpatients, adult services or the police should take place.

The trust was unable to provide numbers of safeguarding referrals specifically for community inpatient services; instead they provided the numbers of referrals across all their services, broken down between the two predecessor trusts and the merged trust.

Staff were trained to recognise adults at risk and were supported with an effective safeguarding adult’s policy in place which was easily accessible on the Trust’s intranet. Staff we spoke with demonstrated they understood their responsibilities and adhered to trust safeguarding policies and procedures. In addition, details of the process to follow and relevant telephone contact numbers for external agencies were available to staff at the nurse stations.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All staff had access to the trust’s infection prevention and control policies and procedures which provided staff with guidance on appropriate infection prevention and control practice.

All three wards were clean and well maintained. Each site had cleaning schedules and checklists which were signed and dated. The service used ‘I am clean’ stickers to indicate that equipment had been cleaned before its next use.

Across all three wards all staff were observed to be compliant with best practice regarding hand hygiene and staff were noted to be bare below the elbow. Where personal protective equipment was required, for example gloves or aprons, we observed staff using it appropriately. Additional protection for barrier nursing was in operation at the time of our visit.

Hand hygiene audits were undertaken monthly to measure compliance with the World Health Organisation’s (WHO) ‘5 Moments for Hand Hygiene.’ These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients. Results for February 2019 demonstrated 100% compliance for Philip ward and Anna ward and 84% compliance for Darwin ward. The information was displayed on the ward board on each ward.
During our inspection Samuel Johnson hospital were managing a contained outbreak of the Norovirus infection. (Norovirus is a highly contagious infection that causes diarrhoea and vomiting lasting for one to two days. Outbreaks of the virus is common in semi-enclosed environments such as hospitals, nursing homes, schools and cruise ships.)

Both affected wards were visited by the trusts Infection Prevention and Control (IPC) team and matron each day, where affected patients were assessed and a plan discussed for ongoing management of the outbreak. Staff adhered to protocols and practices on the wards for managing infectious diseases as per Burton trust’s IPC policy. However, we noted there was no visible signage outside the affected wards to alert visitors about the outbreak. We brought this to the attention of the matron who rectified this immediately. Since our inspection, the management of Norovirus policy has been updated to reflect practice trust wide. This included the use of signage when any part of a ward was affected.

PLACE Assessments

These self-assessments are undertaken by teams of NHS and private/independent health care providers and include at least 50 per cent members of the public (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, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The data presented below are the 2018 PLACE scores, based on data collected from March 2018 to June 2018.

Please note that PLACE scores are only available at site level.

Samuel Johnson Community Hospital scored similarly to the England average for cleanliness. The hospital scored better than the England average for condition, appearance and maintenance.

Sir Robert Peel Community Hospital’s scores for both metrics were similar to the respective England averages.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Cleanliness %</th>
<th>Condition, appearance and maintenance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>98.1%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Sir Robert Peel Hospital</td>
<td>98.6%</td>
<td>93.4%</td>
</tr>
<tr>
<td>England average (NHS community)</td>
<td>98.8%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

Each ward conducted weekly audits of cleanliness on the ward. Data presented by the Trust for February 2019 showed between 97% and 98% cleanliness scores across all three wards.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Appropriate resuscitation equipment was available on each ward and staff demonstrated that they knew how to use the equipment. Training on the use of emergency equipment was carried out as part of mandatory life support training.
The resuscitation equipment appeared visibly clean. Single-use items were sealed and in date and emergency equipment had been serviced. Records indicated resuscitation equipment had been checked weekly by staff and was ready for use in an emergency. However, we noted that an airway device was only available in one size. Staff told us that they were following Burton Trust policy which was different to Derby Trust policy for resuscitation equipment. The resuscitation policy was being reviewed following the acquisition and staff were aware of potential changes that could be made.

Safety alerts issued to healthcare staff and NHS organisations on patient safety issues regarding medical devices were received by the ward managers who actioned them where required. All alerts were displayed in the treatment room and emailed to all nursing staff.

Arrangements for managing waste and clinical specimens minimised the risk of avoidable harm to patients. This included classification, segregation, storage, labelling, handling and treatment and disposal of waste.

The design, maintenance and use of facilities and premises was appropriate. There were lifts available. Staff demonstrated to us they were aware of how to raise faults or concerns with facilities and equipment. During our inspection we checked the service dates for 11 items of patient equipment; all equipment was within its service date.

During our inspection we saw that the dayroom on Anna ward had two additional beds placed there. This was to address the capacity shortage during the winter pressure period. We were told that only those patients who were up and about would ever be cared for in the dayroom. There were portable screens for privacy purposes and, oxygen and suction available if required. Staff had conducted a risk assessment and assured us that no patients would be admitted to the dayroom beds during the Norovirus outbreak as there were no toilet facilities within the dayroom. This meant that barrier nursing would not be possible if a patient in the dayroom showed signs of diarrhoea or vomiting.

Regular quality checks of the environment were made by the matron on each ward and displayed on each ward. Data provided by the trust showed that in February 2019, the matron’s quality checks scored between 95% and 99% across all three wards. Equipment checks during the same period scored 100%.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.

Comprehensive risk assessments were recorded for nutrition, skin condition, VTE prevention and falls risk. Patients who had undergone a mental capacity assessment prior to admission were required to undergo a further assessment on admission to determine whether their mental capacity had changed.

Patients admitted to all three wards across both hospitals were deemed fit for discharge and therefore generally clinically well and not in need of interventional care such as intravenous fluids. However, staff understood that patients could become unwell and knew how to identify this and act appropriately.

Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, medical emergencies and challenging behaviour. Patients who were most at risk of falls were care for in a bay close to the nurse’s station and where they were most visible to
staff. Where enhanced care was required for patients who needed one-to-one supervision, this was arranged after consultation with the matron. However, some ward staff told us that enhanced care was not always available when needed.

Nursing staff used a national early warning scoring system (NEWS) to record routine physiological observations such as blood pressure, temperature, and heart rate twice each day. NEWS was used to monitor patients and to prompt support from senior nursing and medical staff when required. Staff told us that more frequent observations were taken where a NEWS score was higher than three and if this went up to five, then potential sepsis was considered and escalated to the senior clinician and the sepsis protocol followed.

A sepsis screening tool, based on national guidance, was available to staff and gave guidance as to when staff should consider screening the patient for sepsis. Sepsis is a severe infection which spreads in the bloodstream. Patients being treated for sepsis were to be treated in line with key immediate interventions, based on the ‘Sepsis Six Bundle’, outlined on the sepsis screening tool. We reviewed a patient who had been screened for sepsis and found appropriate actions had been taken.

If blood tests or x-rays were needed, these were carried out on site and reviewed by the assistant specialist doctor on a daily basis.

Ward managers were available to support less experienced members of the nursing staff. Support was also provided by the consultant geriatrician and palliative care consultant who visited the wards each week and could be contacted out of hours if required. The GP out of hour’s service was also utilised during the evenings and weekends. Where emergency support was required the local NHS ambulance trust would be called.

**Staffing**

**Safer staffing levels**

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

A standard staffing model was followed to review staffing requirements on each ward, and where additional supervision was required, this was arranged on a day by day basis. Generally, each ward ensured there were a minimum of three qualified staff and three non-qualified staff on each ward during the day and at night there were two qualified and two non-qualified staff on duty. Staffing levels were displayed on all three wards and information displayed indicated actual staffing levels mostly met planned staffing levels. Where there were ‘gaps’ in staffing, bank and agency staff had been utilised. Staffing was monitored on a shift by shift basis by the ward managers on the wards and discussed with the matron during daily rounds and any staffing issues were escalated in the daily staffing huddle.

There were appropriate arrangements in place for using bank and agency staff. We saw that there was a formal three-day induction process for those bank or agency staff who were new to the ward area, and relevant information was shared by ward sisters and staff. Managers told us that they usually tried to use the same bank and agency staff where possible to maintain consistency. Staff told us that bank and agency staff were never left in charge of the ward. Clinical supervision was provided by the practice development team for bank staff.

Staff told us that they generally had sufficient staff to meet the needs of patients, however, on one of the days we visited Samuel Johnson hospital, both wards appeared to be short of staff. Staff told us this could be due to a heavier than usual workload because of the additional needs of
patients who had contracted Norovirus. This had been rectified when we visited again two days later and both wards appeared to be fully staffed.

During our inspection we observed a shift handover taking place. Handover involved all the staff on duty for the shift, including therapy staff. This ensured all staff had an appropriate awareness of each patient on the ward.

Staff fill rates compare the proportion of planned hours worked by staff (nursing, midwifery and care staff) to actual hours worked by staff (day and night). Acute trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for qualified nursing staff during the day means that in January 70% of the planned working hours for daytime qualified nursing staff were actually ‘filled’.

Details of staff fill rates within community inpatient services under the rehabilitation specialty for registered nurses and care staff in December 2018 for each site published on their website by the trust are below:

For community inpatient services, there is information for both Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital.

**Qualified nursing staff**

<table>
<thead>
<tr>
<th>Location</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required shifts</td>
<td>Filled shifts</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>2193.0</td>
<td>2051.0</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>1102.5</td>
<td>915.5</td>
</tr>
</tbody>
</table>

**Care staff**

<table>
<thead>
<tr>
<th>Location</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required shifts</td>
<td>Filled shifts</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>2624.5</td>
<td>2587.8</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>1099.5</td>
<td>1119.0</td>
</tr>
</tbody>
</table>

(Source: Safer Staffing Data – Trust website – rehabilitation specialty)

**Planned v Actual Establishment**

**Qualified nursing staff**

The trust reported their staffing numbers by department for qualified nurses in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital as below for the periods from April 2017 to March 2018 and from November 2017 to October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>30.7</td>
<td>38.1</td>
</tr>
</tbody>
</table>
Medical staff

The trust reported their staffing numbers by department for medical staff in community inpatients at Sir Robert Peel Community Hospital below for the periods from April 2017 to March 2018 and from November 2017 to October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>0.1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Medical cover was provided at Sir Robert Peel hospital by visiting GPs who would attend whenever one of their patients was being cared for at the hospital. GPs met with the consultant geriatrician weekly to discuss their patients. The Trust was not responsible for GP appraisal, however, any changes to care or guidelines was communicated to GPs through regular contact and occasional educational sessions. Any performance issues were managed individually by the consultant geriatrician.

The service planned to increase medical cover at both hospitals.

Qualified allied health professionals

The trust reported their staffing numbers by department for qualified allied health professionals in community inpatients at Sir Robert Peel Community Hospital below for the period from April 2017 to March 2018 and from November 2017 to October 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>April 2017 to March 2018</th>
<th>November 2017 to October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTE)</td>
<td>Planned staff (WTE)</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>1.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>2.3</td>
<td>1.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

Vacancies

Qualified nursing staff by site

Vacancy rates for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital as of March 2019 are shown below. The trust had a target vacancy rate of 6%.
<table>
<thead>
<tr>
<th>Site name</th>
<th>Number of vacancies</th>
<th>Number of substantive staff</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>7.82</td>
<td>64.94</td>
<td>10.7%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>7.05</td>
<td>48.97</td>
<td>12.6%</td>
</tr>
</tbody>
</table>

The Trust informed us that they had recently filled many of the vacancies through active recruitment programme which included open days. They had recruited 4.5 WTE qualified staff.

**Medical staff by site**

Vacancy rates for medical staff in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust had a target vacancy rate of 6%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Number of vacancies</th>
<th>Number of substantive staff</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>0.0</td>
<td>15.2</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>2.1</td>
<td>2.8</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

The Trust employed one consultant geriatrician and one palliative care consultant who visited the wards at both hospitals one day each week and provided support during the out of hours period. There was also an associate specialist doctor available between the hospitals during the hours of 9am to 5pm each weekday. (Associate specialists are senior hospital doctors, responsible to named consultants) Locum doctors were used to cover gaps in the rota due to annual leave. The senior consultant had submitted a request to the Board to increase the medical staffing provision and was awaiting a decision on this.

The local GP out of hours service was contacted for urgent advice during the evenings and weekends.

**Allied health professionals by site**

Vacancy rates for qualified allied health professionals in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust had a target vacancy rate of 6%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Number of vacancies</th>
<th>Number of substantive staff</th>
<th>Total % vacancies overall (excluding seconded staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>17.5</td>
<td>36.0</td>
<td>48.6%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>-2.9</td>
<td>23.0</td>
<td>-12.7%</td>
</tr>
</tbody>
</table>

*Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy*

**Turnover**

**Qualified nursing staff by site**
Turnover rates for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust’s target of having a turnover rate of between 8% and 12% was not met for qualified nurses at either site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Average staff in post</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>10.9</td>
<td>30.4</td>
<td>35.9%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>3.9</td>
<td>11.7</td>
<td>33.5%</td>
</tr>
</tbody>
</table>

**Medical staff by site**

Turnover rates for medical staff in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust reported no turnover for medical staff at either site over these 12 months.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Average staff in post</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>0.0</td>
<td>1.3</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Allied health professionals by site**

Turnover rates for allied health professionals in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust reported no turnover for allied health professionals at either site over these 12 months.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Average staff in post</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>0.0</td>
<td>1.3</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>0.0</td>
<td>2.5</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

**Sickness**

**Qualified nursing staff by site**

Sickness rates for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October
2018 are shown below. The trust’s target sickness rate of 3.8% was met for qualified nurses at both sites.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of sick days in the last 12 months</th>
<th>Number of substantive staff</th>
<th>Sickness rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>174.2</td>
<td>11,792.6</td>
<td>1.5%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>137.4</td>
<td>4,376.5</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

**Medical staff by site**

Sickness rates for medical staff in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust’s target sickness rate of 3.8% was met for medical staff at both sites.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of sick days in the last 12 months</th>
<th>Number of substantive staff</th>
<th>Sickness rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>2.0</td>
<td>464.5</td>
<td>0.4%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>0.0</td>
<td>19.2</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Allied health professionals by site**

Sickness rates for qualified allied health professionals in community inpatients at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital for the period from November 2017 to October 2018 are shown below. The trust’s target sickness rate of 3.8% was met for qualified nurses at both sites.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total number of sick days in the last 12 months</th>
<th>Number of substantive staff</th>
<th>Sickness rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>2.0</td>
<td>452.0</td>
<td>0.4%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>7.5</td>
<td>905.7</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

**Nursing - bank and agency**

**Samuel Johnson Community Hospital**

The table below shows the numbers and percentages of hours in community inpatients at Samuel Johnson Community Hospital that were covered by qualified nursing bank and agency staff or left unfilled by department from November 2017 to October 2018.

Of the 109,245.4 total working hours available for qualified nurses at Samuel Johnson Community Hospital, 13.3% were filled by bank staff and 2.3% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period 1,097.0 hours (1.0% of total establishment) were left unfilled.
Of the 56,890.5 total working hours available for non-qualified nurses at Samuel Johnson Community Hospital, 14.4% were filled by bank staff and 4.4% were filled by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period 1,790.0 hours (3.1% of the total) were left unfilled.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Qualified</td>
<td>109,245.4</td>
<td>14,483.8</td>
<td>13.3%</td>
<td>2,539.3</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>56,890.5</td>
<td>8,181.8</td>
<td>14.4%</td>
<td>2,481.5</td>
</tr>
<tr>
<td>Total</td>
<td>166,135.9</td>
<td>22,665.6</td>
<td>13.6%</td>
<td>5,020.8</td>
</tr>
</tbody>
</table>

Sir Robert Peel Community Hospital

The table below shows the numbers and percentages of hours in community inpatients at Sir Robert Peel Community Hospital that were covered by qualified nursing bank and agency staff or left unfilled by department from November 2017 to October 2018.

Of the 99,646.4 total working hours available for qualified nurses at Samuel Johnson Community Hospital, 10.8% were filled by bank staff and 0.7% were filled by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period 851.0 hours (0.9% of the total) were left unfilled.

Of the 48,512.4 total working hours available for non-qualified nurses at Sir Robert Peel Community Hospital, 13.5% were filled by bank staff and 3.0% were filled by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period 1,231.5 hours (2.5% of total establishment) were left unfilled.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Agency usage</th>
<th>Not filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Qualified</td>
<td>99,646.4</td>
<td>10,718.3</td>
<td>10.8%</td>
<td>709.8</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>48,512.4</td>
<td>6,556.5</td>
<td>13.5%</td>
<td>1,445.8</td>
</tr>
<tr>
<td>Grand Total</td>
<td>148,158.8</td>
<td>17,274.8</td>
<td>11.7%</td>
<td>2,155.5</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Suspensions and supervisions

During the reporting period from November 2017 to October 2018, the trust reported that there were six cases of staff in community inpatient services being suspended and one staff member being temporarily deployed.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
Patient records were a combination of paper records (patient notes) and an electronic system which was used for recording patient information, risk assessments and care provided. This enabled all staff including allied health professionals to access patient records and share relevant information. Paper records were kept in lockable trollies.

We checked 10 patient records and found these to be comprehensive, Patient care records were multidisciplinary and we saw entries had been made by nurses, doctors and therapy staff, including physiotherapists, occupational therapists, speech and language therapists and dietetics staff.

Where patients moved between teams, services and organisations including referral, discharge and transfer, information was shared appropriately, in a timely way and in line with trust policy.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines.

We checked 10 electronic medicines charts and found that patients received the right medication at the right dose at the right time. The charts were audited by the trust pharmacist and results fed back to ward staff.

Staff had been trained in the safe administration of medicines and we observed staff to administer medicines in line with Nursing and Midwifery Council (NMC) standards for medicines management and trust policy.

Disposable ‘Do not disturb’ tabards were in use across the wards for medicine rounds to minimise interruptions and reduce the risk of medicine errors.

Patients medicines were stored in individual boxes within the medicines trolley and these were checked by the pharmacist who visited the wards daily to review the medicines charts; this included reviewing the use of antibiotics, medicines and reconciliation of medicines for new admissions and to discuss medicines with individual patients.

A senior ward sister, available on each ward, was a non-medical prescriber. They were supported by the geriatric consultant from the local NHS acute trust who oversaw the clinical care of the patients. Non-medical prescribing is undertaken by a health professional who is not a doctor. It relates to any medicine prescribed for health conditions within the health professional’s field of expertise. At the time of our inspection, senior ward sisters informed us that additional senior nurses were being considered to attend training for non-medical prescribing. This would increase the number of clinicians able to prescribe within their field of expertise in the absence of a consultant or visiting GP.

Controlled drugs (CDs) were stored appropriately, stock levels were checked daily by ward staff and monthly by the pharmacist. The nurse in charge of the ward carried the CD keys. Controlled drugs are prescription medicines, which are governed by the misuse of drugs legislation (1971). The law determines the storage, production; supply and prescribing of these medicines were stored, managed and recorded safely and appropriately. Medicines records were accurately completed.

Emergency medicines such as those used in a cardiac arrest and anaphylaxis (an extreme and severe allergic reaction) were available on each ward and easily accessible to staff.
Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they would be fit for use. Records indicated temperatures for refrigerators had been checked daily and included guidance for staff in the event of a temperature being out of the required range.

Safety alerts issued to healthcare staff and NHS organisations on patient safety issues including medicines safety alerts were received by the ward managers who actioned them where required. All medicines alerts were displayed in the treatment room and emailed to all nursing staff. Any medicine recall alerts were actioned by the pharmacist who alerted staff and checked medicine stock with nursing staff on the wards.

**Incident reporting, learning and improvement**

**The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. For example; when there was a delay in sending a sample when a potential infection was suspected, this was discussed with staff and adherence to protocol reinforced. Staff confirmed that incidents were discussed at ward meetings and they usually received direct feedback about any incident they had reported.

There was a policy and procedure for reporting incidents which was available to staff on the intranet. This policy and procedure determined the responsibility of all staff with regard to the reporting and investigation of all incidents or adverse events in the trust.

Across the three wards two serious incidents had been reported during the previous quarter. Both these were moderate/serious harm due to falls. The most frequently reported incident categories were pressure ulcers, falls and staffing.

All incidents were recorded on the trust’s electronic risk management system. This was configured to ensure that incidents were escalated to and reviewed by appropriate clinicians and managers ensuring that incidents were followed up and feedback sent to the reporter. Learning was shared at monthly ward meetings. Staff told us that there was an open culture that encouraged reporting of incidents.

All staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. Examples of incidents raised included falls and staffing. However, we were not assured all patient safety incidents were raised through the trust’s electronic risk management system because the Norovirus outbreak had not been recorded as an incident at the time of our inspection.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 and September 2018, the trust reported no never events in community inpatient services.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents**

Data from the pre-acquisition period for Derby Teaching Hospitals NHS Foundation Trust are included in this analysis. Because these data related to the same legal entity as the merged trust we have used this to form part of our judgement.
In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in community inpatients which met the reporting criteria set by NHS England from January to December 2018, two pressure ulcers and two falls.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents (SiRI) – Trust data**

From November 2017 to October 2018, trust staff within community inpatients services reported six serious incidents.

The number of the most severe incidents recorded by the trust incident reporting system is not comparable with that reported to Strategic Executive Information System (STEIS).

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

**Prevention of Future Death Reports (remove before publication)**

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations made by coroners with the intention of learning lessons from the cause of death and preventing deaths.

The relevant documents for this section provided in the RPIR are password protected, this would need to be queried on inspection so this section can be populated.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

**Safety performance**

**Safety Thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

**Samuel Johnson Community Hospital – Community hospital ward settings**

From November 2017 to November 2018 the trust reported 31 new pressure ulcers, one fall with harm and one new catheter urinary tract infection in patients with a catheter in community inpatients wards at Samuel Johnson Community Hospital. Rates of pressure ulcers by month are in the table below.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Samuel Johnson Community Hospital**
Sir Robert Peel Community Hospital – Community hospital ward settings

From November 2017 to November 2018 the trust reported 12 new pressure ulcers and no falls with harm or new catheter urinary tract infection in patients with a catheter in community inpatients wards at Sir Robert Peel Community Hospital. Rates of pressure ulcers by month are in the table below.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Sir Robert Peel Community Hospital


Safety thermometer information was displayed on each ward and easily accessible to the public and all patients. Information included infections, risk, falls, pressure ulcers, and staffing levels.

Information provided by the Trust showed that for the period of September 2018 to January 2019 the service had achieved 100% harm free care on Anna ward; between 90% and 100% for Darwin ward; and between 95% and 100% for Philip ward.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We reviewed 10 patient care records. We found patient's physical, mental health and social needs had been holistically assessed, and care and treatment delivered in line with Trust policy and guidance.

All the care records we reviewed included evidence of an assessment of emotional well-being and physical health with outcomes reviewed where appropriate. Patients who had previously been assessed as not having capacity, underwent a further capacity assessment on admission to check whether this had changed. Patients with a long-term condition or complex needs had a clear personalised care plan which was up to date and had clear outcome goals. Evidence based tools were used to assess patients, for example; a nationally recognised tool was used to assess pain in patients living with dementia.

Therapy staff including physiotherapists, occupational therapists, speech and language therapists and dietetic therapists were included as part of the wards establishment and worked alongside the nursing staff to assess, plan and deliver care. This meant that patients received relevant therapy services in a timely and coordinated way.

Staff could access National Institute for Care Excellence (NICE) guidelines, quality standards and other good-practice guidance through the trust’s intranet system. For example; Type 1 diabetes, prevention and management of pressure ulcers; and stroke rehabilitation.

When changes were made to guidelines and policies, staff were made aware of this and asked to read these. Ward sisters made amended policies and guidelines available to staff in printed form for ease of reading and kept a record of this.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

We observed that there was a varied diet offered to patients and food looked appetising and well presented. Patients were encouraged to eat their meals at a dining table with other patients to improve their appetite and where required, patients received assistance with eating.

A dietitian visited the wards daily to assess the needs of patients and to help improve their nutrition.

Patient’s care plans included an appropriate nutrition and hydration assessment and management plan. A nutritional risk assessment was carried out on admission to establish the level of support the patient required. Nutritional management plans were updated when the patient’s requirements changed.
Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff tried to ensure that pain relief was given in a timely way so that therapy sessions could be conducted with minimal pain, however, therapy staff said that there were occasions where this was not possible.

Staff used nationally recognised tools to assess pain where relevant, for example, people living with dementia or a communication difficulty.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Ward managers collected information about a variety of quality outcomes and reviewed whether patients receiving rehabilitation were meeting their goals. For example, information was routinely collected for number of falls, including falls with harm; nutritional status, pressure ulcers, and venous thromboembolism prevention scores. Information was also collected regarding length of stay in hospital and patient satisfaction.

Results were discussed at monthly ward meetings, board rounds, and weekly ward assurance meetings, and were displayed on each ward. Changes were made to practice where required. For example:

- For patients with dementia and those who liked to retire to bed early, a change was made to the time when patient's physiological observations were recorded so that patients could retire to bed at a time they were used to rather than waiting up. This meant that patients with dementia were less likely to become distressed about disturbances to their routine.
- A pressure ulcer scheme was introduced which ensured that all patients had their skin integrity inspected within two hours of admission.
- Patients with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place had this reviewed on admission and their capacity assessment was reviewed where relevant.

Audits – changes to working practices

The Trust conducted local audits to monitor the quality and effectiveness of care provided. These included:

- Pressure ulcers.
- NEWS2 chart audits.
- Continence audits.
- Call bell audits.
- DNACPR documentation audits.

We reviewed a sample of the most recent audits which identified that staff adhered to policies and protocols, and there were no issues identified.

Senior leaders also conducted regular practice checks that included:

- Clinical competency checks (for individual staff).
• Safety checks (walkabout style). These included observational checks on falls hazards, environment, staff welfare, fire safety, security, and COSHH assessments.
• Quality ward rounds. These included observations how quickly call bells were answered, and how patient’s nutritional needs were addressed.

We reviewed a governance report presented to the Board and found that outcomes of audits and quality checks were discussed.

The Trust had conducted a local audit for community inpatients to check the effectiveness of conducting medicines reviews for patients who were taking more than five medicines concurrently. The first cycle audit involved 37 patients and found that polypharmacy had not been considered consistently as a risk factor for falls, and that medicines reviews had not previously been fully documented. The audit was unable to conclude whether medicines reviews had reduced the number of falls. However, recommendations were made to improve practice and there were plans to conduct a second cycle audit with a larger cohort of patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff told us that they had received an annual appraisal each year which was valuable and they had a personal development plan. There was funding available for staff to attend external courses where appropriate and we noted there were some dementia champions on each ward who had attended dementia training. Staff were encouraged to attend courses on leadership and mentorship where relevant, as well as courses specific to their role and to the patient group such as training relating to dementia, long term conditions and rehabilitation.

There were a limited number of staff who were non-medical prescribers, however we were told there were plans to increase this.

New staff received an induction to the hospital and role and clinical competencies were assessed by the senior sister on an ongoing basis. Bank and Agency staff also received an induction and competency checks.

Where relevant, poor performance was managed in conjunction with the human resources (HR) team in a supportive way through regular meetings, supervision and competency checks.

Clinical Supervision

The trust provided the following information about their clinical supervision process:

“For medical staff, the trust maintains a database of all Educational Supervisors (ES) in line with General Medical Council (GMC) requirements. The information pertains to courses attended, number of supervised trainees and whether the individual is a clinical supervisor (CS) or ES. The database is regularly updated and information is provided to Health Education England (HEE) upon request.

There is currently a disconnect between the ES recognition at the two sovereign organisations. Derby Teaching Hospitals have historically recognised the ES role at 0.1 PA whereas Queen’s Hospital, Burton have recognised at 0.25 PA. Work is on-going to harmonise the payments following the acquisition in July 2018.

A programme of in-house training is provided on both sites for supervisors with the topics focusing on issue pertinent to the roles.
The role of ES is monitored through the job planning process with a specific trust objective set.

Annual feedback is taken from the foundation trainees regarding their ES’s and any issues are addressed by the Foundation Programme Directors. The college and specialty tutors maintain close links with their specialty ES.

The trust has robust medical education governance arrangements in place with the two directors of postgraduate medical education attending the executive medical director’s regular information sharing meeting. In addition, there are active Postgraduate Medical Education committees on both main sites which link directly to the Medical Education Group and from there directly to the trust’s sub-committees. In addition, medical education issues are highlighted through the executive medical director’s monthly board report.

For nursing staff, clinical supervision is currently offered within the preceptorship period of newly qualified nursing staff. This was developed as a pilot for newly qualified nursing staff to assess the voluntary compliance with the programme with the vision of rolling out this to all newly qualified clinical staff. This would also include the new and emerging roles such as the nursing associates. The pilot programme has a requirement of meetings at five stages within the first year which comprise of the following: 1) Initial employment on the preceptorship programme, 2) three months, 3) six months, 4) nine months and 5) at the final stage of the programme at 12 months. The compliance of these stages are recorded on the trust’s Learning Management System called Our Learning Hub and currently stand at the following at each stage: 1) 71%, 2) 38%, 3) 34%, 4) 16% and 5) 22%.

Work is ongoing to improve overall compliance which includes a standardised approach across UHDB and to roll out to all clinical staff. A core component of revalidation is critical reflection and discussion of practice. ESR also hold records for the revalidation process of nursing staff which is monitored on a monthly basis which ensures nursing staff meet the requirements to be able to practice safely. The current compliance rates of 100%. In relation to midwifery, clinical supervision is referred to as professional midwifery advocacy and this is accessed as and when the individual requires it. It is recorded locally within their personal portfolio.”

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Appraisal rates

**Samuel Johnson Community Hospital**

From November 2017 to October 2018, 96.8% of staff in community inpatients at Samuel Johnson Community Hospital received an appraisal compared to a trust target of 90%. The trust’s appraisal completion targets were met by three out of five staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>27</td>
<td>27</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>62</strong></td>
<td><strong>96.8%</strong></td>
<td><strong>90.0%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

**Sir Robert Peel Community Hospital**

From November 2017 to October 2018, 97.1% of staff in community inpatients at Sir Robert Peel...
Community Hospital received an appraisal compared to a trust target of 90%. The trust’s appraisal completion targets were met by all six staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number completed</th>
<th>Number required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>35</td>
<td>97.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

**Multidisciplinary working and coordinated care pathways**

Staff in different roles worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Care was delivered and reviewed in a coordinated way and involved all members of the multidisciplinary team (MDT). Patient care records were multidisciplinary and our review of records confirmed an MDT approach to the patient’s pathway of care. Where necessary, staff could make a referral to a psychiatric liaison nurse to access mental health services within the trust. They also liaised regularly with the community matrons, district nurses, GPs and social care team.

A ‘ward board’ took place each morning on each ward. This was a multidisciplinary team (MDT) and included the matron, nurse in charge, a physiotherapist, an occupational therapist, a dietitian, a speech and language therapist and a social worker. The team focussed on discharge from the point the patient had been admitted. In addition, a weekly ward round was conducted with the consultant, matron and MDT.

Patients were admitted from other hospitals within the trust at a point in which they were deemed fit for discharge to a care facility; discharged with a care package; or required rehabilitation prior to discharge. The MDT worked together to plan for patients discharge as quickly as possible. However, there were sometimes delays in placing patients in a care facility due to issues with funding. In these situations, ward staff and therapists continued to provide rehabilitation to the point of discharge.

Where patients were receiving palliative care, or had more complex needs, additional key staff were involved in discussions about their care in weekly Board rounds with consultants and other staff.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
All patients who had received a mental capacity assessment from another hospital were routinely re-assessed as part of their admission process to assess whether this had changed.

We checked five Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms and found that capacity assessments had been conducted appropriately and discussions with relatives documented in the patients record.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff at Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital were eligible for two levels of combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The completion target for both modules was 90%.

### Samuel Johnson Community Hospital

A breakdown of compliance for MCA and DoLS training for the period from November 2017 to October 2018 for qualified nursing staff in community inpatients at Samuel Johnson Community Hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 2</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act and Deprivation of Liberty Safeguards - level 1</td>
<td>16</td>
<td>19</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for the level 2 training but was not met for the level 1 training.

The trust’s mandatory training data show no medical staff as eligible for either level of MCA and DoLS training for the period from November 2017 to October 2018 at Samuel Johnson Community Hospital.

From November 2017 to October 2018 one qualified allied health professional in community inpatients at Samuel Johnson Community Hospital was eligible for both levels of MCA and DoLS training. This member of staff had completed both modules.

### Sir Robert Peel Community Hospital

A breakdown of compliance for MCA and DoLS training for the period from November 2017 to October 2018 for qualified nursing staff in community inpatients at Sir Robert Peel Community hospital is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for either level of MCA and DoLS training.
The trust’s mandatory training data show no medical staff as eligible for either level of MCA and DoLS training for the period from November 2017 to October 2018 at Sir Robert Peel Community Hospital.

The trust’s mandatory training data show that all four allied health professionals at Sir Robert Peel Community Hospital had competed the level 1 MCA and DoLS module. These staff were not eligible for MCA and DoLS level 2.

**Deprivation of Liberty Safeguards**

From October 2017 to September 2018 the trust reported that 152 Deprivation of Liberty Safeguards (DoLS) applications were made to the Local Authority, 35 of which were pertinent to community inpatients services and occurred at London Road Community Hospital.

The highest monthly volume of DoLS applications for community inpatients services was seven (March 2018).

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS; CQC records)

**Is the service caring?**

**Compassionate care**

**Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.

During our inspection, staff on all three wards were observed to be polite and courteous to patients and responded compassionately and in a timely manner when patients needed help. Staff introduced themselves to patients, interacted with them and showed kindness and patience. Staff understood and respected the personal, cultural, social and religious needs of patients and took these into account in the way they delivered care.

All three of the patients and two relatives we spoke with, were positive about their experience at this hospital and were extremely positive about all the healthcare staff.

Staff were committed to ensuring that patient’s privacy and dignity needs were understood and respected and our observations confirmed this. Both hospitals had implemented a PJs paralysis initiative which is a campaign launched by NHS England in 2018 aimed at getting older people up and dressed so that they don’t spend any longer than is clinically necessary in hospital. There were posters around each of the wards which were visible to patients and relatives and explained the initiative and its benefits.

Staff and therapists worked together to ensure all people who could get dressed and out of bed were encouraged and helped to do this.

The service included patient satisfaction data on their safety thermometer and displayed results on the wards for patients and relatives to see. The latest results showed 95% satisfaction for patient experience.

The service conducted monthly patient surveys where 10 questions were asked of patients. We reviewed the survey results for the previous 12 months and found that scores were consistently between 97% and 99% each month.

The Friends and family test results for February 2019 showed that for community inpatient services, 95% of patients would recommend the service to friends and family.
PLACE - data in relation to privacy, dignity and wellbeing

These self-assessments are undertaken by teams of NHS and private/independent health care providers and include at least 50 per cent members of the public (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, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The data presented below are the 2018 PLACE scores, based on data collected from March 2018 to June 2018.

Please note that PLACE scores are only available at site level.

Both Samuel Johnson Community Hospital and Sir Robert Peel Community Hospital scored worse than the overall England average for community hospitals for privacy, dignity and wellbeing in the 2018 PLACE scores.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Privacy, dignity and wellbeing score 2018 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>84.1%</td>
</tr>
<tr>
<td>Sir Robert Peel Hospital</td>
<td>77.8%</td>
</tr>
<tr>
<td>Trust community inpatients</td>
<td>81.4%</td>
</tr>
<tr>
<td>England average (NHS community)</td>
<td>83.4%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

During our inspection we observed patients being treated with respect and saw that staff preserved their dignity, privacy and wellbeing.

Screens were used appropriately and staff introduced themselves. Patients were encouraged to get dressed and out of bed during the day and to socialise with others. Therapists and staff encouraged patients to participate in activities to improve their sense of wellbeing.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Staff understood the impact of caring for a loved one with complex or challenging needs and gave relatives time to discuss care and be involved in planning their discharge.

All members of the multidisciplinary team were committed to ensuring the emotional needs of patients and their carers was considered. Throughout our inspection we observed many good examples where staff were providing emotional support and signposting to additional support where required. A member of the chaplaincy team visited wards one day each week to offer spiritual support and could be called at short notice when required.

Each ward had a large wall display which identified all the various organisations, charities and other avenues for help and support that were available for patients and relatives.

There were dementia champions on each ward.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**
Each ward used a ‘This is Me’ booklet and encouraged relatives to help patients write down their likes and dislikes and other things that were important to them. Although the booklet was devised to help people living with dementia, staff encouraged other older people to use it to help staff communicate with them more effectively.

Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included for example, access to interpreting and translation services and the use of specific communication aids such as for example, picture cards.

Patient’s carers and family members were welcomed and treated as important partners in the delivery of their care. A communications clinic was implemented to provide relatives with dedicated time to speak with members of the multi-disciplinary team about the care and discharge package requirement for their loved one. The meeting took place whilst the patient was on the ward and was repeated whenever changes occurred or as often as required.

In situations where a patient was identified as being at the end of their life, provision was made for relatives and carers to stay with their loved one in hospital.

There was a wall board on each ward which identified local services and how to access them.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

**The service took account of patients’ individual needs.**

The three wards at Sir Robert Peel hospital and Samuel Johnson hospital provided rehabilitation care for older people who were deemed fit for discharge to a care facility or to their home with a care package or after some rehabilitation. The majority of patients were admitted from other hospitals within the trust with the aim of planning an effective discharge.

The Trust had taken account of the patient demographic and provided a skill-mix within their workforce that suited the needs of the patients. They had developed a multidisciplinary approach to all aspects of care and involved all staff in daily MDT meetings and handovers to enable all aspects of patient’s needs were being discussed and addressed. The patient’s relatives were invited to regular communication clinics with the MDT. These were usually 20 minute meetings where all aspects of the patient’s care and rehabilitation was discussed with the relatives and plans agreed for enabling an effective discharge.

The communications clinic was introduced by the matron to address a previous problem whereby the board rounds were frequently interrupted by relatives wishing to have their questions answered. The impact of the change was that relatives now had a dedicated time to discuss their loved one’s care with the MDT and the Board round was more productive with less interruptions.

The service worked in collaboration with local GPs, social care team and local fire services to provide a ‘frailty hub’. This was a one-stop-shop service where patients with dementia and/or frailty were referred by their GP be reviewed by a consultant, GP, therapy team and a pharmacist at one appointment. This joint venture was re-named the ‘Staying Well Clinic’ and aimed at preventing falls and admissions to hospital.

There was also a discharge facilitator who visited the wards daily to progress patients’ discharge plans and worked with a discharge decision support tool to ascertain funding for care placements and packages where required. Where appropriate, a ‘Home First’ package of care was arranged
for patients whose needs were minimal. This was a six-week package of care which was free to patients and included physiotherapy at home.

There was dementia friendly signage and clocks in use. There were a variety of distraction aids including games, crafts and hand-made ‘fiddle-blanket’s and ‘fiddle-mitts’ which patients were able to take home with them.

Each ward had a dayroom where patients and relatives were encouraged to spend time together engaged in various activities with therapists, such as potting plants and needlecrafts. This enabled therapists and staff to assess patient’s needs as well as serving as a distraction for agitated patients. There was also a large screen TV and tables were set for mealtimes to encourage patients to eat together in more normalized setting. For patients who were unable to come to the dayroom, there was a table available in their bay which was set out for mealtimes.

Ward moves

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example, if a patient is moved several times because there is no room in the speciality ward they should be on.

Samuel Johnson Community Hospital

From November 2017 to October 2018, 80.5% of patients on the wards within community inpatients at Samuel Johnson Community Hospital did not move wards during their admission, 19.5% moved once or more.

Samuel Johnson Hospital

From November 2017 to October 2018, 80.6% of patients on the wards within community inpatients at Samuel Johnson Community Hospital did not move wards during their admission, 19.4% moved once or more.

(Source: Universal Routine Provider Information Request (RPIR) Universal P43 – Ward moves)

Moves at night

The trust were asked to list ward moves between 22:00 and 08:00am for each core service for the most recent 12 months. From November 2017 to October 2018, the trust reported that there were 201 moves at night for community health inpatient services.

The data below shows the number of ward moves at night by hospital site over these 12 months in the community health inpatient services being inspected. No data were provided for Anna ward at Samuel Johnson Community Hospital.

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Number of moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>Darwin ward</td>
<td>4</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>Philip ward</td>
<td>10</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) Universal P44 – Moves at night)

During our inspection we were told that staff tried to avoid moving patients wherever possible, but occasionally needed to accept patients at night to free up a bed at Queens hospital Burton.

Mixed sex breaches
Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. Whilst these are specifically for MH providers the same definitions apply to CHS and Acute providers from a CQC perspective. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children’s and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children's unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported that from November 2017 to October 2018 there were no mixed sex breaches within community inpatients services.

(Source: Universal Routine Provider Information Request (RPIR) P47 – Mixed sex)

Meeting the needs of people in vulnerable circumstances

The service had arrangements in place to meet the needs of people in vulnerable circumstances.

There was a range of physical aids to support patients who required additional help; pressure reliving mattresses for patients who were bed bound; communication aids for patients who had a hearing, visual problem, dementia or had a learning disability.

Staff encouraged patients to engage in activities that interested them and provided a variety of books, music, games, TV and group activity sessions. We heard about an example whereby a patient was unable to communicate well. When staff learned that they used to work as a typist, they brought in a typewriter which improved their communication and engagement.

The service responded to the specific needs of patients, many of whom were experiencing dementia or confusion, and extended visiting hours to 11am-to 8pm. This enabled relatives to participate more in their care.

For patients who were at the end of their life, a fast track discharge process was in place where this was appropriate. Relatives and carers were encouraged to stay over with their loved one and a personal care pack and sleep-over chair was provided for them.

For patients with longer term needs or more complex needs, a discharge plan usually involved input from the social care team and funding was usually required to secure a care package or placement. We were told that complex discharges often took longer to arrange due to delays in obtaining funding.

PLACE Assessments (remove before publication)

These self-assessments are undertaken by teams of NHS and private/independent health care providers and include at least 50 per cent members of the public (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, the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The data presented below are the 2018 PLACE scores, based on data collected from March 2018 to June 2018.

Please note that PLACE scores are only available at site level.
Samuel Johnson Community Hospital scored worse than the England average for being dementia friendly and for being disability friendly.

Sir Robert Peel Community Hospital scored better than the England average for being dementia friendly. The hospital’s score for being disability friendly was similar to the England average.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Dementia friendly %</th>
<th>Disability %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>74.3%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Sir Robert Peel Hospital</td>
<td>80.9%</td>
<td>90.5%</td>
</tr>
<tr>
<td>England average (NHS community)</td>
<td>80.6%</td>
<td>86.4%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

During our inspection we observed dementia friendly signage in place at both hospitals. There was also dementia friendly wall clocks and games. Volunteers had donated a supply of knitted blankets and mitts that were designed with buttons and ribbons to help patients who were agitated.

Access to the right care at the right time

Accessibility

The largest ethnic minority group within the trust catchment area is “Asian or Asian British - Pakistani” with 2.9% of the population.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>Asian or Asian British - Pakistani</td>
<td>2.9%</td>
</tr>
<tr>
<td>Second largest</td>
<td>White - Any other White background</td>
<td>2.6%</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian or Asian British - Indian</td>
<td>2.6%</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian or Asian British - Any other Asian background and Mixed - White &amp; Black Caribbean</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – P48 Accessibility)

There were no specific admission criteria for all three wards, however, we were informed that they only accepted adults. The care provision was tailored to meet the needs of patients who were currently receiving rehabilitation following a health-related event or due to frailty or dementia.

Patients were generally admitted from acute hospitals in the locality and were at the point of being clinically fit for discharge home with a care package, or to a care home facility. Patients continued with their programme of rehabilitation whilst being cared for in the community hospitals and waited for the care package to be agreed, funding to be acquired, or a care home bed to be assigned.

There were occasions where a patient may be admitted directly from the community if required. We were not made aware of a formal waiting list for admission, however we were told that beds were always in demand from the local acute hospitals.

Whilst in hospital, patients could access care, treatment, assessments and test results quickly. Patients received a full assessment within two hours of admission.

Bed occupancy
The trust provided information regarding average bed occupancies from November 2017 to October 2018.

The breakdown of bed occupancy levels by ward for community health inpatient services as of October 2018 is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Average bed occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>Anna ward</td>
<td>93.0%</td>
</tr>
<tr>
<td></td>
<td>Darwin ward</td>
<td>94.8%</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>Philip ward</td>
<td>91.4%</td>
</tr>
</tbody>
</table>

Both of Samuel Johnson Community Hospital’s inpatient wards reported 100% bed occupancy for November and December 2017. However, neither reported 100% bed occupancy over the subsequent 10 months through to October 2018.

(Source: Community Routine Provider Information Request (RPIR) Community CHS7 – Bed occ & LOS)

**Average length of stay data**

The trust provided average length of stay data for the period from November 2017 to October 2018.

A breakdown of average length of stay by ward for community health inpatient services as of October 2018 is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Average length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Community Hospital</td>
<td>Anna ward</td>
<td>16.4 days</td>
</tr>
<tr>
<td></td>
<td>Darwin ward</td>
<td>13.3 days</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital</td>
<td>Philip ward</td>
<td>13.4 days</td>
</tr>
</tbody>
</table>

(Source: Community Routine Provider Information Request (RPIR) Community CHS7 – Bed occ & LOS)

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

**Delayed discharges**

The trust supplied the overall numbers of delayed discharges by month for its community health services overall but did not provide separate figures for community inpatients services.

From November 2017 to October 2018 there were 1,948 delayed discharged in the trust’s community health services. This amounted to 27.7% of the total discharges in this core service. The trust’s monthly performance for these 12 months is shown in the chart below.
Learning from complaints and concerns

Complaints

From October 2017 to September 2018 the trust received 12 complaints about community inpatient services across the whole Trust. One of these related specifically to inpatient services at Samuel Johnson hospital regarding delays experienced with the discharge process. We reviewed the response letter provided to complainants after an investigation had concluded and found the response to be comprehensive and appropriate.

The trust took an average of 54.0 working days to investigate and close these complaints. This was not in line with the trust’s complaints policy, which states complaints should be responded to within 45 working days.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

All staff were aware of the complaints process but told us that there were very few complaints. Where complaints were made, the senior ward sisters conducted a full investigation and shared their finding with the matron. an apology would be made if appropriate and a response letter sent to the patient or relative. We were informed that the main theme for complaints was about the long wait for a care package or a place to become available in an allocated care facility.

Compliments

From October 2017 to September 2018 the trust received 1,516 compliments. Of these 14 related to the trust’s community inpatient services, which accounted for less than 1% of all compliments received by the trust as a whole.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments

Is the service well-led?

Leadership
Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Leadership at the two community hospitals was provided by a matron and three senior ward sisters, supported by the divisional nursing director and the divisional medical director from the trust. The matron had links and a clear voice with the board, attended monthly business meetings, and felt supported and valued by the senior leadership team.

The matron had direct links with local commissioners and had regular communication regarding sustainability of the service.

All three senior ward sisters were highly committed to their leadership role and had the skills, knowledge, experience and integrity that they needed to lead staff on their wards. Leaders appeared to understand the challenges to quality and sustainability which they faced and were knowledgeable about the main risks which were presented at board level by the matron.

Staff told us that the matron and the senior sisters were very visible and approachable.

Multi-disciplinary meetings took place at ward level each day and included all the staff who were directly involved in the patient’s care. These were led by the ward sisters who oversaw all activity on their ward and reported daily to matron. There was a weekly ward review held on each ward led by a senior leader and medical staff.

The senior managers had attended a leadership programme at trust level, and although there was no formal succession planning programme in place, all other qualified staff were encouraged to attend mentorship and leadership training. Funds were provided for this by the trust.

Vision and strategy

The trust had a vision for what it wanted to achieve.

The trust's vision was ‘Exceptional care together’ and was underpinned by four values; compassionate, approachable, respect and excellence. The vision and values were reflected in the trust's five objectives which formed the basis of the trust's five-year strategy.

The trust raised staff awareness of the strategy by producing a ‘plan on a page’ for staff. Staff we spoke with could talk about the vision, values and strategy. The strategy was aligned with the local health and social community including commissioners, providers, voluntary and independent sectors, NHS England and local education institutions.

Most staff we spoke with could describe the trust’s vision and values but thought that these were in the process of changing due to the acquisition. Staff told us the values were about being patient focussed.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

As a mainly nurse-led service, a variety of different roles were encouraged. This included advanced nurse practitioners, apprenticeship nurses, newly qualified nurses, student nurses, and a variety of therapist roles. All roles worked together and had an appreciation of each other's different roles.
We observed a positive culture across the wards. Staff we spoke with were patient-focussed, and proud of the partnership working between the nursing and therapy staff. We observed staff delivering care and demonstrating behaviours in line with the trust vision and values.

Staff felt valued, listened to and supported by leaders and managers and described working for community inpatient services as ‘like being one big family’. Staff told us how they enjoyed working in a friendly, caring workplace where everyone pulled together to achieve a common goal.

During handover meetings we observed staff working collaboratively and sharing responsibility to achieve the best possible outcome for the patients.

Therapy staff were considered as important and highly valuable members of the team and essential to the rehabilitation of patients. They had a strong working relationship with nursing staff.

Therapy staff worked closely with falls prevention teams in the community and therapy team managers attended regular meetings with relevant groups such as the frailty team, senior nursing teams and ward based nursing teams. They also had links with external providers such as nutrition steering groups and dementia steering groups.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good understanding about duty of candour and talked of being open and transparent with the patients and relatives.

There were processes in place for providing all staff at every level with the development they needed. These included appraisals, one to one discussions and formal training courses.

**Governance, Risk management and quality measurement.**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.

There were processes in place for sharing information upwards to the senior management team and downwards to ward staff. These included; monthly ward meetings, monthly one-to-one meetings, and weekly ward assurance meetings. The matron submitted a monthly governance report to the trust board each month. Items discussed included; pressure ulcers, falls, medicines errors, ward assurance scores, infection prevention and control issues, ward environmental audit results, serious events, complaints, patient experience, staffing, and recruitment.

The matron led a Ward Board daily on each ward where she met with the MDT to review the quality and risk status of each ward; and share information and ideas on how to improve patient outcomes. We saw notes of some meetings where the focus was on what had gone well and what needed to improve. This was in addition to the daily board round which was a daily review of each patient by the nurse in charge of the ward and the MDT.

There were systems in place for collection of information to monitor whether patients receiving rehabilitation were meeting their goals. For example;

- Quality ward rounds were conducted to collect information on; the number of falls, nutritional status, pressure ulcers, venous thromboembolism prevention scores, length of stay in hospital and patient satisfaction.
- Local audits were conducted to monitor adherence to protocols for pressure ulcers, NEWS2 charts, continence management, time to respond to call bells, and DNACPR documentation.

Practice checks were conducted by senior sisters that included; Clinical competency checks for individual staff, safety checks to observe the environment for falls hazards, staff welfare, fire safety, security, and COSHH adherence.
Staff were clear about their roles and who they were accountable for, and to whom.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a Trust-wide risk register with risks identified and discussed at regular leadership meetings. Risks were appropriately rated and we saw actions in place to minimise the risks. There were no risks relating specifically to community inpatient services at the time of our inspection. Leaders told us they had recently downgraded a risk relating to staff recruitment due to their recent success with a recruitment initiative.

We were assured that ward sisters had sufficient oversight of their wards and the matron had oversight of the community inpatient services. Staffing levels and skill-mix were under daily review by the ward managers and the matron, and bank and agency staff used when necessary.

Potential risks were considered when planning future services, for example; seasonal demand. Additional beds were made available on each ward during the winter pressure period and additional staff were scheduled when required.

However, we were not assured that additional demands placed upon staffing during an outbreak of Norovirus was effectively addressed at the time of our inspection.

Performance including patient outcomes was regularly reviewed and improved through a programme of audit and quality checklists.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

There were effective systems to monitor and report on quality and performance measures, which were reported monthly and displayed on the wards.

The trust had implemented an electronic system for staff to record all care interventions and patient assessments and progress. This enabled other relevant health professionals to access patient information in a timely way for the benefit of the patient.

There were arrangements to ensure the availability and confidentiality of identifiable data and records which were in line with security standards.

We saw records securely stored to avoid access by unauthorised personnel. However, on one occasion we observed patient identifiable information insecurely stored in a clinical room, this was acted on immediately by a senior manager.

**Engagement**

The trust engaged with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Prior to the acquisition to form University Hospitals of Derby and Burton NHS Foundation Trust, an extensive staff, patient, public and stakeholder engagement programme was undertaken at the start of the process in July 2016.

The engagement programme provided internal and external stakeholders (including staff and governors at both Trusts, CCGs, GPs, MPs, local government, health and scrutiny committees, Healthwatch organisations, patients and the general public) with an opportunity to receive regular updates on the proposals, to be engaged and involved in the strategic direction of travel and development of the collaboration and to be assured on the process being followed.

The trust reported that they held around 164 staff, stakeholder, patient and public meetings held over the project period, and around 700 people had their say in a public survey.
Following the acquisition, a new strategy for Patient and Public Engagement was being developed for the Trust. Patient feedback was obtained through the NHS Friends and Family test, service user carer experience survey and electronically through a patient opinion website. Feedback both positive and negative was discussed at monthly ward meetings.

Without exception, staff felt engaged and able to raise concerns and felt empowered to suggest new ways of working within their areas. Staff took part in trust-wide staff surveys.

The two organisations previously ran separate staff recognition schemes; PRIDE awards and Celebrating Success at Royal Derby Hospital and Going the Extra Mile (GEM) awards at Queens Hospital Burton. Following the acquisition, these had been amalgamated into ‘Making A Difference Awards’, which were tied to the trust’s new vision and values. The first winners of the new awards were to receive them in May 2019 and a new combined annual ceremony was due to take place in September 2019.

Local awards ‘GEM’ Awards’ were given to staff by the trust in recognition of them demonstrating outstanding care and compassion to patients, and a member of staff had been nominated for a ‘PRIDE’ award which is an award presented by patients.

The matron engaged with local stakeholders to ensure effective discharge pathways. For example; ambulance service, GP services, social care services and voluntary organisations. The matron also met with other local trusts where patients sometimes attended for tests and treatment in order to streamline the process to receive results and improve communications.

**Learning, continuous improvement and innovation**

*The trust was committed to improving services by learning from when things went well and when they went wrong and promoting training.*

Comprehensive training programmes, in-house teaching and competency assessments ensured staff learnt and maintained knowledge and skills necessary to deliver safe care.

Learning from incidents, complaints and audits was shared with all staff at team and multidisciplinary team meetings.

Staff had embraced the PJ paralysis initiative across all three wards and used distraction therapy to encourage patients to be more active and engaged.

The service worked in partnership with local stakeholders to create an integrated frailty pathway. Partnership included the community teams, primary care services, voluntary organisations, secondary care, and end of life care. The main aim was to enable people who were frail, to remain independent and maximise wellbeing. The collaboration provided a single point of access for people to access support and information in one appointment. It also enabled the service to actively identify the frail population, plan care and align resources more effectively through ongoing MDT meetings. The project was currently being evaluated.
Facts and data about this service

University Hospitals of Derby and Burton NHS Foundation Trust was formed on 1 July 2018 with the acquisition of Burton Hospitals NHS Foundation Trust by Derby Teaching Hospitals NHS Foundation Trust under its existing registration with the CQC. As such, our legal position is that the merged trust is the same legal entity as Derby Teaching Hospitals NHS Foundation Trust but with additional locations.

Prior to the acquisition the trust’s two minor injuries units were both run by Burton Hospitals NHS Foundation Trust. Therefore, data from the acquired Burton Hospitals NHS Foundation Trust are included in this report (where no new data are available) but we have not included any data from the former Derby Teaching Hospitals NHS Foundation Trust.

Where data for the acquired Burton Hospitals NHS Foundation are included, this is for contextual purposes and does not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Details of emergency departments and other community urgent and emergency care services

The trust has two minor injuries units:

- Samuel Johnson Community Hospital Minor Injuries Unit, open from 8am to 9pm.
- Sir Robert Peel Community Hospital Minor Injuries Unit, open from 8am to 10pm.

Both units are open seven days a week.

The clinical teams at both units consist of nurses and emergency nurse practitioners.

Both units include a resuscitation room, children’s room, eye room, plaster room and clinical treatment and examination rooms.

(Source: Acute RPIR - Context tab; Universal RPIR – Sites tab)

Activity and patient throughput

Over the seven months from December 2017 to June 2018 there were 30,266 attendances at the former Burton Hospitals NHS Foundation Trust’s community urgent and emergency care services, an average of approximately 4,324 per month.

Attendance figures for the trust’s community urgent and emergency care services for the first five post-acquisition months (July to November 2018) are not available. This is because the post-acquisition data include data for another unspecified type 3 department(s) previously belonging to Derby Teaching Hospitals NHS Foundation Trust. The data cannot be disaggregated by site.

However, based on the known attendance figures for the pre-acquisition period, a reasonable estimate of the number of attendances at the former Burton Hospitals NHS Foundation Trust’s community urgent and emergency care services over the 12 months from December 2017 to November 2018 would be approximately 51,900.
Over the seven months from December 2017 to June 2018 there were 34 emergency admissions through the former Burton Hospitals NHS Foundation Trust’s community urgent and emergency care services. This does not take account of patients who may have been referred on from these services to the emergency department at Queen’s Hospital Burton and subsequently admitted.

(Source: NHS England)

Following inspection, the trust provided information that showed between 1 July 2018 and 31 January 2019 there were 10,178 adult attendances (average of 1,454 per month) and 3,867 child attendances (average of 552 per month) at Samuel Johnson Minor Injuries Unit. For the same period there were 10670 adult attendances (average of 1,524 per month) and 4,722 child attendances (average of 675 per month).

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

**Mandatory training completion rates**

Staff in the trust’s community urgent care services had a mandatory training completion target of 90% for all mandatory training. This was inherited from the pre-acquisition trust Burton Hospitals NHS Foundation Trust.

**Trust wide**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for all staff in community urgent care is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food safety</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>51</td>
<td>51</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>49</td>
<td>51</td>
<td>96.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load handling</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>45</td>
<td>51</td>
<td>88.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>29</td>
<td>33</td>
<td>87.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>28</td>
<td>33</td>
<td>84.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>43</td>
<td>51</td>
<td>84.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>42</td>
<td>51</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>27</td>
<td>33</td>
<td>81.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust had an overall training completion rate of 87.2% for all staff in its community urgent care services. The 90% target was met for six of the 18 mandatory training modules for which staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff in the trust’s community urgent care services is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>25</td>
<td>29</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>23</td>
<td>29</td>
<td>79.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>23</td>
<td>29</td>
<td>79.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>22</td>
<td>29</td>
<td>75.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>18</td>
<td>29</td>
<td>62.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training completion rate of 85.7% for qualified nursing staff in its community urgent care services. The 90% target was met for four of the 14 mandatory training modules for which staff were eligible.

**Samuel Johnson Community Hospital Minor Injuries Unit**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for all staff at Samuel Johnson Community Hospital Minor Injuries Unit is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food safety</td>
<td>23</td>
<td>23</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>23</td>
<td>23</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training module</td>
<td>Number trained</td>
<td>Number eligible</td>
<td>Completion rate</td>
<td>Target</td>
<td>Met Yes / No</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>Trust induction</td>
<td>23</td>
<td>23</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>23</td>
<td>23</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>13</td>
<td>15</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>12</td>
<td>15</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>18</td>
<td>23</td>
<td>78.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Load handling</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control – non-clinical</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>8</td>
<td>13</td>
<td>61.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had a training completion rate of 89.7% for staff at Samuel Johnson Community Hospital Minor Injuries Unit. The trust’s training targets were met for nine of the 18 mandatory training modules for which staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff at Samuel Johnson Community Hospital Minor Injuries Unit is shown below:

The trust had a training completion rate of 86.8% for qualified nursing staff at Samuel Johnson Community Hospital Minor Injuries Unit. The trust’s training targets were met for seven of the 14
mandatory training modules for which staff were eligible.

**Sir Robert Peel Community Hospital Minor Injuries Unit**

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for all staff at Sir Robert Peel Community Hospital Minor Injuries Unit is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food safety</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Load handling</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust induction</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric basic life support</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>26</td>
<td>28</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>25</td>
<td>28</td>
<td>89.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Patient handling online</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Adverse incident reporting</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>22</td>
<td>28</td>
<td>78.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control 2</td>
<td>14</td>
<td>18</td>
<td>77.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire lecture (staged evacuation)</td>
<td>21</td>
<td>28</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>12</td>
<td>16</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>20</td>
<td>28</td>
<td>71.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric immediate life support</td>
<td>10</td>
<td>16</td>
<td>62.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control - non-clinical</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had a training completion rate of 86.8% for all staff at Sir Robert Peel Community Hospital Minor Injuries Unit. The trust’s training targets were met for seven of the 18 mandatory training modules for which staff were eligible.

A breakdown of compliance for mandatory training courses from November 2017 to October 2018 for qualified nursing staff at Sir Robert Peel Community Hospital Minor Injuries Unit is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust induction</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Food safety</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Departmental induction</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient handling practical with champion</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Patient handling online 13 16 81.3% 90% No
Information governance 13 16 81.3% 90% No
Adverse incident reporting 13 16 81.3% 90% No
Fire lecture (staged evacuation) 13 16 81.3% 90% No
Conflict resolution 12 16 75.0% 90% No
Immediate life support 12 16 75.0% 90% No
Infection control 2 12 16 75.0% 90% No
Paediatric immediate life support 10 16 62.5% 90% No

The trust had a training completion rate of 84.8% for qualified nursing staff at Sir Robert Peel Community Hospital Minor Injuries Unit. The trust’s training targets were met for four of the 14 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We reviewed the mandatory training figures held on site at Samuel Johnson Minor Injuries Unit which showed that of the 18 current members of staff, 16 were over 90% compliant with their mandatory training. Explanations were provided for the two members of staff not meeting the 90% target.

Following inspection, the service submitted information showing that 12 outstanding courses had been booked for staff at Sir Robert Peel Minor Injuries Unit to attend mandatory training. Compliance was to be monitored through exception reporting at the medicine business unit senior team and performance management meetings.

Letters were to be sent to all non-compliant staff outlining support available and further action if their mandatory training rates remained below the target of 90%.

Staff we spoke with said it was difficult to attend mandatory training at the Royal Derby hospital site, particularly when some courses were only for an hour. Information sent by the trust said there would be an exploration of additional courses to be provided on site to support with releasing staff.

Safeguarding

Safeguarding training completion rates

Staff in the community urgent care services had a mandatory training completion target of 90% for all mandatory training. This was inherited from the pre-acquisition trust Burton Hospitals NHS Foundation Trust.

Trust wide

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for all staff in the trust’s community urgent care services is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent awareness</td>
<td>38</td>
<td>40</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Basic safeguarding adults
<table>
<thead>
<tr>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>40</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Adult protection awareness
<table>
<thead>
<tr>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>31</td>
<td>93.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Child protection 1
<table>
<thead>
<tr>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>40</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Child protection 2
<table>
<thead>
<tr>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>31</td>
<td>83.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Child protection 3
<table>
<thead>
<tr>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>30</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training completion rate of 90.1% for all staff in its community urgent care services. The trust’s training targets were met for three of the six safeguarding training modules for which staff were eligible.

### A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff in the trust’s community urgent care is shown below:

### Training module
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic safeguarding adults</td>
<td>28</td>
<td>29</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>28</td>
<td>29</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>27</td>
<td>29</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>24</td>
<td>29</td>
<td>82.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training completion rate of 89.1% for qualified nursing staff in its community urgent care services. The trust’s training targets were met for three of the six safeguarding training modules for which staff were eligible.

### Samuel Johnson Community Hospital Minor Injuries Unit

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for all staff at Samuel Johnson Community Hospital Minor Injuries Unit is shown below:

### Training module
<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic safeguarding adults</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training completion rate of 93.7% for all staff in Samuel Johnson Community Hospital Minor Injuries Unit. The trust’s training targets were met for all six safeguarding training modules for which staff were eligible.
A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff at Samuel Johnson Community Hospital Minor Injuries Unit is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child protection 2</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training completion rate of 92.3% for qualified nursing staff at Samuel Johnson Community Hospital Minor Injuries Unit. The trust’s training targets were met for all six safeguarding training modules for which qualified nursing staff were eligible.

**Sir Robert Peel Community Hospital Minor Injuries Unit**

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for all staff at Sir Robert Peel Community Hospital Minor Injuries Unit is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent awareness</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic safeguarding adults</td>
<td>21</td>
<td>22</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>18</td>
<td>22</td>
<td>81.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>13</td>
<td>17</td>
<td>76.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>13</td>
<td>17</td>
<td>76.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training completion rate of 87.2% for all staff at Sir Robert Peel Community Hospital Minor Injuries Unit. The trust’s training targets were met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from November 2017 to October 2018 for qualified nursing staff at Sir Robert Peel Community Hospital Minor Injuries Unit is shown below:

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic safeguarding adults</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent awareness</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>12</td>
<td>16</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>12</td>
<td>16</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust had an overall safeguarding training completion rate of 86.5% for qualified nursing staff at Sir Robert Peel Community Hospital Minor Injuries Unit. The trust’s training targets were met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following inspection, the service submitted updated safeguarding training information as follows:

**Sir Robert Peel Minor Injuries Unit**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic safeguarding adults</td>
<td>20</td>
<td>22</td>
<td>91.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult protection awareness</td>
<td>16</td>
<td>17</td>
<td>94.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 3</td>
<td>14</td>
<td>17</td>
<td>82.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 2</td>
<td>14</td>
<td>17</td>
<td>82.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Child protection 1</td>
<td>17</td>
<td>22</td>
<td>77.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The outstanding courses related to six members of staff at Sir Robert Peel Minor Injuries Unit; two reception staff and four registered nurses. Six courses were booked to take place in March 2019 and actions were in place to ensure the remainder were booked and compliance monitored.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

The trust was unable to break down their adult safeguarding referrals by core service.

However, the trust was able to provide a breakdown of children’s safeguarding referrals by Burton Hospitals NHS Foundation Trust, and the former Burton trust’s services within the new merged trust, from October 2017 to September 2018. This was not possible for Derby Teaching Hospitals NHS Foundation Trust’s services either pre- or post-acquisition.

For Burton Hospitals NHS Foundation Trust, and the former Burton trust’s services within the new merged trust, the trust provided the number of children’s safeguarding referrals for urgent and emergency care overall, but not specifically for community urgent care.

These services made 141 children’s safeguarding referrals from June 2017 to May 2018.

Across the 12-month period, there were fewer children’s safeguarding referrals during the latter six months of this 12-month period (62) than during the first six months (79).
The number of adult safeguarding referrals received for Burton Hospitals NHS Foundation Trust, and the former Burton trust’s services within the new merged trust, were provided at trust level only, and not broken down by core service.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Following inspection, the trust provided information stating that 11 safeguarding children referrals were made by the minor injuries units between January 2018 and February 2019. Some referrals were made by the receiving hospital, rather than the minor injuries units.

From July to December 2018 the local authority was contacted on 48 occasions to discuss a paediatric admission. This was in addition to any formal safeguarding referrals that had been made.

Staff we spoke with at both minor injuries units understood the safeguarding process and provided examples of cases they had dealt with or referred to the safeguarding team. They knew where to find contact details for the council’s first response team, emergency duty team and the trust’s safeguarding team.

There were protocols in place as to when a child safeguarding referral should always be made, and staff were familiar with these. For example, a referral to the first response (local safeguarding) team was mandatory for any child who arrived at either of the minor injuries units with a dog bite. Staff we spoke with had experience of completing the multi assessment social health online form for the regional safeguarding team.

At Samuel Johnson Minor Injuries Unit there was a safeguarding information board in the office with all relevant contact details for the safeguarding team. There was a folder containing paper copies of the safeguarding referrals made, with a record of actions taken by the team.

At Sir Robert Peel Minor Injuries Unit we saw the safeguarding process on the electronic patient record system that both sites used. This flagged up an alert on the patient record when someone attended who had a previous safeguarding notification logged on the system.

Safeguarding information was shared with the team informally at Samuel Johnson Minor Injuries Unit and in scheduled daily huddles at Sir Robert Peel Minor Injuries Unit.

Routine checks and balances were in place to minimise the risk of a child not being followed up after attending a minor injuries unit. When a child was transferred from either minor injuries unit this was followed up with a phone call to the receiving service to check the child had arrived safely.

Details of any child asked to come back for review were documented in the communications book which was checked every morning. If the child did not attend the appointment, and the family did not respond to letters, the minor injuries unit contacted social services. If the family contacted the minor injuries unit to explain the injury or illness was resolved, this was documented.

Cleanliness, infection control and hygiene

Systems were in place to maintain standards of cleanliness and hygiene. Both minor injuries units were visibly clean and tidy, with completed cleaning schedules in place.

Infection prevention and control audits were in place and we saw evidence that between November 2018 and January 2019 both minor injuries units were compliant with the standards with one exception. This was an undated sharps box which was identified in the audit and an action to re-check at the next audit was documented.
Both minor injuries units had a link nurse whose role was to provide advice and take the lead for infection prevention and control. Personal protective equipment was readily available, in use and stored correctly.

We observed staff following correct handwashing techniques. Promotional hand hygiene posters were displayed and alcohol-based hand rubs were visible and in use throughout both minor injuries units.

Sharps bins adhered to British standards, were dated appropriately, free from protruding needles and stored safely above floor level. Disposable curtains used in both minor injuries units were clearly dated and changed routinely every six months.

Patients deemed to be at risk of spreading infection, for example those presenting with sickness or diarrhoea, were isolated to a side room which was cleaned once they had been discharged or transferred. Meticillin-resistant Staphylococcus aureus (MRSA) is a type of bacteria that’s resistant to several widely used antibiotics. For patients who had previously been diagnosed with a meticillin-resistant Staphylococcus aureus infection, a red alert was visible on the electronic patient record.

Environment and equipment

Both minor injuries units were situated within community hospitals where other facilities were available, for example cafeterias and large car parks. Both minor injuries units were clearly signed and easily accessible.

As well as the clinical rooms there were rooms for resuscitation, an eye room and a plaster room. All were clean and tidy with relevant information displayed on the walls. Children’s waiting areas with toys were available in both minor injuries units.

Staff had immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation of a patient in cardiorespiratory arrest. There was also a ‘hypo box’ that contained all the necessary equipment to adequately manage an episode of hypoglycaemia (low blood sugar levels) suffered by patients with diabetes.

Emergency equipment such as the resuscitation trolley, ‘hypo box’ and oxygen had completed checklists which were up to date. These ensured the equipment was stocked correctly and ready for use.

Equipment was listed on an asset register and serviced regularly as required.

Clinical waste was stored separately to domestic waste in a secure designated storage area. A poster in the sluice area provided segregation information for different categories of waste.

Stock was organised and stored in a tidy, visibly clean environment with a rotation system to ensure older items were used first.

However, waiting rooms sometimes became full and staff said some patients had to stand at busy times.

Assessing and responding to patient risk

Emergency Department Survey 2016

Data for type 3 emergency departments including minor injuries units were included in the Emergency Department Survey for the first time in 2016.
A defining characteristic of an emergency care service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment.

However, because the type 3 data set was quite small (there were 49 trusts that ran type 3 emergency departments), it was not possible to analyse this data at trust level. For further information on why trust results for type 3 departments have not been produced, please see the quality and methodology report available on our emergency department survey web page on the CQC website.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
The minor injuries units were operated using a 'see and treat' system. This meant patients were seen directly by the emergency nurse practitioner treating them who completed the episode of care, without further triage or assessment.

This system requires that safeguards are in place to ensure that patients who require immediate attention are not waiting for longer than one hour to be seen. If the wait is longer than this, the Royal College of Emergency Medicine standard requires that patients should have an assessment by a clinician (Initial assessment of Emergency Department patients, 2017).

Patients presenting at the minor injuries units were initially booked in by receptionists without clinical training. The receptionists had a first contact protocol which listed circumstances when they must immediately alert nursing staff.

The first contact protocol provided a list of 16 symptoms and conditions for receptionists to look out for. These included any breathing difficulties, chest pain, uncontrolled bleeding and severe pain. The protocol instructed reception staff to inform a member of staff for any patient that was a concern and not to be afraid to interrupt a nurse seeing another patient.

All children up to the age of 12 months old must be seen by a member of nursing staff within 15 minutes of arrival, regardless of the reason they were attending.

Between 1 April 2018 and 28 January 2019 at Samuel Johnson Minor Injuries Unit 64.2% (14,597) of patients were seen within one hour and 31% (7,062) were seen within one to two hours. Around 4.1% (947) of patients waited between two and three hours and 0.51% (115) of patients waited between three and four hours. Three patients waited longer than four hours.

When we returned to Samuel Johnson Minor Injuries Unit on 13 February 2019 we sat with the receptionist for one hour to observe patients being booked in. During that time eight patients presented, of which three met the criteria set out in the first contact protocol for requiring immediate attention. All were treated appropriately.

Between 1 April 2018 and 28 January 2019 at Sir Robert Peel Minor Injuries Unit 62.6% (15,292) of patients were seen within one hour and 32.3% (7,899) of patients were seen within one to two hours. Around 4.4% (1,083 patients) waited two to three hours and 0.43% (106) patients waited between three and four hours. Thirteen patients waited longer than four hours.

We spoke about waiting times with four patients at Sir Robert Peel Minor Injuries Unit; two had waited an hour to be seen, one had waited an hour and a half and one child had waited two hours. All said that it was worth waiting as the location of the unit was convenient for them.

We looked at waiting times on the electronic patient record for 16 patients. Of these, two waited longer than an hour to be seen.

During our inspection we asked staff at different levels of seniority about patient assessment
processes and standing operating procedures and were told the only formal process was the first contact protocol. This was a list of symptoms and conditions for receptionists to look out for in patients presenting at the minor injuries units. If they identified any of the listed symptoms or conditions, they were required to report them to a qualified nurse.

Reception staff we spoke with at Samuel Johnson Minor Injuries Unit said they had received some basic training several years ago but not recently.

Staff at Sir Robert Peel Minor Injuries Unit said the sister came and monitored the waiting area regularly and we saw two patients at different times sitting in a chair close to the receptionist so they could be observed. The risk register for the acute medicine business unit identified a risk to patient safety caused by a lack of adherence to the consistent patient assessment processes and standard operating procedures at Sir Robert Peel Minor Injuries Unit.

There was no formal protocol in place for what happened when it was time for the units to close and patients were still arriving. Staff managed the situation as best they could and stayed until patients had been seen.

Samuel Johnson Minor Injuries Unit had a local arrangement in place with the ambulance service to receive patients with minor injuries. There was a legacy standard operating procedure in place for this process, which was overdue for renewal but still relevant.

The protocol required that a telephone conversation between the clinician on scene and nurse in charge was undertaken to discuss the patient’s presenting condition and whether conveyance to the minor injuries unit would be appropriate. Transfers to the unit were at the discretion of the nurse in charge.

The standard operating procedure set out a list of symptoms and conditions suitable to transfer as well as detailing exclusion criteria.

Sir Robert Peel Minor Injuries Unit did not accept ambulance transfers. Both minor injuries units saw patients who had been sent by their GPs, but these were not official referrals. These patients were required to walk-in and wait with all the other patients.

Staff used a sepsis screening tool as part of the assessment process which we saw in use on the electronic patient record. Information about the six signs of sepsis, including reference to national guidelines, was on display in the minor injuries units. There was a paediatric sepsis screening and action tool in use for all children under the age of five years.

Staff we spoke with were familiar with the signs of sepsis and said they rang 999 if it was suspected. Early warning scores for adults and children were in use and completed on the electronic patient record. An example of a completed early warning score was on display at Sir Robert Peel Minor Injuries Unit with reference to diagnosing sepsis and a “think sepsis” reminder.

There was a pathway in place for mental health patients with a comprehensive assessment process. The assessment required staff to assign a level of risk once completed, and complete an accompanying action plan, using the mental health risk assessment matrix attached to the documentation.

Fraser guidelines, were in place, for use when deciding whether a child could consent to contraceptive or sexual health advice and treatment.

Other risk alerts on the electronic patient record included meticillin-resistant Staphylococcus aureus (MRSA), mental health, safeguarding and past admissions to the minor injuries units.
Information about the procedure and clinical advice for recognising a sick seriously ill child was in both minor injuries units.

The electronic record system included an alert system for staff which identified when patients had previously been diagnosed with a meticillin-resistant Staphylococcus aureus (MRSA) infection, a mental health condition, identified as a safeguarding concern or were involved in clinical trials. This enabled staff to make decisions about their care which were fully informed.

Staff at Sir Robert Peel Minor Injuries Unit had a daily huddle where any concerns or issues were raised. There was no formal handover or huddle at Samuel Johnson Minor Injuries Unit but they had an informal ‘catch up’ when the staff arrived for the late shift at 1.30pm.

**Nurse staffing**

The trust reported their qualified nursing staff numbers as below for community urgent care as of March and October 2018.

At Samuel Johnson Community Hospital’s Minor Injuries Unit, there was a modest increase in the number of qualified nurses in post in October 2018 compared to March 2018. However, at Sir Robert Peel Community Hospital’s Minor Injuries Unit, there was a small decrease in the number of qualified nurses in post in October 2018 compared to March 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff (WTEs)</td>
<td>Planned staff (WTEs)</td>
</tr>
<tr>
<td>Samuel Johnson Community Hospital MIU</td>
<td>10.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Sir Robert Peel Community Hospital MIU</td>
<td>14.3</td>
<td>14.1</td>
</tr>
<tr>
<td>Total staff</td>
<td>25.0</td>
<td>25.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

All eligible nursing staff working in the minor injuries units were emergency nurse practitioners so had completed extra training to equip them with the knowledge, skills and qualifications to assess, diagnose and decide on the appropriate course of treatment for patients. The newly qualified nurses were working towards their qualification to become emergency nurse practitioners.

Staffing levels were calculated based on activity at the minor injuries units over recent years. There was no acuity tool in use but staff at both minor injuries units said this was not necessary and that staffing numbers were appropriate and worked well.

At Samuel Johnson Minor Injuries Unit, the department employed two band 7 senior sisters and an experienced band 6 nurse who shared the role of nurse in charge. At the time of inspection, they had a total of 13 nurses, one healthcare assistant and four reception staff.

The unit was staffed from 7.30am ready to open for patients at 8am. The unit closed to patients at 9pm. The senior sister said they aimed to have four qualified staff on shift although this was not always achieved. There was an informal process of ringing colleagues to come and provide
support or cover if necessary. When required, the sister escalated staffing issues to the matron.

At Sir Robert Peel Minor Injuries Unit there were a minimum of four qualified staff per shift on duty. The team comprised one band 7 senior sister, 11 band 6 emergency nurse practitioners and five band 5 emergency nurse practitioners. Two of the band 5 emergency nurse practitioners were paediatric nurses. One of the band 6 emergency nurse practitioners was dual trained and midwifery trained.

Sir Robert Peel Minor Injuries Unit was staffed from 7.30pm until 11pm, and open for patients between 8am and 10pm. The final hour on duty for qualified staff was described as a 'mop up' for patients still in the unit.

The senior sister told us that the establishment figure for qualified staff at Sir Robert Peel Minor Injuries Unit was 16.9 and at the time of our inspection it was 14.9. Two new people were due to start at the unit and once they were in post the unit would be over-staffed.

There were no combined cross-site meetings between the minor injuries units and staff told us they rarely saw each other apart from occasionally on a training course.

Vacancy rates

From November 2017 to October 2018, the trust reported a vacancy rate of 2.7% for qualified nursing staff in community urgent and emergency care. The trust had a target vacancy rate of 6%.

The breakdown by unit was as follows:

- Samuel Johnson Community Hospital Minor Injuries Unit: 2.8%
- Sir Robert Peel Community Hospital Minor Injuries Unit: 2.7%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of our inspection, all vacancies had been filled at the minor injuries units, although some new staff had not yet started in post.

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 12.0% for qualified nursing staff in community urgent and emergency care. This was within the trust’s target of a turnover rate of between 8% and 12%.

The breakdown by unit was as follows:

- Samuel Johnson Community Hospital Minor Injuries Unit: 6.9%
- Sir Robert Peel Community Hospital Minor Injuries Unit: 16.2%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

There had been several staff who had retired and returned to work at the minor injuries units and these staff showed as part of the turnover rates, despite still working for the service.

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 2.8% for qualified nursing staff in community urgent and emergency care. This was lower than the trust’s target of
3.8%.

The breakdown by unit was as follows:

- Samuel Johnson Community Hospital Minor Injuries Unit: 0.8%
- Sir Robert Peel Community Hospital Minor Injuries Unit: 4.3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

There had been some long term sickness of staff at Sir Robert Peel Minor Injuries Unit however these were resolved at the time of inspection.

Bank and agency staff usage

The trust provided bank and agency staff usage data for qualified midwifery and nursing and unqualified midwifery and nursing, in community urgent care.

From November 2017 to October 2018, the trust reported that 6.4% of qualified nursing hours in community urgent care were filled by bank staff. In addition, 0.3% of qualified midwife hours were not filled by bank or agency staff to cover staff absence. There was no agency qualified nursing staff usage over this period.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank Hours</th>
<th>Bank %</th>
<th>Unfilled Hours</th>
<th>Unfilled %</th>
<th>Total hours available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson</td>
<td>217</td>
<td>1.0%</td>
<td>0</td>
<td>0.0%</td>
<td>22,561</td>
</tr>
<tr>
<td>Sir Robert Peel</td>
<td>2,976</td>
<td>10.8%</td>
<td>139</td>
<td>0.5%</td>
<td>27,468</td>
</tr>
<tr>
<td>Total</td>
<td>3,193</td>
<td>6.4%</td>
<td>139</td>
<td>0.3%</td>
<td>50,028</td>
</tr>
</tbody>
</table>

Over the same period, the trust reported no bank or agency usage or hours left unfilled for unqualified nursing staff in its community urgent care services.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Suspensions and supervisions

During the reporting period from November 2017 to October 2018, the trust reported that there were no cases of staff in its community urgent care services being suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Medical staffing

The trust’s staffing data show no medical staff allocated to the trust’s community urgent and emergency care services from November 2017 to October 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing, vacancy, turnover and sickness tabs)

Records

Patient records were held on an electronic system. The minor injuries assessment was comprehensive and had space where risks were highlighted, as well as an area for the nurse to
write in free text. They included initial assessment, observations, medical history and a clinical management plan, followed by a discharge plan with an electronic letter to the GP which was sent immediately.

We reviewed 10 full sets of patients records during the inspection, and one set for a patient still in the department so not all parts of the record could be accessed.

All the records were signed, dated, legible and had allergies noted. All had a diagnosis and management plan documented, observations recorded and all made reference to pain management and provision.

Risk alerts on the electronic patient record included meticillin-resistant Staphylococcus aureus (MRSA), mental health, safeguarding and past admissions to the minor injuries units.

There was also a mini mental health memory checklist, that indicated if staff needed to refer patients to mental health services (this worked on a scoring system that was a paper copy).

**Medicines**

Patient group directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

Both minor injuries units used patient group directions which enabled the appropriately qualified nursing staff to administer medication as set out in their documentation. We checked the patient group direction documentation and at Sir Robert Peel Minor Injuries Unit it was completed correctly. However, at Samuel Johnson Minor Injuries Unit it was incomplete.

There were several inconsistencies in the documentation at Samuel Johnson Minor Injuries Unit; for example, staff members had signed and dated the patient group direction forms confirming they were competent to supply and/or administer the medicines, but the forms had not all been signed and dated by an approver. This did not meet the standard for good practice for developing, authorising, using and updating patient group directions as set out by the National Institute for Health and Care Excellence.

We raised this with the senior sister and the matron at the time of our inspection. Both agreed to put plans in place to put this right. All of the patient group directions were to be reviewed and re-authorised.

We re-visited the Samuel Johnson Minor Injuries Unit later in the inspection period and saw evidence that this work was underway. Patient group directions were not to be in use until all correct processes had been completed.

We checked medicines at both minor injuries units and found them to be correctly stored and in date. There were pharmacy teams on site at the community hospitals where the minor injuries units were based, and they carried out weekly reconciliations of stored medicines. FP10 prescription forms were stored securely.

Room and fridge temperatures where medicines were stored were monitored and recorded. Advice from pharmacy was sought when fridge temperatures went out of range.

**Incidents**

There was a process for reporting incidents and staff told us they knew how to use it. When an incident form was completed on the electronic system, copies were sent to the relevant senior
sister and matron. Investigations were completed at a local level by the senior sister and signed off by the matron.

However, when staff on both sites provided us with some examples of recent issues that had arisen at the minor injuries units, they said they had not reported these as incidents. One of the senior sisters said she had reported a missed diagnosis approximately 18 months ago but did not report operational issues, only clinical incidents.

There had been one serious incident in community urgent and emergency care, as detailed below. The investigation into this incident identified that it had not been reported at the time of the event.

The action plan for the serious incident included a key action to ensure staff were encouraged and equipped to submit electronic reports following incidents and this was to be reviewed through the business unit governance process. This was in keeping with the Overarching Risk Management Policy for University Hospitals of Derby and Burton NHS Foundation Trust which set out an objective to encourage and maintain a high standard of incident reporting and management, to enable early identification of risks and trends and facilitate appropriate corrective and preventative actions.

However, the level of timely incident reporting still appeared to be an issue. Data submitted by the trust following inspection showed that between 1 July 2018 and 31 December 2018 only seven incidents had been reported by Samuel Johnson Minor Injuries Unit and 11 incidents had been reported by Sir Robert Peel Minor Injuries Unit.

When we re-visited the Samuel Johnson Minor Injuries Unit later in the inspection period we saw that three recent incidents had been appropriately submitted.

**Never Events**

Here we have included data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition. We only provided this for contextual purposes and it did not form part of our judgement.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January to December 2018, the trust reported no incidents classified as never events in community urgent and emergency care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

Here we have included data for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in community urgent care which met the reporting criteria set by NHS England from January to December 2018.

This was a diagnostic incident and occurred in early April 2018. The serious incident was
reported to STEIS in late June 2018, nearly three months after occurrence. It is unclear from the incident description at which minor injuries unit the serious incident occurred.

(Source: Strategic Executive Information System (STEIS))

When necessary, incidents were discussed in the weekly acute medicine business unit governance meeting. We requested minutes for governance meetings where the minor injuries units were discussed but did not receive them.

Managers told us that if an incident occurred that could potentially be classified as a serious incident the matrons for the minor injuries units would review the event and alert the governance team. The governance team issued a scoping template to be completed by the matrons within 72 hours. Serious incident investigations were expected to be completed within 60 days.

Serious Incidents (SIRI) – Trust data

From November 2017 to October 2018, trust staff within community urgent care services reported one serious incident.

This was the same serious incident as reported to STEIS (described in the section above).

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Information provided by the trust following inspection showed that between 1 January 2018 and 31 December 2018 three complaints were closed and investigated as serious incidents. Information about the details and outcomes of the complaints were requested by CQC, but not received.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The Safety Thermometer does not contain separate data for the trust’s community urgent and emergency care services for the period from October 2017 to October 2018.

(Source: NHS Digital)

The minor injuries units did not collect Safety Thermometer data.

There was a ward assurance tool that the minor injuries units used to assess each other’s performance and this included some safety information, for example tissue viability and falls risk documentation.

Senior managers told us outcomes from this should be fed back at team meetings and that if either minor injury scored below 95% they were asked to provide an action plan in the relevant area.

We saw results from the ward assurance audits. Since July 2018 results for each unit were complete with the exception of one month which was missing; in July 2018 results were omitted for Samuel Johnson Minor Injuries Unit and in October 2018 results were omitted for Sir Robert Peel Minor Injuries Unit.

Of the results that were available, all were above 95% except for in November 2018 when Samuel Johnson Minor Injuries Unit achieved 94.90% compliance. For December 2018 and January 2019 both units were 100% compliant with the ward assurance standards.
Is the service effective?

**Evidence-based care and treatment**

The electronic patient records system included tools which facilitated assessment of people’s physical, mental health and social needs.

There was a pathway in place for mental health patients. An emergency department mental health initial assessment form was used when appropriate, and this included detailing the patient’s background history, assessing the patient’s presentation and behaviour, as well as discussion about the person’s level of social support. It included asking the patient whether they were willing to wait for treatment.

The assessment required staff to assign a level of risk once completed, and an accompanying action plan, using the mental health risk assessment matrix attached to the documentation.

For children and young people, the Pathos assessment tool was available with a pathway setting out what action to take once completed. This was in line with best practice set out by the Royal College of Nursing (Mental health in children and young people, RCN 2014).

A standard operating procedure for dealing with patients presenting with mental health issues was in place. We reviewed this at Samuel Johnson Minor Injuries Unit where it was readily available to staff. It set out contact details for the acute psychiatric team and details for out of hours provision including the crisis team and the consultant psychiatric on-call at a local NHS provider of mental health services.

Dental patients were assessed at the minor injuries units but no antibiotics were prescribed as there was no patient group directive in place to facilitate this. Pain relief and advice was given and contact details for dental services were provided.

There were numerous other assessment tools with pathways available on the electronic patient record to be used as and when required. These included early warning scores for adults and children, pain scores, deep vein thrombosis assessments and the Ottawa knee and ankle rules which helped decide whether an x-ray was needed after an acute injury to the knee, foot or ankle. Plaster guidance was accessible for staff and clinical pathways for dehydration in children and meningitis were also seen.

**Nutrition and hydration**

There were no inpatients at the minor injuries units so nutrition and hydration was not provided or monitored.

Both minor injuries units were situated within community hospitals with cafeterias and water dispensers on site. This meant patients could access refreshments if required.

**Pain relief**

Patients were asked about pain as part of the assessment process and appropriate analgesia was offered. Pain scoring tools for adults and children were in use as part of the electronic patient record. These included a pictorial tool for those patients who may have communication difficulties.

We reviewed 10 patient records and all referenced pain management and provision. We spoke with five patients and all had been offered or asked about pain relief.

**Patient outcomes**

**Audits – changes to working practices**
The Royal College of Emergency Medicine audits are not relevant to community urgent and emergency care as they only collect data for patients attending type one emergency departments.

(Source: Royal College of Emergency Medicine)

The trust carried out no local clinical audits relevant to this core service as part of their Clinical Audit Programme from December 2017 to November 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The service had access to clinical pathways which reflected care and treatment in line with evidence-based guidance and standards during assessment, referral or transfer to other services. However, this was not monitored or audited.

We did not find evidence of current participation in relevant quality improvement initiatives, such as local and national clinical audits, benchmarking, (approved) accreditation schemes, peer review, research, trials and other quality improvement initiatives.

The service did not audit the appropriateness of referrals to other services, including out-of-hours, urgent treatment centres, accident and emergency, ambulance and pharmacy services.

The minor injuries units participated in the trust audit ward assurance programme. The senior sisters from each unit audited each other’s minor injuries unit.

The audit ward assurance tool was used to record whether standards had been met for ten patients each month. Standards included patient records, pain assessments, patient information given and whether the patient had been made aware of the water fountain and café.

Staff showed us a summary of ward assurance outcomes between May 2018 and January 2019. Each unit had one month’s scores missing, but where they had been audited the service consistently achieved scores above 95% compliance with the standards.

Competent staff

Clinical Supervision

The trust provided the following information about their clinical supervision process:

There were no medical staff allocated to the trust’s community urgent and emergency care services from November 2017 to October 2018.

For nursing staff, clinical supervision was offered within the preceptorship period of newly qualified nursing staff.

Information provided by the trust indicated that the electronic staff records for the revalidation process of nursing staff was monitored on a monthly basis. Data from the provider information request showed compliance rates of 100% in November 2018.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

At Samuel Johnson Minor Injuries Unit there were a total of 13 nurses, three of whom were trained in paediatric nursing. This was taken into consideration when planning the rotas but it was not possible to have a children’s nurse on duty at all times.
At Sir Robert Peel Minor Injuries Unit, the team comprised one band 7 senior sister, 11 band 6 emergency nurse practitioners and five band 5 emergency nurse practitioners. Two of these band 5 emergency nurse practitioners were paediatric nurses. One of the band 6 emergency nurse practitioners was dual trained and midwifery trained.

At both units staff had undertaken further taken courses, for example training in minor injuries or minor illness, supplementary to that included in the emergency nurse practitioner course.

No formal clinical supervision was in place at Samuel Johnson Minor Injuries Unit although a senior sister said staff did participate in reflection meetings. There were no records of staff competencies held at Samuel Johnson Minor Injuries Unit. A senior sister told us these had been completed when staff first started, but not updated, in some cases for many years.

We returned to the Samuel Johnson Minor Injuries Unit later in the inspection period and saw work was underway to bring up to date the competencies for staff. The senior sisters had been allocated one day per week in the rota from 1 March 2019 to complete this work.

Evidence of minor injuries unit emergency nurse practitioner competencies at Samuel Johnson had been recognised by the trust as a gap and they had set up a working group meeting weekly to address this. Competency packages were to be standardised across the minor injuries sites using an evidence based approach.

At Sir Robert Peel Minor Injuries Unit there was a student lead as student emergency care practitioners undertook placements there.

One of the band 6 emergency nurse practitioners was the lead for offering clinical supervision which was not mandatory. The senior sister at Sir Robert Peel Minor Injuries Unit said they were robust with maintaining professional development as there were no medical staff on site.

We saw the competency framework tool used by staff at Sir Robert Peel Minor Injuries Unit. This was a comprehensive booklet adapted from the consultation assessment and improvement instrument in assessment (CAIIN) for qualified nurses to work through over a couple of years. It included categories with component weighting and criteria for allocation of marks or grades.

Competencies in the framework included effective and safe use of patient group directives and administration of relevant medicines. Medical conditions such as head injury, abdominal pain and mental health were detailed, as well as a paediatric log sheet of common presentations. Competency records were reviewed as part of the appraisal process at Sir Robert Peel Minor Injuries Unit.

Reception staff at Sir Robert Peel Minor Injuries Unit had received some training in use of the first contact protocol and recognising when patients were unwell.

When we spoke with senior managers for the minor injuries units we were told that the matron within the acute medicine business unit would ordinarily be responsible for overseeing routine matters such as updating competencies, however this post was currently vacant.

**Appraisal rates**

From November 2017 to October 2018, the trust’s appraisals data show that all 14 eligible qualified nurses in the minor injuries unit at Samuel Johnson Community Hospital received an appraisal. All four eligible administrative and clerical staff, and the one member of additional clinical services staff, had received appraisals over the same period. The trust set a target of 90% for appraisal completion.
Over the same period the data showed that all 13 eligible qualified nurses in the minor injuries unit at Sir Robert Peel Community Hospital received an appraisal. Four out of five eligible administrative and clerical staff (80%) and the one eligible member of additional clinical services staff had received appraisals over the same period. The trust’s 90% target for appraisal completion was therefore technically not met for administrative and clerical staff but was met for the other two staff groups.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Both minor injuries units had good links with other teams. They had regular contact with a psychiatric liaison team during the day and the crisis team out of hours. They had open access to a falls team, and good links with a community intervention team who provided short term support to people in their own homes to try and prevent hospital admissions.

For speciality services they regularly dealt with eye casualty at Queens Hospital, Burton on Trent, and staff listed other teams and agencies they had frequent contact with, for example maxillofacial services for conditions such as dental abscess.

There was a process set up with an NHS hospital in a neighbouring geographical area which meant x-rays could be fast-tracked into their services when their forms were used at the minor injuries units.

Staff spoke regularly with local GPs and care homes and had a good relationship with the local ambulance service. We observed good cross-agency communication during our inspection.

Seven-day services

Both minor injuries units were open seven days per week. Samuel Johnson Minor Injuries Unit was open between 8am and 9pm daily, and Sir Robert Peel Minor Injuries Unit was open between 8am and 10pm.

X-ray services were available on at both minor injuries units between 9am and 5pm on weekdays. There was no x-ray service on site on Sundays but on Saturday it was available until 2pm at Samuel Johnson Minor Injuries Unit and 12 noon at Sir Robert Peel Minor Injuries Unit.

Health Promotion

There was a wide range of leaflets and health promotion information available to patients including display boards with telephone numbers for other services. These included mental health support organisations, information about certain conditions and injuries, and where to seek support for domestic violence or abuse.

A comprehensive assessment was undertaken for all patients and pathways were in place for a wide range of conditions. These included information about referring to different services when appropriate.

Both minor injuries units spoke with GPs or other agencies when required. Staff provided examples of this.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion
**Trust level**

Staff in the trust’s community urgent care services were eligible for two levels of combined Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The completion target for both levels was 90%. This requirement was inherited from Burton Hospitals NHS Foundation Trust.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty Safeguards training for the period from November 2017 to October 2018 level for all staff in the trust’s community urgent care services is shown below.

The number of all staff in all staff groups shown as eligible in the trust’s training data is smaller than would be expected, based on the numbers eligible for other mandatory training modules.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for both modules for all staff in the trust’s community urgent care services.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty Safeguards training for the period from November 2017 to October 2018 level for qualified nursing staff in the trust’s community urgent care services is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for both modules for qualified nursing staff in the trust’s community urgent care services.

**Samuel Johnson Community Hospital**

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty Safeguards training from November 2017 to October 2018 for all staff at the Samuel Johnson Community Hospital Minor Injuries Unit is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for both modules for all staff at the Samuel Johnson Community Hospital Minor Injuries Unit.
The 90% target was met for both modules for all staff at Samuel Johnson Community Hospital Minor Injuries Unit.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty Safeguards training from November 2017 to October 2018 for qualified nursing staff at Samuel Johnson Community Hospital Minor Injuries Unit is shown below.

<table>
<thead>
<tr>
<th>Training module</th>
<th>Number trained</th>
<th>Number eligible</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 1</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity act and deprivation of liberty safeguards - level 2</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for both modules for qualified nursing staff at Samuel Johnson Community Hospital Minor Injuries Unit.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff at the minor injuries units did not undertake capacity assessments. If a patient came in who appeared confused they took steps to seek advice from the patient’s family or carers before giving treatment if they felt it was in the patient’s best interest. Staff provided recent examples of when this had happened.

If they were concerned about a patient’s mental health, they contacted the mental health team.

Fraser guidelines, were in use for deciding whether a child could consent to contraceptive or sexual health advice and treatment.

**Deprivation of Liberty Safeguards**

Senior managers we spoke with said no deprivation of liberty safeguard applications were made by the minor injuries units as this would not apply to the care provided in community urgent and emergency care.

**Is the service caring?**

**Compassionate care**

All care we saw during our inspection was delivered with compassion. We saw staff engaging well with patients, listening to them and putting them at ease.
Staff showed consideration towards the patients, for example when patients were transferred from the unit by ambulance and had to leave their cars on site, staff rang the car parking company to ensure they did not receive a parking fine.

Patients attending the minor injuries units were invited to complete a satisfaction survey through text message. The most recent results from December 2018 showed there were 185 responses to the survey which was comparable to the number of returns received in November 2018. These response rates were lower than usual due to a technical issue identified with the text messaging survey. This has since been resolved.

Overall the scores for individual questions improved slightly in comparison with the previous month, apart from reception/kindness/respect which dipped slightly across both sites. Information about waiting times remained the lowest scoring question, although the actual score improved slightly in comparison with the previous month.

Friends and Family results provided by the trust for December 2018:

<table>
<thead>
<tr>
<th>Area</th>
<th>% Recommend</th>
<th>% Not recommend</th>
<th>Number of responses</th>
<th>% of Discharge figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samuel Johnson Minor Injuries Unit</td>
<td>92.31%</td>
<td>3.85%</td>
<td>104</td>
<td>4.5</td>
</tr>
<tr>
<td>Sir Robert Peel Minor Injuries Unit</td>
<td>95.29%</td>
<td>0.00%</td>
<td>85</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Emotional support**

We observed a child with a head injury being assessed at Samuel Johnson Minor Injuries Unit. All appropriate care was given and the nurse was caring and calmed the child.

Staff displayed understanding when talking about patients living with dementia or mental health problems. They provided examples of how they had taken time to ensure those who may need extra support received it.

**Understanding and involvement of patients and those close to them**

We spoke with five patients, including three children, and five family members. All patients and carers were satisfied with the care they received at the minor injuries unit and all were given information about their condition and treatment.

We observed nursing staff explaining the assessment process in detail to the parent of a child attending a minor injuries unit. Information was provided, regarding monitoring the child at home.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

At Sir Robert Peel Minor Injuries Unit there was a whiteboard in the waiting area listing staff on duty in the unit. The board did not provide information regarding waiting times which was an issue raised in the patient survey. Samuel Johnson Minor Injuries Unit did not have a display board showing staff or waiting times.

Staff at both minor injuries units said they regularly (daily) saw patients who had been unable to get an appointment with their GP or practice nurse, for example to have dressings changed. This
was challenging to manage as although the units were not intended to provide this service, staff felt they could not turn patients away. This meant that other patients were having to wait longer.

The premises and facilities at both minor injuries units were appropriate for the services delivered; both units were within community hospitals.

**Meeting people’s individual needs**

Pathways and supporting information were in place and available to staff where appropriate, for example at Samuel Johnson Minor Injuries Unit there was a folder containing information related to patients presenting with mental health problems.

Children’s waiting areas with toys were available in both minor injuries units.

The assessment process was comprehensive and had tools which promoted identification of patients who may be vulnerable, for example those with mental health needs, frequent attenders or patients with safeguarding concerns.

The minor injuries units had access to support services they could refer people to, for example a club for patients who wanted to learn how to use a computer. On one site there was a weekly class held in the cafeteria where people could participate in seated exercise to music.

Staff worked across services to coordinate people’s involvement with families and carers, for example speaking regularly with the local care homes when their patients attended.

**Access and flow**

**Percentage of patients admitted, transferred or discharged within four hours (type 3 emergency departments)**

Data is included for the acquired Burton Hospitals NHS Foundation Trust for the period up to the acquisition. We only provided this for contextual purposes and it did not form part of our judgement.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From December 2017 to November 2018 the trust’s community urgent and emergency care services consistently met the standard, and consistently outperformed the England average. In both July and November 2018, 99.9% of patients were admitted, transferred or discharged within four hours. The trust admitted, transferred or discharged within four hours, all patients who attended its community urgent care services in the remaining 10 months.

**Four-hour target performance – University Hospitals of Derby and Burton NHS Foundation Trust community urgent care services**
The trust submitted the following information after the inspection regarding waiting times:

### Samuel Johnson Minor Injuries Unit 1 April 2018 to 29 January 2019

<table>
<thead>
<tr>
<th>Wait Time (Minutes) for Initial Assessment</th>
<th>Attendances</th>
<th>Proportion of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 30</td>
<td>12,159</td>
<td>59.66%</td>
</tr>
<tr>
<td>31 to 60</td>
<td>5,345</td>
<td>26.22%</td>
</tr>
<tr>
<td>61 to 90</td>
<td>2,134</td>
<td>10.47%</td>
</tr>
<tr>
<td>91 to 120</td>
<td>634</td>
<td>3.11%</td>
</tr>
<tr>
<td>121 to 150</td>
<td>91</td>
<td>0.45%</td>
</tr>
<tr>
<td>151 +</td>
<td>19</td>
<td>0.09%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,382</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Samuel Johnson Minor Injuries Unit 1 April 2018 to 29 January 2019

<table>
<thead>
<tr>
<th>Wait Time (Minutes) for Treatment</th>
<th>Attendances</th>
<th>Proportion of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 30</td>
<td>12,212</td>
<td>59.92%</td>
</tr>
<tr>
<td>31 to 60</td>
<td>5,305</td>
<td>26.03%</td>
</tr>
<tr>
<td>61 to 90</td>
<td>2,126</td>
<td>10.43%</td>
</tr>
<tr>
<td>91 to 120</td>
<td>630</td>
<td>3.09%</td>
</tr>
<tr>
<td>121 to 150</td>
<td>90</td>
<td>0.44%</td>
</tr>
<tr>
<td>151 +</td>
<td>17</td>
<td>0.08%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,380</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Sir Robert Peel Minor Injuries Unit 1 April 2018 to 29 January 2019

<table>
<thead>
<tr>
<th>Wait Time (Minutes) for Initial Assessment</th>
<th>Attendances</th>
<th>Proportion of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 30</td>
<td>11,941</td>
<td>53.69%</td>
</tr>
<tr>
<td>31 to 60</td>
<td>6,724</td>
<td>30.23%</td>
</tr>
<tr>
<td>61 to 90</td>
<td>2,557</td>
<td>11.50%</td>
</tr>
<tr>
<td>91 to 120</td>
<td>758</td>
<td>3.41%</td>
</tr>
<tr>
<td>121 to 150</td>
<td>138</td>
<td>0.62%</td>
</tr>
<tr>
<td>151 +</td>
<td>123</td>
<td>0.55%</td>
</tr>
</tbody>
</table>
Sir Robert Peel Minor Injuries Unit 1 April 2018 to 29 January 2019

<table>
<thead>
<tr>
<th>Wait Time (Minutes) for Treatment</th>
<th>Attendances</th>
<th>Proportion of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 30</td>
<td>11,902</td>
<td>53.53%</td>
</tr>
<tr>
<td>31 to 60</td>
<td>6,744</td>
<td>30.33%</td>
</tr>
<tr>
<td>61 to 90</td>
<td>2,567</td>
<td>11.54%</td>
</tr>
<tr>
<td>91 to 120</td>
<td>760</td>
<td>3.42%</td>
</tr>
<tr>
<td>121 to 150</td>
<td>135</td>
<td>0.61%</td>
</tr>
<tr>
<td>151 +</td>
<td>128</td>
<td>0.58%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,236</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

* Corrected total

Median Wait Time (Minutes) for Treatment

<table>
<thead>
<tr>
<th></th>
<th>Samuel Johnson Minor Injuries Unit</th>
<th>Sir Robert Peel Minor Injuries Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2018</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>August 2018</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>September 2018</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>October 2018</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>November 2018</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>December 2018</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>January 2019</td>
<td>24</td>
<td>26</td>
</tr>
</tbody>
</table>

Performance data provided by the trust showed that between 1 April 2018 and 31 December 2018 there were approximately 20,380 attendances at Samuel Johnson Minor Injuries Unit including planned and unplanned follow-up attendances. During the same period there were approximately 22,240 attendances at Sir Robert Peel Minor Injuries Unit. Of these, between 2-3% required a transfer to hospital from the minor injuries units. Exact figures were not available due to some recording issues in May 2018.

**Learning from complaints and concerns**

**Summary of complaints**

From November 2017 to October 2018 the trust received no complaints about its community urgent care services.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Information provided by the trust following inspection showed that between 1 January 2018 and 31 December 2018 there had been five complaints about the minor injuries units. Three of these were closed and investigated as serious incidents. The other two were resolved, one within 25 days and one within 29 days.

Information about the details of the complaints were requested by CQC, but not received.

**Number of compliments made to the trust**
From November 2017 to October 2018 the trust received 50 compliments about community urgent and emergency care. The breakdown by unit was as follows:

- Samuel Johnson Community Hospital Minor Injuries Unit: 31
- Sir Robert Peel Community Hospital Minor Injuries Unit: 19

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Within the trust there was a business unit for each site (Royal Derby Hospital and Queen’s Hospital) and two specialist medicine business units across both sites.

The two minor injuries units were managed within the acute medicine business unit at Queen’s Hospital, Burton upon Trent. There was a general manager and a clinical director in the business unit, and a matron for the Emergency Department who also provided support for the minor injuries units as they had a background as an emergency nurse practitioner.

The matron for acute medicine, which included the minor injuries units, had been a vacant post since the beginning of December. Senior managers said the matron’s role for the minor injuries units had changed “numerous times” in recent years.

Temporary cover was being provided by a matron in specialist medicine business unit two. This matron was still also responsible for her own clinical areas in community inpatients so was not operationally managing the minor injuries units, but was dealing with certain issues that arose, such as staffing levels.

The matron reported to the divisional nursing director for medicine and took any concerns to them or the general manager. There was an open door policy and this had improved since the acquisition.

Senior managers acknowledged some challenges with managing the minor injuries units. These included a lack of clarity as to their longevity in the current regional structure of emergency and urgent care, and a historical culture of ‘leaving well alone’ as there did not appear to be any major issues with how they were operating.

The matron visited the minor injuries units weekly, and the general manager visited monthly. Staff we spoke with had not seen the clinical director on site, although the executive medical director visited the minor injuries units monthly and had been visible and supportive during a recent difficult time at one site. This was acknowledged by staff and managers.

Information provided by the trust showed that the community hospitals were included on the lists of visits made by the trust board and the chief executive.

Vision and strategy

Following the acquisition process the trust set up an online workshop, also called a discussion platform, accessible to all staff, to develop, shape and co-create a vision, set of values, behavioural charter, and key actions for the new organisation. Staff we spoke with were aware of the trust-wide initiative to develop these.
As a result of this the trust had created a set of ‘pride’ objectives: putting patients first, right first time, investing resources wisely, developing people and ensuring value from partnerships. The ‘care’ values of compassion, attitude, respect and equality made up the trust’s vision which was to take pride in caring.

At a local level these objectives and values were not yet embedded. When asked about the vision and strategy for the minor injuries units, staff did not know the answers.

**Culture**

Staff we spoke with at both minor injuries units were supportive of each other and proud of the service they provided.

The minor injuries units did not hold joint meetings or share best practice; however, they did provide cover for each other in exceptional circumstances. Staff at both units gave examples of when this had happened and were appreciative.

The matron had recently introduced a monthly meeting for senior sisters working at the community hospitals, and the band 7s from the minor injuries units were invited to attend this. However, the meeting was held off site, which meant that their attendance was difficult to organise and it had not yet happened.

Staff we spoke with were keen to develop but said some opportunities were limited due to funding issues. Some staff had completed extra minor illness and minor injuries training but several staff we spoke with were keen to be given the opportunity. All staff we spoke with were dedicated to their roles and were enthusiastic about developing further.

Staff at both minor injuries units discussed the negative impact on them of multiple organisational changes that had taken place over recent years. These changes were also acknowledged by managers who described the situation as “unsettling”. Staff at different levels raised concerns over the future of the minor injuries units in their current structure which left them feeling unclear about their future strategic direction.

Over the course of our inspection different staff used terms such as “self-sufficient”, “self-managing” and “stand alone” in reference to the minor injuries units. Staff we spoke with said that since the acquisition meetings and training were often held at Derby which made it difficult for them to attend.

**Governance**

There was a trust wide governance structure in place with a hierarchy of groups and committees which ultimately reported to the trust board and council of governors.

There was a weekly emergency medicine meeting where any urgent issues were discussed. We requested the minutes from these meetings, or for any meetings where there was evidence of discussion about governance for the minor injuries units but did not receive them. We received an agenda template and an action log for the Burton acute medicine business unit. The action log did not appear to include anything in relation to the minor injuries units.

Since our inspection a weekly meeting has been set up between the matron and the senior sisters to ensure there is an avenue for the transference of information from the minor injuries units to the board.

Senior managers said nothing was flagging as an operational concern for the minor injuries units.
Team meetings were not held as frequently as planned. Staff at Samuel Johnson Minor Injuries Unit said they were held every four to six weeks and were minuted with action plans. However, the last two sets of available minutes were dated May 2018 and November 2018. These minutes showed discussions were held around learning following complaints and incidents.

We requested meeting minutes from both minor injuries units but did not receive any from Sir Robert Peel Minor Injuries Unit.

**Management of risk, issues and performance**

There was a local risk register in place and risks that were assessed as reaching an identified threshold (a score of 12 on the risk matrix) were added to the divisional risk register. This was managed through the monthly quality committee meetings chaired by a non-executive director.

Following inspection, the trust provided some performance data showing activity at the minor injuries units. This provided information about the number of attendances and waiting times, however there was no narrative with the data, or any action plans to make improvements.

There was no formal business continuity plan in place for the minor injuries units.

**Information management**

There was no clear holistic understanding of performance, for example there were no target times within which patients should be seen, and no action plans to improve existing performance.

We did not see evidence that quality and sustainability related to the minor injuries units received sufficient coverage in relevant meetings at all levels.

We did not see evidence that issues were being identified in a timely manner, or that actions were being taken when they were identified. For example, it had been identified following a serious incident investigation that incidents were not being routinely reported. This situation had not been audited or resolved.

**Engagement**

Following the acquisition on 1 July 2018 there was an engagement programme whereby regular newsletters were sent out and staff, patient, public and stakeholders were invited to question and answer sessions on the acquisition and public engagement events. Frequently asked questions and answers were available on the trust websites and intranets, as well as the bespoke joint website for the life of the acquisition programme.

The service offered satisfaction questionnaires to all patients attending the minor injuries units. Patient survey responses were analysed by the service and overarching themes were identified and discussed. For December 2018 the negative points raised in the survey related mainly to communication issues, facilities and methods of payment for prescriptions. These comments had been relayed to the appropriate matron and staff in pharmacy.

There was a staff inclusion workstream at the trust that aimed to recognise and showcase staff from a wide range of faiths and cultures, raising awareness of inclusion issues within the wider workforce and normalising conversations on inclusion.

Following the acquisition, a new strategy for patient and public engagement was being developed for the trust.
Learning, continuous improvement and innovation

Staff we spoke with were keen to learn and work towards continuous improvement. Some had taken the opportunity to undergo further training, but others had been told there were funding restrictions which prevented them from completing the same courses as their colleagues.

The two minor injuries units did not meet up to share learning or best practice.