The Dudley Group NHS Foundation Trust

Inspection report

Trust Headquarters, Russells Hall Hospital
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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

In 2014 we inspected both Russells Hall and Corbett Hospital. Corbett hospital only provided outpatient, diagnostic imaging and surgery services. The ratings for these core services in the Russells Hall report, dated 2014, reflect evidence from both locations.

Background to the trust

The Dudley Group NHS Foundation Trust operates acute hospital services from three hospital sites:

- Russells Hall hospital
- Corbett Outpatient Centre.
- Guest Outpatient Centre.

In addition, the trust provides community services in a range of community facilities to the populations of Dudley, parts of Sandwell borough and some communities in South Staffordshire and Wyre Forest.

The trust serves a population of around 450,000 covering these boroughs with services commissioned by Dudley Clinical Commissioning Group.

The trust has 629 core inpatient beds, 21 escalation beds and 152 day case beds.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

The trust runs services at Russells Hall Hospital, Corbett Hospital and the Guest Hospital.

Russells Hall Hospital provides urgent care, medical care, surgery, children and young people services, maternity services, outpatients, diagnostics, end of life and critical care services.

Outpatient services are also provided at the Corbett and Guest hospitals. Corbett hospital provides day case treatment alongside a range of outpatient services which include radiology, pharmacy, gynaecology, physiotherapy, rehabilitation and a wheelchair supply and maintenance service. Guest hospital is a satellite hospital which offers additional outpatient facilities.

The Trust also provides community services for adults (including sexual health) and End of Life Care. There are no community services for inpatients or children and young people. The community services provide clinical care to patients who are acutely, chronically or terminally ill in their own homes or from GP practices or health centres. The services are multidisciplinary and include nursing staff and allied health professionals. The Dudley Group was the first trust in the area to be awarded Foundation Trust status in 2008.

We inspected services at Russells Hall Hospital and community services for adults.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 5 December 2017 and 18 January 2018, we inspected five core services provided by the trust at Russells Hall hospital and community adult services including sexual health. At our last inspection in March 2014 three core services (accident and emergency, critical care and maternity) were rated as requires improvement. Surgery, children and young people and end of life care were rated as good. Through our ongoing monitoring of the trust we had concerns about children and young people services and medicine services which were rated as good at the last inspection. Therefore we decided to also inspect these services on this inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at trust level. Our findings are in the section headed is this organisation well led? We inspected the well-led key question on 16, 17 and 18 January 2018.

What we found

Overall trust

Russells Hall Hospital

Our inspection of the core services covered only Russells Hall hospital and community services (community adults and sexual health).

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good. We rated two of the trusts core services as good, two as requires improvement and one as inadequate. We rated community services including sexual health as good.
- In rating the trust, we took into account the current ratings of the four core services and community end of life services that were not inspected this time.
- Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.
- We rated well-led at the trust level as requires improvement.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- The executive team recognised that there was still work to do to ensure a robust safety culture across the whole organisation.

Summary of findings

- Staff did not always understand how to protect patients from abuse. Not all staff had received the right level of training and were not always recognising's and reporting abuse.
- We rated safety in urgent care services as inadequate. We found significant failings in the identification and management of deteriorating patients. Triage processes were inconsistent and not exercised in line with the trusts local policy and national guidelines. We saw examples where patients had been exposed to and potentially suffered avoidable harm as a result of these failings.
- Some of the core services did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- There were not always suitable premises and equipment in place. There was limited storage in medical and high dependency units and there were not enough sinks for the number of cots in the special care baby unit, however staff we spoke with on the ward were aware of this concern and described how they worked to mitigate this risk such as maintaining high standards of handwashing techniques.

However;

- The service provided mandatory training in key skills to all staff and compliance was generally good.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

Are services effective?

Our rating of effective went down. We rated it as requires improvement because:

- Care and treatment was not always based on national guidance and managers were not checking to ensure staff followed guidance. Some core services did not always monitor the effectiveness of care and treatment and then use the findings to improve.

However;

- 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.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- 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.
- 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.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

Summary of findings

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff provided emotional support to patients to minimise their distress.

However;

- In urgent and emergency services patient's privacy and dignity was not always respected. The Friend and Family Test results were worse than the England average and patients did not always have their call bells within reach.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service took longer than expected to respond to complaints.
- People could not always access the service when they needed it. In some areas such as the urgent and emergency care department, the children and young peoples department and maternity some waiting times and arrangements to admit, treat and discharge patients were not always in line with good practice.
- Bed occupancy rates were higher than recommended limits in some areas. This impacted on the provision of a suitable environment to receive care. There were some mixed sex breaches.

However;

- The service took account of patients' individual needs although children between the ages of 16 to 18 did not necessarily gain access to the children's ward or paediatric facilities.
- The trust planned and provided services in a way that met the needs of local people.

Are services well-led?

- Our rating of well-led went down. We rated it as requires improvement overall with one area, the urgent and emergency care department being inadequate because: The trust did not have effective systems for identifying risks, robust plans to eliminate or reduce them, and coping with both the expected and unexpected. In urgent and emergency care services we found that systematic failings and lack of oversight in the service at all levels had led to patients being exposed to the risk of avoidable harm.
- The arrangements for governance and performance management were not always operated effectively.

However;

- 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.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Summary of findings

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all the ratings into account in deciding the overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our personal professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in maternity and community services including sexual health. See outstanding practice area of the report below for further details.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 26 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued six requirement notices to the trust .This meant the trust had to send us a report saying what action it would take to meet those requirements.

Our action related to breaches of legal requirements in urgent and emergency care, critical care, and children and young people.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- The maternity matron for outpatients, community midwifery, and the midwifery-led unit, had been offered the committee member role of midwife on the Postnatal Care Guidelines Committee of the National Guideline Alliance for the duration of the development of the guideline.
- The maternity service had a training programme in place for the frenulotomy procedure.
- The service had used charitable funds to refund women who chose to use a home pool birth.
- There were examples of excellent innovative multidisciplinary working within the community services.
- There was a vanguard project which was being undertaken in collaboration with Dudley Clinical Commissioning Group, Dudley and Walsall Mental Health Partnership NHS Trust, the Black Country Partnership NHS Foundation Trust, Dudley Metropolitan Borough Council and Dudley Council for Voluntary Service. This involved all six organisations working together to develop a new care model to improve the way the most vulnerable people in Dudley were looked after.

Summary of findings

Areas for improvement

Action the trust MUST take is necessary to comply with legal obligations. Actions a trust SHOULD take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services in line with six legal requirements. This action related to three services.

In urgent and emergency services:

- The trust MUST ensure that all patients presenting to the emergency department receive appropriate levels of clinical observation to identify any deterioration in their condition.
- The trust MUST ensure that all systems and processes in place to identify and manage patients with deterioration effectively are followed.
- The trust MUST ensure that all required patients presenting to the emergency department receive a robust clinical assessment in line with national guidelines and standards and within 15 minutes of arrival.
- The trust MUST ensure that triage is undertaken in a consistent manner and an evidence based system is used.
- The trust MUST ensure that all systems used to treat patients safely are used in their correct and full form and any deviation is reported to the trust board and undertaken based on robust clinical rationale and evidence.
- The trust MUST ensure that all staff complete mandatory training and additional training for their role as per trust's policy.
- The trust MUST ensure risks are managed appropriately and effectively.
- The trust MUST ensure that PGD's (patient group directions) are up to date and reviewed regularly.
- The trust MUST ensure all staff are trained in and to the appropriate level of safeguarding for adults and children and ensure all staff refer patients to the local authority when safeguarding is required.
- The trust MUST ensure all staff complete any forms and assessments designed to keep patients safe in line with local and national standards.
- The trust MUST ensure patients dignity and privacy is maintained at all times.
- The trust MUST ensure there is sufficient senior consultant cover to meet the required standards in the emergency department.
- The trust MUST ensure that there is an effective and easily identifiable system in place to identify patients with allergies.
- The trust MUST ensure that all patients waiting to be seen receive an adequate level of supervision and observation to identify any changes in their condition.

In critical care:

- The trust MUST ensure that all premises meet the requirements of relevant guidance and requirements, such as the Department of Health, Health Building Notes.

Summary of findings

- The trust MUST ensure the service has a robust, transparent and inclusive approach to governance, which includes and supports all critical care areas.
- The trust MUST ensure there is sufficient numbers of staff, who are suitably trained and competent, to care for the number and acuity of patients.
- The trust MUST ensure all current risks are comprehensively documented using the systems in place by the trust, and are routinely and robustly reviewed and mitigating actions taken where necessary.
- The trust MUST ensure that patient's privacy and dignity is maintained and promoted at all times during care delivery.
- The trust MUST ensure that relevant clinicians and teams are aware of all patients receiving critical care to ensure the safe delivery of care and treatment.
- The trust MUST ensure that staff record an accurate, complete and contemporaneous record of the care provided to patients.
- The trust MUST ensure that all serious incidents are recorded and investigated accordingly. The provider must ensure that lessons learnt are shared across all critical care areas.

In children and young people:

- The trust MUST ensure that medical staffing is adequate to manage clinical care and safeguarding of paediatric patients both within working hours and out of hours.
- The trust MUST ensure that medical staff undertaking safeguarding duties take part in relevant supervision as required by trust policy.
- The trust MUST ensure that medical staff are in line with the trust target for mandatory training.
- The trust MUST ensure that medical staff are fully involved in the clinical governance arrangements for the children and young person's service.
- The trust MUST ensure nursing staffing levels meet the Royal College of Nursing (RCN) and British Association of Perinatal Medicine (BAPM) guidelines.

Action the trust SHOULD take to improve

We told the trust that it should take cation either to comply with a minor breach and did not justify regulatory action, to avoid breaching a legal requirement in the future or to improve services. This action relates to five services.

In medical care:

- The trust SHOULD ensure appropriate staffing levels are maintained in line with local and national standards and keep bank and agency staff cover to a minimum.
- The trust SHOULD ensure staff are compliant with Venous Thromboembolism (VTE) risk assessment, and other safety checks to keep patients safe from harm, for example, safe medicines management and checking systems to keep patients safe from harm.
- The trust SHOULD ensure that the discharge lounge is fully functioning, suitably resourced and appropriately supervised to ensure patients are cared for in a safe and caring manner.
- The trust SHOULD ensure they review the patients admitted to the coronary care unit to prevent mixed sex breaches. The provider should ensure all mixed sex breaches are reported appropriately.

Summary of findings

- The trust SHOULD consider the use of national audits to help them understand how they compare with other medical care wards to improve services.

In critical care:

- The trust SHOULD ensure all critical care departments comply with the current guidance for the Provision of Critical Care Services (GPICS).
- The trust SHOULD ensure that critical care services continue to submit data to the required national data sets, for example the Intensive Care National Audit Research Centre (ICNARC).
- The trust should ensure that staff assess the care needs of patients in line current best practice and guidance, for example the Critical Care Minimum Data Set (CCDS) published by the Intensive Care Society.
- The trust SHOULD ensure the service uses local and national audit data to improve patient care.
- The trust SHOULD ensure that a specialist staff are available (in line with current national guidance and requirements) throughout critical care areas, including pharmacists and microbiologists.
- The trust SHOULD consider how they review how information is shared between all critical care departments.

In maternity:

- The trust SHOULD ensure mandatory training compliance is improved in particular for children's safeguarding, mental health act and mental capacity training, neonatal resuscitation and adult resuscitation training.
- The trust SHOULD ensure guidelines are reviewed and updated in a timely manner.
- The trust SHOULD ensure the clinical audit programme for maternity services is fully embedded within the service.
- The trust SHOULD ensure women complete their antenatal appointments in a timely manner.
- The trust SHOULD ensure they have a Non-Executive Director with responsibility for maternity services.
- The trust SHOULD consider if there is sufficient bereavement support and that there are suitable areas for women and their families to spend time after experiencing bereavements.

In children and young people:

- The trust SHOULD ensure that children aged 16 to 18 are provided with a responsive approach to accessing paediatric services.
- The trust SHOULD ensure toys within the paediatric outpatients department are cleaned, and this is appropriately monitored.
- The trust SHOULD ensure that children and young people are represented at board level.

In community services for adults including sexual health:

- The trust SHOULD ensure that all staff complete mandatory training and additional training for their role as per trust's policy.
- The trust should ensure that all community staff are up to date with appraisal rates.
- The trust SHOULD ensure the community podiatry department completes infection control and prevention audits.
- The trust SHOULD ensure community patients care plans are person centred and not generic.
- The trust SHOULD ensure waiting times for treatment are in line with good practice.

Summary of findings

- The trust should ensure that interim managers provide adequate time and support to the new manager to ensure the positive changes made are so far continued and embedded.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall managing of a trust and the quality of its services. For that reason, we look at the quality of its services and we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services-in other words how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- The chief executive (CEO), the chief operating officer (COO), the chief nurse and the medical director had all been in post less than nine months at the time of our inspection. The capacity of the executive team was impacted on due to either no deputy structure being in place or individuals who did not have the capacity or expertise to take the issues forward. This had resulted in the executive team taking on multiple roles to try to resolve issues in a timely manner, it was recognised this could not continue and key areas of responsibility needed to be transferred to those who were accountable. We saw that the executive team had already addressed and prioritised many issues and that they were actively recruiting to strengthen the capacity of the team.
- The executive team recognised that there was still work to do to ensure a robust safety culture. Although the executive team were clear in their commitment to this. It was not always clear how the trust were assured when the actions they had implemented had not brought about the required improvements. Developing a positive patient safety culture was an area of focus for the trust.
- There were some areas of risk where the oversight, recognition and action was at times inadequate. Due to the significant number of risks facing challenged areas within the trust, we found the executive team had not always applied sufficient scrutiny to determine the level of risk. An example of this was the recognition by the executive team that there were issues in relation to safeguarding within the emergency department but they had not taken action to undertake an audit or review to determine the level of risk.
- However, we did see evidence the executive team had made the board aware about some of the risks they had identified. In some instances, they had sought support from other agencies such as their commissioners and NHS improvement and NHS England. During our interviews with executives, we were aware they had concerns about safeguarding particularly as there was limited expertise within the trust. Recruitment was underway to appoint to these key positions and key staff were due to start shortly after the inspection.
- Quality dashboards had recently been put into place by the executive team to have oversight of quality overall and in each specific ward area, these had been well received by staff who would for the first time see their progress and how they were improving in key areas.
- There was a governance structure in place; however, this did not provide adequate assurance to the board. Members of the executive team felt that the committee structure worked well, particularly the finance and performance and audit committee. It was recognised by the executive team that the clinical quality, safety and patient experience committee needed to revise groups reporting to them and the structure so that the committee could receive greater clarity of assurance and not get involved in detailed work. The team also recognised that the divisional governance structure needed further work to ensure consistency. The main committee which oversaw clinical quality and safety was the Clinical Quality Safety and Patient Experience Committee (CQSPE). The board development programme planned to focus on the effectiveness of committees in the future.

Summary of findings

- There were divisional governance meetings where operational governance issues would be discussed and escalated through the formal committee structure. Although there was an established governance framework, key issues of risk and patient safety were not always identified through these frameworks. This was because senior staff in some areas did not always recognise areas of risk and poor practice.
- The executive team were aware the Board Assurance Framework (BAF) required further improvement. It focused on the outcome of the risk rather than the risk itself. A lack of focus on the risks meant that the key controls did not address the potential impact. We could see the BAF was improving but this was work in progress.
- The executive team and senior leaders were not always advised of, and did not always recognise new or emerging risks within the trust; however, they did have good knowledge of the risks that were recorded on the risk register. Some of the executive team did recognise the level of risk in challenged areas and were taking some decisive courses of action.
- The controls on the trusts risk register did not fully describe the risks of potential harm to patients. Not all risks were captured on the risk register and some risks had been on the risk register for a long time. It was not always clear what actions were being taken to control and mitigate risks. There was some confusion amongst senior leaders over what should be on the risk register and what should be on the BAF. However, we recognise that the risk registers were an area the executive team were developing as they had identified significant gaps. The implementation across the trust had been inconsistent and the team told us they were moving this forward to ensure risk registers were in place across the trust.
- The trusts safeguarding arrangements and processes were at times inadequate and lacked robustness which placed children at risk of potential harm. Children's and young people's services did not have representation at the board.
- We saw that Duty of Candour regulations were not always followed or properly understood. However, we recognised that in some departments for example maternity, staff demonstrated a good understanding of duty of candour and could give examples of when it had been applied.
- The trust recognised they needed to improve their process for learning from deaths reviews and in cascading learning from deaths to wider staff groups. Whilst the trust already had a process in place using a three tier process of validation, MDT review and Mortality Surveillance Group review, it recognised that there was a need to look in more detail at the documentation of adequacy of care, DNACPR and end of life care, issues of avoidability and the application of the duty of candour.
- The current IT system was in need of an upgrade and was not fit for purpose, with data being said to provide reassurance rather than assurance. However, the trust board had recognised that the current IT system was inadequate and coming to the end of its life cycle. They had committed to significant investment in 2016/17 with a go live date of April 2018.
- There were frustrations amongst staff in relation to data, for example not having enough analyst capacity and having to wait for information requested. Committees were not making the best use of assurance data due in weaknesses in the infrastructure.
- Some areas of the trust had clear strategies in place in line with the overall strategy. Others were in the process of being rewritten, refreshed or were still in need of updating. Some staff felt that some of the strategies were basic, lacking in ambition or in need of development when specifics had changed. The executive team told us that they were revising all corporate, clinical and workforce strategies in 2018/19.
- There were gaps in the trusts information on ethnicity. This meant that a significant number of staff were reported as ethnicity unknown or not declared. There were few Black, Asian and minority ethnic (BAME) employees in non-clinical senior leadership posts and the likelihood of entry in to the formal disciplinary process was higher for BAME employees who also had less access to training.

Summary of findings

- The results from the NHS staff survey 2016 showed the trust scored worse than average compared to other similar trusts in seven key areas. These areas included reporting errors, near misses or incidents witnessed in the last month, satisfaction with the opportunities for flexible working patterns, working extra hours, agreeing that their role makes a difference to patients/service users, experiencing physical violence from patients, relatives or the public in the last 12 months, reporting most recent experience of violence and reporting most recent experience of harassment, bullying or abuse.
- We reviewed the Freedom to Speak Up Guardian update (December 2017) and saw that between April 2017 and November 2017 the majority of concerns raised to the Freedom to Speak Up Guardians related to line and senior managers regarding perceived behaviour :bullying, harassment and perceived unfair behaviours such as unfair recruitment, rotas and concerns about redeployment of staff. However, members of the executive team have since told us that the instances regarding bullying had now been considered in greater detail and it had been found that none of the cases associated to bullying involved a senior manager or members of the executive team. Some of the matters had been referred to the HR department and all were resolved without any requirement for a formal investigation.

However

- The executive team were open and honest about the challenges they were facing and appeared to work very well together. They had a clear vision and were able to articulate how they wished to improve the service in the future. They were very responsive in addressing areas of risk which we raised with them.
- The Trust had a five year strategy in place which spanned the years 2015-2020, this was underpinned by a further clinical strategy for 2017/18 – 2020/2021 which set out how its services will look in the future. The trust's five year strategy was due to be refreshed. The Trust also had an annual plan which was updated each year and supported the delivery of these strategies. The progress of the annual plan was reported to the Trust Board on a quarterly basis and we saw this reflected in meeting minutes.
- Overall, most staff felt that communication from the executive team had improved and that the leadership team were engaged, driven to listen and reacted when concerns were raised. Staff also felt engaged and informed. They felt that the culture was one of openness and honesty and told us that members of the executive team attended regular meetings, focused on quality and were visible in patient areas at times of high pressure.
- The results from the NHS staff survey 2016, showed the trust scored better than the average for similar trusts in seven key findings. Areas included witnessing potentially harmful errors, near misses or incidents in the last month, staff confidence and security in reporting unsafe clinical practice, attending work in the last three months despite feeling unwell because they felt pressure, staff satisfaction with resourcing and support, experiencing physical violence from staff in the last 12 months, experiencing harassment, bullying or abuse from staff in the last 12 months.
- We found that when issues were raised through the trusts governance structure, they did reach the board and when the board were aware of these issues they planned actions to address them. The trust board fostered a 'ward to board' approach to governance and had a number of methods and structures to facilitate this. These included clinical area quality and assurance reviews.
- There was a quality dashboard in place. The dashboard contained key performance indicators for patients, visitors and staff to see on the wards. The trust had identified further development was required in relation to quality improvement.
- The trust were currently involved in the development of a multi-speciality community provider model (MCP).
- Patient and public engagement was strong. We noted that there were plans in place for a new patient experience structure which included additional staff. Patients had been involved in walk arounds at the trust and children from local schools had been involved in reviewing changes in the paediatric area.

Summary of findings

- The medical director had worked hard to engage the medical leaders and consultants within the organisation since his appointment in October 2017. Staff working in these roles told us that they felt the medical director had made a significant positive impact since his appointment. They also told us that the work and changes he had implemented had made them feel more valued and supported as both clinicians and leaders.
- Patient and staff stories were included in board meetings. The trust had improved patient experience, for example a fruit stall was now in operation outside the main entrance and the children's play area had been refurbished. Patients and governors had been involved in walk rounds.
- The trust was compliant with the requirements of the Fit and Proper Persons regulation.
- The trust were being proactive to address recruitment issues. Staffing reviews had been undertaken, and business cases had been approved. The trust were also offering staff incentives to improve recruitment.
- The trust had commissioned independent reviews and had drawn up action plans as a result. There was an audit committee at the trust who commissioned external, professional advice. There was an audit plan in place that was updated regularly.
- There were good systems of accountability for medicines via the medicines management group to support governance and management of medicines throughout the trust.
- There was a cost improvement plan in place; schemes had been identified to support this, for example through land sale and a reduction in bank and agency staff.
- The trust were investing in a digital trust programme to develop a full electronic patient record.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement →← Apr 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Russells Hall	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018
Overall trust	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement →← Apr 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018	Good ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018
Community	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Overall trust	Requires improvement ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018	Good ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018	Requires improvement ➔➔ Apr 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Russells Hall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓↓ Apr 2018	Requires improvement Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement →← Apr 2018	Inadequate ↓ Apr 2018	Inadequate ↓ Apr 2018
Medical care (including older people's care)	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Surgery	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Critical care	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement →← Apr 2018
Maternity	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Services for children and young people	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018
End of life care	Requires improvement Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Outpatients	Good Mar 2014	N/A	Good Mar 2014	Requires improvement Mar 2014	Good Mar 2014	Good Mar 2014
Overall*	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Overall*	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute health services

Background to acute health services

The trust provides all the acute services we inspected from the Russells Hall location.

Summary of acute services

Requires improvement 

Our rating of these services stayed the same. We rated them as requires improvement.

The summary of acute services appears in the overall summary of this report.

Russells Hall Hospital

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Dudley
West Midlands
DY1 2HQ
Tel: 01384456111
www.dgoh.nhs.uk

Key facts and figures

Russells Hall is part of The Dudley Group NHS Foundation Trust. Core services provided at Russells Hall include urgent care, medical care, surgery, children and young people, maternity, outpatients, diagnostics, end of life and critical care. The trust has approximately 629 inpatient beds, 21 escalation beds and 152 day case beds. The trust employs around 4,147 whole time equivalent staff (WTE).These included 482 medical staff, 1,225 nursing staff and 2,440 other staff

Summary of services at Russells Hall Hospital

Requires improvement

Our inspection of the trust covered only this hospital and community services. What we found is summarised within the overall summary.

Urgent and emergency services

Inadequate 

Key facts and figures

The trust had one Emergency Department (ED), located at Russell's Hall hospital. At the time of our inspection, the hospital was building a new front entrance to the emergency department and building works were underway during our inspection with a planned completion date in 2018.

Russells Hall hospital is located in the heart of the Black Country area it covers a population of around 450,000 people in mainly urban areas. The emergency department (ED) provides care for the population at Dudley, Stourbridge and the surrounding towns and villages, 24 hours a day, seven days a week.

The trust also provides a paediatric emergency department, but during our inspection on 5th and 6th December 2017, it did not provide a 24-hour service. Opening times for paediatric ED varied depending on the adult follow up clinic, which was held at the paediatric ED. Staff from ED covered this clinic each morning.

The paediatric emergency department was a small area within the main department and consisted of a small reception area with a corner for children to play with toys, three cubicle spaces and one triage room. The area was very small and cramped however; staff told us that there new emergency department will provide a paediatric 24 hour service. The paediatric department was segregated from the main department by lockable doors which were only accessed by authorised staff using a swipe card system.

The main ED consisted of a dedicated ambulance triage bay with 12 cubicles, and a separate triage room for patients. A four-bedded resuscitation area, with one dedicated space for paediatric patients. A six-bedded clinical decision unit (CDU), 16 treatment cubicles in the majors area (nine that were used for newly presenting patients and seven High Dependency cubicles to monitor patients who are not yet ready to be transferred to a ward), plus a dedicated cubicle for a trial 'fit to sit' area with two chairs. There were five further treatment cubicles in the minors' area with a dedicated ophthalmology assessment room.

Once a decision is made that a patient requires an inpatient bed; patients either access the emergency assessment unit (EAU), that is split into 18 cubicles or one side room, with an additional area with three trolley spaces, five beds and a further eight beds specifically for frailty assessment.

Patients also have access to the Ambulatory Emergency Care Unit (AECU). Patients can also be directly admitted to paediatrics department (only during opening times), stroke unit, and cardiology unit when appropriately referred from other settings.

There were 180,001 attendances from April 2016 to March 2017 at The Dudley Group NHS Foundation Trust. The percentage of attendances resulting in an admission was 16.5% which was lower than the England average of 21.6%. This had also decreased from 2015/16.

Between January 2017 and April 2017, there were 65 reported deaths within the emergency department.

There was an urgent care centre co-located with the emergency department. An external provider ran this centre. At the main ED reception desk a 'streaming nurse' who worked for the urgent care centre (UCC), saw all self-presenting patients who attended ED at the hospital. Patients with minor illnesses or injuries were diverted either to UCC or to the minors' area within the emergency department.

The UCC was located further down the corridor from ED and both ED and the UCC shared the same reception area.

Urgent and emergency services

We carried out an unannounced visit at ED on 5 and 6 December 2017 followed by a focused unannounced inspection on January 11, 2018. During our focussed unannounced visit on 11 January, we found that CDU had closed and another ward named IMAU (Intermediate Medical Assessment Unit) had opened in its place. We also re-visited the department due to concerns found on 16 and 17 January 2018.

ED at Russells Hall hospital was last inspected by CQC in March 2014, as part of the new hospital inspection programme and a follow up to the Keogh review that took place in 2013.

At that time urgent care services were rated as 'Requires Improvement'

We inspected the service to determine if it was safe, effective, caring, responsive, and well led. We found 'safe' and 'well-led' domain had significantly deteriorated. During our inspection, we took on board the challenges ED faced due to the building works, however this did not affect the conclusion of our ratings.

We reviewed 88 patient records throughout our inspection and we spoke with 24 staff and 12 patients.

Summary of this service

Our rating of urgent care services went down. We rated it as inadequate because:

- The emergency department was not providing safe, effective and responsive care and treatment and the care and treatment provided at times exposed patients to the risk of avoidable harm.
- Safeguarding procedures and processes in place to safeguard and protect vulnerable patients were not always used. We saw examples where this had led to children being exposed to unacceptable levels of risk.
- Patients presenting to the emergency department did not always receive robust and sufficient assessment of their clinical presentation and condition. This posed a significant risk that life threatening conditions would not be identified and treated as quickly as they should have been. We saw examples of patients who had deteriorated unnoticed due to this lack of robust assessment. In some cases, patients waited up to two hours and 30 minutes before receiving an assessment by a trained clinician.
- The triage process in use in the department had been adapted without any evidence base or testing. This had resulted in patients not receiving timely triage and potentially delayed lifesaving interventions. Staff were also unaware of the triage system in use and could not articulate how they reached their decisions to clinically prioritise patients. We saw examples where patients had been triaged into incorrect categories and had deteriorated while waiting to be seen.
- Staff did not monitor patients closely to recognise and treat those at risk of deteriorating. Clinical observations were not undertaken in a timely and consistent manner. In some cases, we saw that patients had deteriorated but this hadn't always been noted by staff. In one case, we saw that a patient, who presented with signs of an illness, had not received observations or any interaction with staff for over five hours.
- Staff did not always follow processes and evidence based pathways to ensure patients were cared for safely and effectively. An example of this was that senior clinicians amended a national early warning score system to remove one key indicator of serious illness. This was undertaken with no consultation with the medical director or evidence base and the rationale provided was that it was identifying too many ill patients and generating too many emergency calls.
- Patients brought into hospital by ambulance crew were not always handed over to the department promptly; this was an issue for both hospital staff and ambulance crew. From June 2016 to May 2017, there were 261 black breaches at the trust's ED. January 2017 saw the highest number of breaches (74).

Urgent and emergency services

- Managers failed to ensure staff had completed their mandatory training.
- Patients with suspected sepsis were not identified or managed appropriately. We saw examples were patients had not received the care they required because of this.
- We saw patients were not wearing allergy wristbands, allergies were not easily identified unless records were consulted or reviewed.
- Managers did not check or review Patient Group Directives regularly.
- There were no separate waiting areas for children in the main emergency department, when children's ED was closed.
- There was lack of space to make reasonable adjustments in cubicles and resuscitation area in the main ED. Patients could not always be observed from the nurses' station.
- Consultant cover at the weekend in ED did not meet required standards with eight hours cover instead of the recommended 16 at weekends.
- There were no x-ray vetting systems for missed fractures. However, when this was highlighted to the trust they took immediate action to review the situation and produce a clearer standard operating procedure to support the process. This led to the utilisation of a red flag process. This is where a red flag is attached to any x-ray where the radiographer identifies any potential abnormality which would include a suspected fracture.
- Patients' dignity and privacy was not always respected. We saw examples where patients were exposed in publicly viewed areas and patients received clinical interventions in public areas.
- We saw patients in cubicles who did not have their nurses call bell close to reach, and some were in cubicles away from the nurses' station.
- We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors at peak times. Patients frequently and consistently experienced unacceptable waits. Staff did not always follow the escalation policy in use to ease and manage patient flow effectively.
- Governance systems were not robust and did not ensure safe and effective care was being delivered. The culture within the department was not open and senior staff did not recognise significant areas of risk and potential harm to patients.
- We saw that risks in the ED were not always recognised and mitigated. An example of this was that the leaders within the department were unaware of the majority of the risks identified during the inspection including lack of safeguarding compliance.
- Senior staff within the service were out of touch with the reality of the quality of care and treatment provided in the department. They were unaware of key risks and took assurances from processes which were not being used and exercised by frontline staff.
- Senior clinicians within the department did not engage or embrace opportunities to improve the practice within the department and failed to recognise and accept areas of poor practice and compliance.
- Senior leaders in the department frequently used overcrowding as a rationale for the significant lapses in care we identified. However, in a number of cases where we identified issues, the department was overstaffed and had significantly less patient attendances than the department's daily average.
- We found cases where patients had suffered serious harm because of lack of implementation and compliance with recognised systems.

However:

Urgent and emergency services

- Staff knew how to report some incidents and managers investigated these incidents.
- Staff supported and provided new staff with an individual induction plan to ensure the skills they bought with them were recognised and any additional training required would be identified.
- Agency staff we spoke with felt supported, and were given a full induction of the department.
- We saw some examples of positive local leadership in the emergency department especially on day two of the inspection.
- We saw that there were provisions in place for patients with a learning disability and dementia and well-being workers were having a positive impact on the service.
- The trust had a psychiatric liaison team available 24 hours seven days a week and an on call psychiatrist available 24 hours a day, seven days a week.
- ED staff we spoke could clearly describe how to make an urgent referral for mental health patients.
- ED staff alerted relevant mental health assessment teams who would respond within the set timescale.
- Staff had access to interpreters to aid communication with patients who could not speak English as a first language or people with hearing difficulties.

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- Safeguarding procedures and processes in place to safeguard and protect vulnerable patients were not always used. We saw examples where this had led to children being exposed to unacceptable levels of risk. In six out of eight records, we found that appropriate action had not been taken to safeguard children from the risk of abuse or actual abuse.
- The compliance levels for safeguarding training were lower than the trusts target of 90%. The compliance level for medical staff with level three children's safeguarding was 51%. The compliance level for nursing staff for safeguarding children level 1 and 2 was again lower than target at 66%.
- Patients presenting to the emergency department did not always receive robust and sufficient assessment of their clinical presentation and condition. This posed a significant risk that life threatening conditions would not be identified and treated as quickly as they should have been. We saw examples of patients who had deteriorated unnoticed due to this lack of robust assessment. In some cases, patients waited up to two hours and 30 minutes before receiving an assessment by a trained clinician.
- The triage process in use in the department had been adapted without any evidence base or testing. This had resulted in patients not receiving timely triage and potentially delayed lifesaving interventions. Staff were also unaware of the triage system in use and could not articulate how they reached their decisions to clinically prioritise patients. We saw examples where patients had been triaged into incorrect categories and had deteriorated while waiting to be seen. We were not assured staff had enough support and information on the triage process and system through-out our inspection.

Urgent and emergency services

- Staff did not monitor patients closely to recognise and treat those at risk of deteriorating. Clinical observations were not undertaken in a timely and consistent manner. In some cases, we saw that patients had deteriorated but this hadn't always been noted by staff. In one case, we saw that a patient, who presented with signs of an illness, had not received any observations or any interaction with staff for over five hours.
- Staff did not always follow processes and evidence based pathways to ensure patients were cared for safely and effectively. An example of this was that senior clinicians amended a national early warning score system to remove one key indicator of serious illness. This was undertaken with no consultation with the medical director or evidence base and the rationale provided was that it was identifying too many ill patients and generating too many emergency calls.
- The Emergency Department (ED) consistently missed the standards around caring for patients promptly; required patients were not always seen for a face-to-face assessment within the 15 minutes of registering on arrival.
- The arrangements for monitoring patients directed back to the waiting room after triage were unclear. We found examples where triage had not been applied correctly, and patients had deteriorated as a result.
- Patients' arrival times were not entered on the system until they had seen the streaming nurse; there were no system in place to see how long patients were waiting in the streaming queue, which caused concerns, especially those who were at significant risk to deteriorate. This streaming involved a very brief history taking of the patients presenting problems at the front desk of the emergency department; it did not include any assessment of vital signs, clinical examination, or other detailed enquiry. From the streaming service, patients were streamed into triage for an assessment by the emergency department nurse, the UCC or to minors' area. If patients were streamed to the minors' area, they did not receive a documented clinical assessment until a clinician in this area saw them, in some cases this could be over two hours after their initial presentation.
- The criteria for streaming patients was not always followed correctly and this resulted in patients with more serious conditions being directed to the minor's area.
- Managers failed to ensure staff completed their mandatory training. The trust had set a target of 90% for completion of mandatory training. In Urgent and Emergency Care medical and nursing staff failed to meet the target, with medical staff having 67% compliance and nursing staff having 86% compliance overall. There were no plans in place to address the low levels of compliance.
- We saw examples where fridge temperatures in the resuscitation area had exceeded temperatures up to 15 degrees from August 2017. However, the fridge was only replaced in November 2017, three months later.
- We saw in CDU the resuscitation medication box was in use despite having an expiry date of November 2017.
- We saw copies of PGD's (patient group directions) that were available on the trust internet, we looked specifically at ED, PGD's, and at least three had expired.
- We saw patients were not wearing allergy wristbands, allergies were not easily identified unless you read records or reviewed the online medication chart.
- On 5 and 6 of December, 2017, we identified that staff were not completing National Early Warning Scores (NEWS) correctly or in line with trust internal policy or acting on these scores appropriately or in line with trust internal policy and process. We reviewed 24 records and 19 were not completed accurately or included a calculated score.
- Staff did not monitor patients on the sepsis pathway or at risk of deteriorating closely or those at risk of deteriorating. In one case, the inspection team had to intervene to ensure a patient was reviewed and attended to as a matter of urgency. This patient in particular was admitted early in the morning and placed on the sepsis pathway, but did not receive antibiotics until two hours later and did not receive timely observations. The trust are currently undertaking a serious incident review into this case.

- Staff told us that senior clinicians in the ED had made a conscious decision to not include oxygen saturation (spo2) scores in their NEWS. When these findings were highlighted to the trust, one of the ED consultants said that if they were included it would trigger too many medical emergency calls.
- As of June 2016 to May 2017, there were 261 black breaches at the trust's ED. Black breaches are defined as patient handovers from ambulance arrival to ED, which take longer than 60 minutes. Most of these breaches occurred from November 2016 to January 2017. Most notably, January 2017 saw the highest number of breaches (74).
- A letter of formal concern was sent to all local trusts from a local ambulance service, raising concerns around patient safety and turnaround times. The letter explained their concerns on the situation with patient handover delays, stated, "It has now become untenable". "The delays are worsening, patients are being put at significant risks of harm, and on a daily basis are stacking emergency calls across the Black Country, and these are emergency calls where the patient needs an ambulance and no vehicle to respond to the patient". The trust responded immediately to the ambulance service and they work very closely, there has been a significant improvement in all areas.
- The ambulance crews we spoke with, throughout our inspection raised the same concerns as the letter we reviewed.

However:

- Incident management and reporting incidents were encouraged throughout ED. Incidents were recorded, reviewed and the learning from incidents were shared. Staff we spoke with understood how and when to report some incidents, staff also told us outcomes from incidents were disseminated down to front line staff. However, we saw lessons learnt from incidents were mainly disseminated down to nursing staff not medical staff. However, we found that staff had not recognised numerous incidents identified during the inspection; these included serious lapses in the care of patients.
- The trust had an observation policy and restraint policy. Staff we spoke within ED were aware of the observation policy and restraint policy. There were no restraints of patients with mental illness in the three months before the inspection.
- Infection prevention and control (IPC) measures were in place to ensure patients were protected against hospital-acquired infections whilst in the department.
- Medicine management appeared to be generally good with medicine cupboards and fridges locked, and in a separate room behind a push button coded lock.
- Medicines documentation and processes were generally good. We saw evidence that problems that arose were identified and quickly resolved through collaboration between nurses and pharmacy staff.
- Staff training around intravenous infusion therapy, medicine management, and drug calculations was provided by the trust.
- Nurse staffing levels met with local standards on all days of the inspection and we found that the trust board had introduced additional staffing over and above required levels.
- The department was clean and equipment was well maintained.
- The care of patients with mental health conditions was good. All triage records where possible mental illness was identified included completion of three deliberate self-harm questions to assess the risk of the patients harming themselves. In all records, the patient had answered no and no further action was taken.

Urgent and emergency services

Is the service effective?

Requires improvement

We rated it as requires improvement because:

- Patients did not always receive evidence based care and treatment. We saw that certain pathways and guidance in use followed national guidance and best practice, however, during our inspection; we saw a lack of understanding and that these pathways were not always followed. This meant patients did not receive evidence based care and treatment at all times.
- Patient outcomes were measured and in some cases were worse than expected when compared to national standards. We found that where audits measuring outcomes for patients had shown room for improvement, the service had not actioned these areas.
- In the 2016 CQC Emergency Department Survey, the trust scored 4.3 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. During our inspection two patients waited over an hour for their pain relief, and one patient in particular was shouting out in pain. No pain relief had been administered since the ambulance crew administered relief on the journey to the hospital. There was no action plan in place to address this finding.
- We saw audits results from the trust engagement with Royal College of Emergency Medicine (RCEM). In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the standards. The trust was placed in the lowest quartiles, performing worse than other trusts for two fundamental standards and similar to the national average for six standards. The service had not taken action in response to the findings of this audit.
- In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the four standards (all of which were set at 100%). However, their performance was similar to the national average for three out of the four standards and worse for one. The service did not have an action plan in place to address any of the areas for improvement identified in this audit.
- In the 2016/17 Severe Sepsis and Septic Shock audit, the trust failed to meet any of the standards (all of which were again set at 100%). However, they performed similar to the national average for all measures. Following the inspection the trust sent us a copy of the sepsis group action plan (2016) and the sepsis CQUIN compliance audit (May 2017) that had been completed by the trust, prior to our inspection.
- In the 2015/16 Vital signs in children audit, the trust failed to meet any of the standards (which were set at 100%), but its results were similar to the UK average for all but one standard. The service did not have an action plan in place to address the areas for improvement identified.
- In the 2015/16 Procedural sedation in adults' audit, the trust failed to meet any of the audit standards (which were all 100%). However the trust performed in the top 25% of all trusts that submitted data to this trust:
- From October 2016 and September 2017, the trust's unplanned re-admissions r rate to A&E within seven days consistently breached the 5% standard, as did the England NHS overall. However, the trusts rate was consistently better than the England average.

The trust reported that as of June 2017 Mental Capacity Act (MCA) and Mental Health Act (MHA) training had only been completed by 88% of staff within Urgent and Emergency Care. This did not meet the trust target of 90%.

However:

- We saw that fluid and food charts were used to monitor patients' intake and output. In addition, we saw volunteer staff, who carried out regular comfort rounds to offer snacks and drinks.
- We observed staff gaining consent throughout our inspection, before any tasks were undertaken. Staff we spoke with were aware of the Gillick competence which is a term 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.
- Multidisciplinary team working was evident throughout ED service with disciplines external to the department. We saw numerous examples of good MDT working between medical and surgical team and the psychiatric liaison team; this was also seen in patient records that we reviewed.
- Staff we spoke with from both the psychiatric liaison service and the trust mental health assessment service described good relationships with ED staff and stated ED staff refer and handover appropriately to both teams.
- ED staff sought support from mental health staff and ward staff for patients who presented with dementia type illness. Staff on the hospital's dementia ward liaised closely with ED staff regarding patients who presented and told us that ED staff alerted them in a timely manner when patients arrived.
- Staff had access to support from radiography, pharmacy, and specialist services 24 hours a day, seven days a week. Support by other services was provided on an on-call basis outside normal working hours.
- Staff were able to access clinical guidelines and local policies via the emergency department section of the trusts intranet.
- Newly qualified nurses completed a yearlong development programme before being signed off as competent in emergency nursing. Nurses' progress was reviewed at regular intervals throughout their first year, and any specific training needs were addressed as they were identified.
- We spoke with four senior nursing staff in the ED department; all showed a good knowledge of the Mental Health Act and Mental Capacity Act. Staff were unware of whom the mental health advocacy service were. However, they were aware they could access the mental health teams for support and the mental health teams knew who the advocacy service was and how to access them for patients.
- If patients were detained under the Mental Health Act, they would be supported to move to another service, either within the hospital or within an external service appropriate for their needs.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- The observation rooms for assessing mental health patients were situated in a busy corridor and both doors had unobstructed windows, which meant passing members of staff and public, had a clear view into the room. This could of affected someone's privacy and dignity.
- From October 2016 to September 2017, the trust's Urgent and Emergency Care Friends and Family Test performance (percentage recommended) was in general worse than the England average. From October to December 2016, the trust's score was higher than the England average, peaking at 93.8% in October 2016 compared to the England average of 86% for the same month. This was followed by a decline in performance from December 2016 through to August 2017, where the trust scored 72.5%, which was lower than the England average of 88% for the same month.

Urgent and emergency services

- We saw examples of staff failing to maintain patient dignity and privacy in CDU and ambulance triage. One patient was hoisted on a busy corridor and no blankets were used to maintain the patients' dignity, and no curtains were used to promote privacy. We also saw one patient being transferred by using a pat slide from a trolley to a bed, in a busy corridor, outside a reception area within the ambulance triage department.
- We saw four patients in cubicles who did not have their nurses call bell close to reach and some patients were away from the nurses' station.
- The children's emergency department was only open for specific periods during the week; many children were seen in the adult emergency department, where they were potentially exposed to hostile sights and sounds.

However;

- Staff were observed speaking with patients waiting on the corridor, and explaining the reasoning behind the waits.
- Staff were observed reassuring patients and their relatives, patients' told us they felt at ease.
- Staff told us that they were frustrated by the inability to move patients out of corridors and out of their departments, to the wards or to the community quick enough; but this frustration never affected their role to care for their patients'.
- Patient told us how friendly staff were, 'although the wait can be long, the staff find a way to be attentive even when they are extremely busy'.
- We were given mixed feedback around patient relative's involvements. Some relatives said they were waiting for hours before any staff would update them on progress, and others we spoke with said they were kept up to date on their relative's condition and were involved in the care planning.
- Patients were happy with the volunteers who provided snacks and drinks throughout the day.
- Patients were encouraged to tell staff if they had any issues or problems, we heard the reception staff confirming how long of a wait there was to see the triage nurse.
- We saw chaplaincy service was available. During our visit at CDU, we met the trust chaplain, who was on their routine visit to the unit.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Patients frequently and consistently experienced unacceptable waits.
- 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 ED. Between November 2016 and October 2017 the trust only met this standard once in March 2017 (96%). This was followed by a period of deterioration in performance to August 2017(87%), the worst performing month for the trust. However, in a number of months the trusts performance was similar or better than the national average.
- Staff working in ED expressed their frustration with patient flow and not being able to move patients through departments quickly. Many issues were around space and building works..
- As of November 2016 to October 2017, the Dudley Group NHS Foundation Trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average. However, since March 2017, performance against this metric showed a trend of decline.

Urgent and emergency services

- As of October 2016 to September 2017, the monthly median percentage of patients leaving the trust's urgent and emergency care services without being seen was better than the England average. However, we saw a general decline in performance for the trust with the percentage of patients leaving each month increasing.
- We found that at the time of our inspection the service was not providing a service which met the needs of children who presented there. The children's emergency department at the time of the inspection was unable to provide a full 24 hours a day seven days a week service for children attending the emergency department at Russells Hall Hospital. The trust commenced a trial of 24 hour opening; however, this is only made possible with the utilisation of high levels of agency nursing staff. This trial commenced after the conclusion of our inspection.
- The children's emergency department only a complement of three qualified children's nurses, which was not sufficient to operate a 24hours a day seven days, a week service.
- The trust had not undertaken a "You're Welcome" audit and it was therefore not possible to evaluate how young person friendly the emergency department or the trust was. The Department of Health (DH) You're Welcome - Quality criteria for young people friendly health services was first published in 2005 with the objective of helping commissioners and providers of health services to improve NHS and non-NHS health services.
- Children, who arrived outside the opening hours of children's ED, were triaged by an adult nurse and then seen in an adult environment.
- The transfer of children to the paediatric ward was via the back entrance to the children's emergency department that opened onto a long, cold, and featureless corridor. Children were trolleyed along this corridor with on many occasions, an unqualified health care assistant. This poses a risk if the child deteriorates en-route to the ward.
- Patients brought into hospital by ambulance crew were not always handed over to the department promptly; this was an issue for both hospital staff and ambulance crew. When we spoke to the ambulance crew, one paramedic said "it is rare to be able to handover patients within 15 minutes".
- Another crew member went on to say, "the ambulance triage department does not seem to have enough nursing staff,", "nurses have to do so much before we can handover our patients, this is putting pressure on us as crew members, as we cannot be on the road doing our jobs". During our inspection, we observed nursing staff in the ambulance triage unit, we saw one band six nurse who was expected to perform a multitude of tasks that appeared to be irrelevant for her triage role. This band six nurse was doing all the above tasks and expected to take handovers from ambulance crew; ambulance crews and nursing staff said this was the main reason behind the delays for crew to handover. Staff also told us they could go for nearly 12 hours without having a break.
- As of August 2016 to July 2017, there were 53 complaints (17%, of total complaints received by the trust).
- The trust took an average of 37 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 40 days. However, there were 13 complaints that took 40 days or longer to investigate and close. Of those, four took over 60 days to close.
- Clinical treatment was the most complained about subject, accounting for 58.4% of all complaints.

However:

- Staff were positive about the responsiveness of security staff within the hospital, when they were called they attended the department very quickly.
- Staff had access to interpreters to aid communication with patients who could not speak English as a first language or people with hearing difficulty. For people who presented at ED with a learning disability, staff could use Makaton, a system of signs and symbols used to help with communication.

Urgent and emergency services

- We saw there were designated learning disability (LD) nurses for the trust who offered support to staff, carers, and patients in order to manage care appropriately while in hospital. The LD nurse worked with known carers in the community to offer support for them should they need to present at ED.
- Psychiatric liaison teams communicated with relevant community teams to provide details of discharge plans as appropriate.
- There was a lead for mental health within the hospital that was able to give advice and support, there were drug and alcohol liaison nurses available for patients presenting with substance misuse who were able to provide advice, support, and direct input to the service. There were also lead practitioners in learning disabilities and dementia.
- There was a designated mental health assessment team and a learning disability nurse working for the trust. There was also a psychiatric liaison team available 24/7 to see medically fit patients in ED.
- Staff knew how to deal with complaints and how to de-escalate a challenging situation.
- The trust has been working closely with capacity lead and local ambulance crew. This is due to the increase of activity in ED and winter pressures. There was an agreement between the trust and local ambulances to have a total of three Hospital Ambulance Liaison Officer's (HALO) working at ED to help with handovers and patient flow.

Is the service well-led?

Inadequate 

Our rating of well led went down. We rated it as inadequate because:

- Senior staff within the service were out of touch with the reality of the care and treatment provided in the department. They were unaware of key risks and took assurances from processes which were not being used and exercised by frontline staff. Senior clinicians within the department did not engage or embrace opportunities to improve the practice within the department and failed to recognise and accept areas of poor practice and compliance.
- We found that the emergency department governance, risk management and quality measures to improve patient safety, care and outcomes were not effectively monitored, we were not assured the trust leadership were managing risks robustly, however towards the end of our inspection, the trust had created an action plan and were put into place to improve risks and patients safety.
- Staff were not aware of the trust values or vision. There was no locally established vision or values set.
- There was a culture of insularity within the department and we found that staff blamed overcrowding for poor compliance with safety measures and poor practice. Senior staff used overcrowding as a rationale for lapses in care we identified. However, in a number of cases where we identified issues, the department was overstaffed and had significantly less patient attendances than the department's daily average.
- Staff did not recognise poor and potentially dangerous practice at all levels. Staff did not consult with the wider trust and board and national evidence bases.
- Staff did not recognise poor and unsafe practice and therefore did not challenge this. An example of this was staff using 'department busy' as a rationale for not safeguarding a vulnerable child. Another example was observed during the inspection whereby the inspection team had to intervene and request assistance for a very unwell patient. When senior staff were asked about this case and what they would do to investigate and do differently, they responded that 'it happened all the time'. This gave the impression that staff accepted poor practice and did not learn from significant incidents and near misses.

- We felt that staff, particularly senior staff, were not entirely sure, of the requirements of duty of candour. Duty of candour means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.
- Governance systems in use in the department were not robust and did not ensure safe and effective care was being delivered. Senior staff within the department, division and trust were unaware of key risks and took assurances from processes which were not being used and exercised by frontline staff.
- There was no overall governance for the holistic management of children over the age of 16 who (with some few exceptions) are cared for in adult clinical domains.
- We saw that risks in the ED were not always recognised and mitigated. An example of this was that the leaders within the department were unaware of the majority of the risks identified during the inspection including lack of safeguarding compliance. Senior staff were unaware of key risks and therefore had not implemented any mitigation.
- We did not see any examples of engagement with patient groups or the public.
- We requested to see the level agreement or contract governing the arrangements between the hospital and UCC. The trust informed us that there was no contract in existence between the trust and the provider for UCC and this was dealt through clinical commissioning group (CCG). This was despite the UCC undertaking duties at the trust.
- During January 11 focused inspection, we found there was an overall insufficient management oversight and governance of the IMAU and in particular the use of the NEWS and the management of the deteriorating patients. There were no effective systems in place

And they were not monitoring or mitigating risks to patients' welfare.

- The arrangements for management responsibility for IMAU area were not clear or robust. The chief nurse and medical director told us that the unit was an extension of ED and fell under the responsibility of ED nursing leadership. When we spoke with the management team, they were unaware that the measuring and monitoring system in place within ED did not extend to IMAU.
- There were no standard operating procedure (SOP) or admission criteria for IMAU to ensure patient were transferred appropriately.

However:

- The lead mental health nurse for the trust had rolled out training to staff across some wards in the hospital regarding mental health awareness. This was measured on the wards that had completed this for its effectiveness and preliminary learning assessments had found improvements in staff knowledge and management of patients experiencing mental illness.
- The ED matron told us they were hoping to have 24 hours seven days a week children's ED and the date we were given was January 2018.
- Staff told us they were aware of and involved with the consultation process for the design of the new build ED.
- Staff in ED all displayed a positive culture of wanting to improve the service they provided to their patients.
- All the staff we spoke with were proud to work at the hospital, the team with whom they work with and the care they provided for patients.
- Clinical and non-clinical staff, regardless of grade, told us they felt part of the ED team and were valued and treated with respect by their colleagues and managers, this was mainly expressed from matron down to front line staff.

- Health care workers felt they were supported to progress in their role. One Health care worker had recently become a band 3 and felt she was encouraged throughout her training. We spoke to a 'novice' staff member who was on training within ED who had come from a non-clinical background and felt supported by all members of staff in ED to progress in her new role of becoming a band two.
- Staff told us they received regular newsletters, which gave updates on developments in the department; details of upcoming training and meetings staff could attend; feedback from staff and patients; information about the department's risks; and any other useful information.
- Staff told us they had a social media closed forums in place where staff were encouraged to share learning.
- The chief nurse was named and respected throughout ED, staff were encouraged to raise their concerns and felt their concerns would be dealt with.
- We observed matrons working with nursing staff providing advice and taking regular patient updates and handovers from front line staff to ensure they were kept up to date on the department.

Areas for improvement

We found 14 areas for improvement in this service. See areas for improvement section of the report.

Medical care (including older people's care)

Good ➔➔

Key facts and figures

The hospital provides a wide range of medical care services primarily based at the Russells Hall Hospital site. Patients with acute medical conditions are assessed and their treatment commenced by a multi-professional acute medical team. Patients are referred from the emergency department or primary care. Patients have an initial assessment and treatment. They are either discharged or transferred to a specialty ward appropriate for their condition, usually within 72 hours of arrival.

The medical care service at the trust provides care and treatment for a number of specialties including, elderly medicine, stroke, gastroenterology, respiratory, haematology, cardiology, endocrinology and cardiology. There are 328 medical inpatient beds located across 14 wards;

West A4 – Elective medical unit (EMU): eight beds

Post coronary care unit (PCCU): 16 beds

Cardiac recovery: six beds

Frail elderly assessment: eight beds

Renal unit: 25 beds

East C1: 48 beds

East C3: 52 beds

West C4 Georgina: 22 beds

West C4 Day case: 15 beds

West C5: 48 beds

West C7: 36 beds

West C8 – Hyper acute stroke unit (HASU): 12 beds

West C8 – Acute stroke unit (ASU): 12 beds

West C8 – Stroke rehab: 20 beds

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 49,315 medical admissions from August 3016 to July 2017. Emergency admissions accounted for 28,683 (58%), 551 (1%) were elective, and the remaining 20,081 (41%) were day case.

Admissions for the top three medical specialties were:

- Acute Medicine: 23,412
- West A2: 42 beds
- Gastroenterology: 8,267
- Rheumatology: 2,680

Medical care (including older people's care)

(Source: HES - CQC Insight)

At the previous inspection, medical care has been rated as good across all five domains. However, there were concerns about the delays in the flow of patients through the hospital. Some patients had to wait for long periods and were subjected to multiple moves within the directorate. Actions had been taken to improve the situation with the introduction of the frail elderly short stay unit. However, this remained an area of improvement for the trust.

The directorate had piloted a dementia care bundle (a small set of evidence-based practices and processes to improve care) but had yet to introduce the bundle across services which would improve outcomes for people living with dementia.

At this inspection we visited 11 wards:

C7 – Gastroenterology

Coronary care –cardiology and post coronary care

Oncology

Hyper acute stroke unit, acute stroke unit and stroke rehabilitation

Respiratory ward

Acute Medical Unit

Catheterization laboratory

Frail elderly assessment unit and, renal unit.

We looked at 15 patient records, spoke with 29 patients and 15 friends and family and a number of staff who worked in medical care. Staff interviews included volunteers, consultants, doctors, nurses, care support workers, physiotherapists, occupational therapist and speech therapists

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Medical care wards were designed to ensure access, flow and discharge was effective while keeping good patient outcomes and safety in mind.
- The department had good systems and processes in place to manage sepsis by introducing bundles, sepsis leads and direct dial numbers to contact the right people who were required to intervene.
- Staff had maintained their caring and supportive approach when dealing with patients despite significant increases in pressure as a result of staffing pressures. Feedback from people who used medical care wards was overwhelmingly positive.
- Manager's, senior nursing staff and clinicians worked closely together to identify areas where the service and patient experience could improve.
- Staff worked well as teams and felt supported by managers and felt valued by the trust as employees.
- There were quality boards throughout medical care and quality information shared with teams, patients and relatives to keep them up to date with what was happening on the wards.

However:

Medical care (including older people's care)

- Staffing remained an issue and there were a significant number of vacancies and bank and agency work across medical care wards. However, this was managed well and bank staff were well inducted into all areas were they worked.
- The trust did not always engage with national audits. There was evidence of how the service had reviewed local audit results and implemented changes to improve performance.
- Staff did not always meet targets for completion of mandatory training.
- Staff did not always carry out full safety checks in the catheter laboratory of all countable items during operative procedures. For example, they carried sharps checks but did not swab count which would be good practice.
- Patient medicines were not always appropriately disposed of to avoid harm

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- Managers and staff took a strategic approach to meet targets set out for mandatory training. As a result, there were significant improvements.
- The trust tasked practice development nurses and senior staff with monitoring and managing compliance.
- Staff provided us with evidence of knowing and understanding the importance of safeguarding all who accessed services. There were some gaps in mandatory safeguarding training at level 3; however, nursing and medical staff working within medicine were meeting the target for adult and children's level 1 and 2 safeguarding.
- The trust employed a safeguarding lead and staff we spoke with could describe the process for referral and escalation when a safeguarding issue had been identified.
- The environment was clean, staff displayed good infection prevention control and there were systems in place to audit and improve. Technical staff ensured equipment was well maintained and ready for use.
- Staff followed national guidance and used a range of evidence based tools to effectively manage patient risks. Local systems and processes all reflected a culture of reducing harm and improving care. Safety concerns were raised by staff and people who used the service. Staff contributions were viewed as valued and integral to learning and improvement.
- Staff told us they were encouraged to be open and transparent, and committed to reporting incidents and near misses. We saw examples of changes to practice, including a change following a never event, the introduction of resources to support safety and improve outcomes for patients.

However;

- Although, we saw no significant impact on care, Staffing levels continued to be an issue. The trust used a high level of bank and agency staff to cover a high number of vacancies and staff sickness.
- Staff fell short of meeting their statutory obligation to patients to keep them safe from harm. For example, in compliance with Venous Thromboembolism (VTE) risk assessment, safety checks of all countable items to prevent foreign body retention and subsequent injury to the patient and safe dispensing of medications.

Medical care (including older people's care)

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff accessed policies and dedicated teams to deliver local and national priorities. There were dedicated teams, for example, dietetic support to deliver nutrition plans to optimise positive recovery outcomes.
- Staff used care bundles and screening tools to improve outcomes. The service used a combination of national guidelines and policy to determine the care and treatment provided.
- The trust audited to monitor practice and outcomes. There were a number of improvements as a result, for example, the number of falls had improved and there were numerous examples, where staff had demonstrated learning from audits and displayed the steps they would take to improve where things were not going so well.
- Staff were required to have a minimum requirement of skill and competency. There were statutory and mandatory training programmes; there were specialist training programmes and additional training for those requiring specialist skills.
- Staff had access to a range of disciplines to support them in achieving the best outcomes for patients. Staff also had access to career progression programmes and leaders in the teams were supported in achieving leadership training to improve their competencies in management and leadership.
- Staff understood the principles and values that underpinned the legal requirements in the Mental Capacity Act and Deprivation of Liberty safeguards.

However:

- The trust had not always used national audits to help them understand how they compare to national audit findings and how they might improve locally using learning from national audits.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff demonstrated considerate care for patients and others involved with those patients. Patients and their families were respected, valued and where possible empowered to be as independent, and involved in their care as they could be.
- Staff received gratitude by way of thank you cards, gifts and compliments. Staff, past patients and friends and families had been involved in fund raising.
- Patients' had access to a range of religious and spiritual personnel and resources. These could be accessed on site and were accessible seven days a week. Patients, families and carers saw their emotional and social needs were considered and support offered.
- Staff displayed consideration for dignity and privacy based on the individual needs of each patient.

Medical care (including older people's care)

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Staff valued the role of the ward clerks who helped manage waiting times, keep delays to a minimum, discharge and where possible avoid cancellations.
- Patients and other stakeholders gave feedback about their experiences in a range of accessible ways, including how to raise any concerns or issues.
- The trust collected feedback which was used to improve the experience of all stakeholders. Positive feedback was used to share good practice and negative feedback helped to help improve.
- People accessing medical care had their individual needs were considered. Those with mobility issues or who required wheelchair access could do so. There was technology for those with impairments and additional needs, for example hearing loop equipment and translation services.
- Patients with loved ones who wanted to stay overnight could access an en-suite family room. There facilities to make hot and cold drinks and each bathroom had a supply of toiletries.
- Daily board rounds, facilitated by a senior decision maker and attended by the multi-disciplinary team helped improve ward access and flow. In addition members of the executive team attended wards regularly to help identify blockages.
- Patients accommodated on non-medical wards as 'outliers' were well managed and received regular reviews.

However:

- The new discharge lounge, which opened on the day of inspection, was not fully functioning, suitably resourced or effectively supervised to ensure patients received a good quality
- The trust did not provide us with any information on how many patients were moved for non-medical reasons and during out of hours periods.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Staff were supported in achieving their competencies through mandatory and specialist training. They were also assisted and encouraged in their career progression.
- Staff told us they felt supported by leadership and that they worked collaboratively. Staff supported each other with a common focus on improving the quality.
- Staff were encouraged to raise concerns and felt confident to do so. They had access to support when they felt there were issues. This made them feel listened to and valued.
- Staff understood duty of candour and there was a culture of ensuring being open and transparent when mistakes were made.

Medical care (including older people's care)

- There were meaningful quality boards for staff, patients and visitors on display to keep up to date with quality, resources and changes from their local service and across the trust.
- Staff demonstrated the trust values. They were involved in driving improvements and culture of innovation and learning.
- Staff were involved in audits to improve delivery of services. Findings from audits were shared and there was learning and changes to practice as a result.
- Staff were actively engaged in helping shape the service and culture. There were meetings with staff engagement staff and examples of pieces of work to help shape services
- Learning, continuous improvement and innovation was encouraged. Staff won awards and there were many examples of initiatives that demonstrated improvements in patient care, treatment and outcomes.

Areas for improvement

We found five areas for improvement in this service. See areas for improvement section of the beginning of the report.

Critical care

Requires improvement 

Key facts and figures

The trust has 20 adult critical care beds located at Russells Hall Hospital:

- Six intensive care beds (level three)
- Eight specialist surgical high dependency beds (level two)
- Six specialist medical high dependency beds (level two)

The trust is part of the West Midlands Critical Care Network and also provides a critical care outreach service 24/7 to support the management of unwell patients outside of the critical care unit.

(Source: Trust Provider Information Request – Context Acute)

Intensive care (or level three) beds were used for patients requiring support for two or more different systems, such as cardiac and respiratory. High dependency (surgical, medical and coronary care) provided level two care, which is when a single organ is supported.

We visited all the critical care units during an unannounced inspection.

We spoke with nine patients, 12 relatives and 27 staff: they were nurses, doctors, therapists, domestic staff and managers. We observed care and treatment, and looked at the records of 12 patients on the critical care units.

Before the inspection, we reviewed performance information about the hospital.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The intensivist team did not have oversight of all patients admitted to surgical high dependency. Individual surgeons oversaw the care of patients within surgical high dependency, which is not in line with the Guidance for the Provision of Critical Care Services 2015 (GPICS) standards.
- Critical care had not embedded shared governance across all areas. Senior staff in the intensive care unit and surgical high dependency unit did share some information with medical high dependency.
- The critical care units had begun to collect and submit national data. The intensive care unit and medical high dependency unit had submitted data for a number of years; however, the surgical high dependency had begun to submit to Intensive Care National Audit and Research Centre (ICNARC) in October 2017.
- We found a lack of intensivist leadership within the surgical high dependency unit
- Senior staff had a lack of understanding about Duty of Candour, and how and when this should be exercised.
- We found senior staff did not recognise and report all risks within the critical care service. Risk registers did not reflect all the risks within each unit.
- The surgical high dependency unit (SHDU) did not meet the requirements of the Department of Health, Health Building Note 04-02: Critical Care Units for the size and layout of a four bedded critical care bay, with limited space

within bed areas. This did not promote the privacy and dignity of patients. We observed staff knocking into each other when multiple bed spaces had curtains pulled round. We observed staff knocking into curtains and allowing others to see into the bed space due to the lack of manoeuvrability within the unit. The trust was aware of this and had begun risk assessing the environment within SHDU

- We found storage across medical and surgical high dependency units and on intensive care limited. Intensive care stored equipment in empty bed spaces due to a lack of storage.
- A consultant trained in critical care medicine did not routinely review all patients on the surgical high dependency.
- The medical high dependency unit had a shortage of suitably trained consultants to deliver on site care seven days a week.
- We had concerns over the number of suitably trained medical staff available overnight to cover the medical high dependency unit.
- Senior staff told us ICU and SHDU had one incident in 2017 that met the serious incident threshold. We identified other incidents that met the threshold of a serious incident; however, the trust had not investigated or reported these appropriately.
- The service did not demonstrate how staff used the data that was collected to improve patient outcomes.
- We found a mixed approach to multidisciplinary working across critical care. On surgical high dependency, individual surgeons lead the care for patients with intensivist input requested on an as required basis. This is not in line with the Guidelines for the Provision of Critical Care Services 2015 (GPICS).
- The service did not have a dedicated pharmacist for each critical care area. A microbiologist did not attend daily ward rounds in line with GPICS; however a consultant microbiologist was available for advice
- The environment on surgical high dependency did not promote the dignity of patients during personal care or examinations.
- We found limited facilities to occupy patients across critical care, resulting in patients not having activities to undertake during the day. We also found this during the previous inspection with little improvement during this inspection.

However:

- We found changes across critical care in response to the previous inspection. For example, new screens had been ordered for the surgical high dependency unit and intensive care unit to protect and promote the privacy and dignity of patients.
- We found local leaders were visible and staff felt supported by unit managers, matrons and senior doctors.
- Nurse staffing on medical high dependency, surgical high dependency and intensive care was sufficient to meet patient needs and national standards.
- We found staff across critical care treated patients and relatives with kindness, compassion and empathy.
- Staff provided appropriate emotional support to patients and families. We observed compassionate support given to families of patients at the end of life.
- We found patients were involved in decision-making processes about their care. Staff involved relatives, where appropriate, in the decision-making process about the patients care

Critical care

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- Not all critical care areas had a dedicated pharmacist, in line with the Guidelines for the Provision of Critical Care Services 2015 (GPICS). A microbiologist did not attend daily ward rounds in line with GIPCS; however, a consultant microbiologist was available for advice.
- The environment on the surgical high dependency unit was not fit for purpose, with limited space within bed areas. We found storage was limited across medical and surgical high dependency units, and on intensive care. Intensive care stored equipment in empty bed spaces due to a lack of storage.
- Consultants did not consistently document patient reviews in patient records.
- A consultant trained in critical care medicine did not routinely review all patients on surgical high dependency.
- Medical high dependency had a shortage of suitably trained consultants to deliver on site care seven days a week.
- We had concerns over the number of suitably trained medical staff available overnight to cover medical high dependency.
- Senior staff told us ICU and SHDU had one incident in 2017 that met the serious incident threshold. We identified other incidents that met the threshold of a serious incident; however, the trust had not investigated or reported these appropriately.

However:

- Mandatory training rates across critical care were 94%, exceeding the trusts target of 90%.
- The service had met the 90% target for all aspect of safeguarding training, including children and adults training.
- Staff knowledge of safeguarding procedures was good across all critical care areas.
- Hand hygiene audits showed 100% compliance across all critical care areas in October and November 2017.
- Nursing documentation across all areas of the critical care services was well completed and reflected the care provided to patients.
- Medicines were managed appropriately across the critical care services.
- Nurse staffing on medical high dependency, surgical high dependency and intensive care units was sufficient to meet patient's needs.

Is the service effective?

Requires improvement ➔

Our rating of effective went down. We rated it as requires improvement because:

- Not all policies and procedures reflected current best practice, and we found out of date policies which were held on resuscitation trolleys in the intensive care unit.

Critical care

- Senior managers could not demonstrate during the inspection how staff used collected data. Following the inspection, the trust did provide examples of how Intensive Care National Audit and Research Centre data was used to improve patient outcomes.
- We found a mixed approach to multidisciplinary working across critical care. On the surgical high dependency unit, individual surgeons led the care for patients with intensivist input requested on an as required basis. This is not in line with the Guidelines for the Provision of Critical Care Services 2015 (GPICS).
- ICU, MHDU and SHDU had access to a pharmacist; however, the pharmacist also provided support to the surgical, intensive care and theatres division and not only critical care. This was not in line with GPICS (2015), which states critical care environments should have access to a suitably trained and dedicated pharmacist for each critical care area. A microbiologist did not attend daily ward rounds in line with GIPCS; however, a consultant microbiologist was available for advice.
- Staff were unable to describe alternative or non-verbal communication methods for assessing patient's pain within critical care. Following the inspection, the trust told us they did use a communication book for patients unable to verbally communicate.

However:

- Patient's had their pain assessed and appropriate pain relief administered in a timely manner across critical care.
- Staff assessed the nutrition and hydration needs of patients, and the hospital provided food for different dietary requirements (such as vegetarian and Halal).
- Staff had the opportunity to develop within their roles by gaining experience and additional competencies, such as blood taking and outreach skills.
- Appraisal rates for staff were good across critical care.
- Staff knowledge of the Mental Capacity Act and deprivation of liberty safeguards. We found that staff used appropriate procedures to gain consent from patients prior to undertaking procedures.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- We found staff across the critical care service treated patients and relatives with kindness, compassion and empathy.
- Staff provided appropriate emotional support to patients and families. We observed compassionate support given to families of patients at the end of life.
- We found patients were involved in decision-making processes about their care. Staff involved relatives, where appropriate, in the decision-making process about the patients care.
- Staff could access faith leaders from multiple religions to provide support to patients and relatives.

However:

- The environment on surgical high dependency did not promote the dignity of patients during personal care or examinations. We observed staff knocking into each other when multiple bed spaces had curtains pulled round. We observed staff knocking into curtains and allowing others to see into the bed space due to the lack of manoeuvrability within the unit.

Critical care

- The response rate from the Friends and Family Test on surgical high dependency and intensive care was very low. Where the trust received five or more response (so a trend could be identified), these were generally positive. However, the percentage of "would recommend" responses dropped slightly for medical high dependency in October 2017.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- We found limited facilities to occupy patients across the critical care services, resulting in patients not having activities to undertake during the day. We also found this during the previous inspection with little improvement during this inspection.
- Bed occupancy was between 80% and 100% between September 2016 and August 2017, which was consistently above the national average.
- The medical high dependency unit was within the worst 5% of trusts for discharging patients within eight hours of becoming medical fit for discharge.
- The service took longer than expected to respond to complaints, taking 79 days to respond and close the one complaint received. This compares to the trust target of 40 days to respond and close a complaint.

However:

- The intensive care unit performed better than the national average for discharging patients within eight hours of the decision to discharge being made.
- Medical high dependency, surgical high dependency and intensive care unit reported no transfers for non-medical reasons between April 2014 and March 2016.
- Medical high dependency, surgical high dependency and intensive care unit had low numbers of discharges between 10pm and 7am, with medical high dependency unit reporting none and the intensive care unit reporting 3% of discharges.

Is the service well-led?

Requires improvement ↓

Our rating of well-led went down. We rated it as requires improvement because:

- We found a lack of intensivist leadership within the surgical high dependency unit.
- Senior staff had a lack of understanding about Duty of Candour and how and when this should be exercised. We saw an example of an incident where duty of candour should have been exercised and was not.
- We found a culture that did not consistently promote challenge, change or clinical inquisitiveness. For example, senior ICU, SHDU and MHDU staff told us at the time of the inspection the service does not routinely screen respiratory patients for influenza or RSV due to a lack of side rooms. Following the inspection, the service began screening patients displaying symptoms for influenza and RSV.
- Governance arrangements did not support a shared learning culture between all three critical care units.

Critical care

- We found senior staff did not recognise and report all risks within critical care, and risk registers did not reflect all the risks within each unit. Significant risks had not been mitigated despite staff telling us they were aware of them. An example of this was that the service had not assessed the risk regarding the lack of storage space within SHDU or ICU.
- The service had not embedded shared governance across all areas. Senior staff in the intensive care unit did share some information with medical high dependency.
- There were limited efforts made to engage with the public and limited areas of innovation outside of the intensive care unit.
- All critical care units did not collect and submit national data, which meant senior staff did not have an overview of performance within critical care. The intensive care unit and medical high dependency unit did submit data to the Intensive Care National Audit and Research Centre (ICNARC); however, the surgical high dependency unit did not, and had not previously, submitted any data to ICNARC.

However:

- We found local leaders were visible and staff felt supported by unit managers, matrons and senior doctors.
- We found changes across critical care in response to the previous inspection.

Areas for improvement

We found 14 areas for improvement in this service. See areas for improvement section of the report.

Maternity

Good

Key facts and figures

The Dudley Group NHS Foundation trust has 51 maternity beds based at Russells Hall Hospital.

The maternity service at the trust forms part of the Women's and Children's directorate. The trust provides a full maternity service, which incorporates community services, antenatal services, midwife and obstetric led delivery services and postnatal care. The service also provides some specialist clinics such as the tongue-tie clinic and diabetic clinic. Tongue-tie happens when the string of tissue under a baby's tongue (frenulum), which attaches their tongue to the floor of their mouth, is too short.

Between July 2016 to June 2017, staff at the maternity unit at Russells Hall Hospital delivered 4,230 babies. This compares to 4,800 babies born at the trust between March 2013 and March 2014. The highest number of deliveries was between July 2016 to September 2016 where 1,151 babies were delivered at the trust.

During our inspection, we spoke with 20 members of staff including leaders of the service, matrons, midwives and administrative staff.

We attended meetings and observed staff handovers and huddles where staff discussed patients' care and treatment. We reviewed nine patient records and five patients' prescription charts.

We spoke with nine women and two partners during our inspection. We also reviewed information displayed on huddle boards and noticeboards located in the department.

We last inspected the maternity department at Russells Hall Hospital in March 2014. For that inspection we rated the maternity and family planning service as Requires Improvement overall.

We inspected the maternity service to determine if it was Safe, Effective, Caring, Responsive and Well led.

Summary of this service

We rated this service as good because:

- We saw there had been an improvement in the incident reporting process since our last inspection. Staff could demonstrate that learning outcomes were shared and in particular in response to the findings of the Quality Improvement Board report.
- Cleanliness and infection, prevention and control procedures were good throughout the maternity department. All areas in the department were clean and tidy. The infection prevention and control audit results in maternity from April 2017 to November 2017 showed there had been no cases of C. Difficile, MRSA or MSSA during this time period.
- Maternity staff had appropriate qualifications, skills, knowledge and experience to provide safe care and treatment to women and their babies.
- In maternity services medical and dental staff met the trust's mandatory training target of 90% with 95% compliance overall. However, nursing and midwifery staff mandatory training compliance fell just below the target with 85% compliance overall.
- Patient records were securely stored in lockable trollies, which was an improvement from our last inspection. We also saw records were completed appropriately.

Maternity

- We saw the service had arrangements in place to safeguard women who had undergone or were at risk of female genital mutilation (FGM).
- The maternity department had a dedicated security guard and entry to the unit was gained via an intercom and camera system.
- The service offered an enhanced recovery programme designed to help women recover more quickly from caesarean sections.
- All comments we received from women and their families about their care within the maternity department was positive. Women confirmed staff treated them with dignity, respect and compassion.
- Eight student midwives would be taking up substantive posts at the hospital once they had completed their training.
- Pain relief was readily available for women. Some midwives had conducted aromatherapy training as another method of relaxation and pain relief for women during labour.
- There was good multidisciplinary (MDT) working between the maternity service and other services at the trust. This ensured the needs of women and their babies were met.
- The clinical audit programme had improved since our last inspection. However, we were not assured it was yet fully embedded within the service. However, a consultant had taken on the responsibility as an audit lead for the service.
- Translation services were accessible if required. Information in a variety of different languages and larger print was available on the unit and to download from the trust's website.
- The Lead Community Midwife was working with health visitors from the Black County Partnership to provide a clinic specifically tailored to the needs of Romanian women and children with face-to-face interpreters to ensure pregnant women were receiving regular antenatal care. This clinic had a drop in facility and was proving very popular with increasing numbers of women attending regularly.
- Telephone support was available to women before and following their appointment at the Early Assessment pregnancy Clinic (EPAC) and colposcopy appointments.
- The risk register for the department accurately reflected the main risks to the department and senior staff regularly reviewed the risks.
- Staff told us service leaders were approachable and visible on the unit. Senior staff confirmed they had an open door policy for all staff.
- Staff understood the vision and strategy for the service. The strategy within maternity took into consideration the Black Country maternity care arrangements to meet the needs of women in the local region.
- The senior midwifery team in maternity had implemented a consultant governance lead role and allocated medical leadership time had been increased for the service.
- The maternity matron for outpatients, community, and the midwifery led unit, had been offered the committee member role of midwife on the Postnatal Care Guidelines Committee of the National Guideline Alliance.
- The maternity service had a frenulotomy training programme. Frenulotomy is a procedure that separates a baby's tongue-tie.
- The service used charitable funds to refund women who want a home pool birth.

However:

Maternity

- The service did not have a dedicated bereavement suite or specialist bereavement midwife. However, we saw the service had developed plans to convert some of the delivery rooms to accommodate a dedicated bereavement suite for women and their families.
- From July 2016 to June 2017, the trust had a ratio of one midwife to every 28 women. This is lower than the England average of one midwife to every 27 women. During our inspection, senior staff told us the current midwife to birth ratio was 1:29.4. However, the service could demonstrate women requiring one-to-one care on both the midwife led unit and delivery suite consistently received it. Senior staff were putting measures in place to increase staffing levels as soon as possible. In addition, the service was implementing the use of the Birthrate Plus acuity tool to give them real time information about the acuity needs in the in-patient areas within the department.
- From April 2016 to March 2017 the total number of caesareans at 1,389 (32.8%) was higher than the England average at 27.4%. For the same time period, the standardised elective caesarean section rate was higher than expected. There were 14.7% (622) elective caesareans compared to an England average of 11.9%.
- Nursing and midwifery staff working within maternity failed to meet the target for safeguarding adults or safeguarding children level 3, with 163 of the 211 eligible staff members (77%) completing adults safeguarding and 166 of the 210 eligible staff members (79%) completing level 3 children's training.
- As of June 2017 Mental Capacity Act (MCA) and Mental Health Act (MHA) training had been completed by 17% of staff within maternity. This did not meet the trust target of 90%.
- During this inspection, we found the service still had eight guidelines requiring review or amendments. However, senior staff ensured staff were sighted on any changes of guidelines or procedures that affected their practice. Senior managers told us they had plans to improve the process for the management and review of procedures in maternity

Is the service safe?

Good

We rated safe as good because:

- Infection, prevention and control practices were good. We saw all areas in the department were visibly clean and tidy and staff adhered to regular cleaning schedules. We observed staff adhered to the arms bare below the elbows rule and did not wear jewellery.
- The service held regular multidisciplinary skills drills training to prepare staff in the unit for emergency situations and to support staff to continually maintain up-to-date knowledge and practical skills. Skills drills are used to manage a number of obstetric emergencies such as vaginal breech birth and the resuscitation of a mother or neonate. As at February 2018, 97% of the 171 midwives had completed maternity skills drills training in the simulation laboratory at the trust and 66% of 18 doctors required to conduct the training had completed this training.
- The maternity unit was situated in close proximity to both the obstetric theatres and neonatal unit should women and babies require transfer to these locations. They were positioned on the same floor and therefore lifts were not required which could cause a potential delay.
- The incident reporting process had improved since our last inspection. We saw lessons had been learned in response to the Quality Improvement Board report.
- All staff we spoke with demonstrated a good understanding of duty of candour and could give examples of when it had been applied within maternity.

Maternity

- Between August 2016 and July 2017 there were three occasions where the duty of candour regulation had been applied in maternity. The duty of candour regulation requires health service bodies to act in an open and transparent manner when things go wrong. Senior staff demonstrated how the duty of candour had been appropriately applied in response to the Maternity Quality Improvement Board report.
- Medical and dental staff working within maternity met the target for safeguarding adults. All of the staff we spoke with were aware of how to recognise abuse and how and who to escalate concerns to.
- In the previous 2014 inspection, midwives on the nursing bank told us they were often tired but felt pressurised to work additional shifts that needed covering. During this inspection, we saw the service had put measures in place to ensure staff could work a maximum of 60 hours a week to prevent overreliance on the same maternity staff.
- We found the quality of patient records were good and were safely stored in lockable trollies. They were contemporaneously completed and legible.
- In maternity services medical and dental staff met the trust's target and achieved 95% compliance overall for mandatory training.
- CTG completion, interpretation, and escalation training was above the trust target. As at December 2017, for medical staff there was 100% compliance and midwives training compliance was at 96.20% against a trust target of 90%.
- Staff had completed risk assessments to a good standard in all of the records we checked. All records we checked also documented staff had used modified early warning scores (MEWS) for all women.
- Audit results showed that staff were carrying out the WHO in line with good practice. Between June 2017 and November 2017, the WHO surgical safety checklist compliance was at 100%.
- We saw the service had arrangements in place to safeguard women who had undergone or were at risk of female genital mutilation (FGM). The trust had a specialist FGM consultant and a FGM specialist midwife. FGM training was available to all staff in the maternity department. The service also had a vulnerable women midwife to support women at risk of sexual exploitation.
- Dedicated security staff monitored the access to the maternity unit 24 hours a day, seven days a week. Staff tagged all babies with an electronic wristband as standard but parents had the option to opt out of this service.
- The pre-operative process for elective caesarean sections included screening women for MRSA.
- We saw medical equipment was in good working order. Regular checks were completed and the equipment we checked was up-to-date with electrical testing.

However:

- The maternity department reported one never event in November 2017 involving an obstetric patient. We saw the service had quickly implemented measures to prevent reoccurrence.
- The service used the Birthrate Plus acuity tool to calculate the staffing requirements needed for the department based on the skill mix of staff, the complexity of women that used the service from the local area in addition to a recent maternity workforce review the trust had conducted. From July 2016 to June 2017, the trust had a ratio of one midwife to every 28 women, which is lower than the England average of one midwife to every 27 women. Despite this, women we spoke with confirmed they felt safe whilst being cared for on the unit and incidents we reviewed were not related to maternity staffing numbers. We saw patients were given bespoke care to suit their needs after an assessment had been completed. Staff always put the safety of women and the babies first and escalated any staffing issues where appropriate. The service could also demonstrate women requiring one-to-one care on both the midwifery led unit and delivery suite consistently received it.

Maternity

- Between May 2017 and October 2017 there were no months where monthly midwife or MSW actual staffing levels met the monthly planned staffing levels for any day or night shifts. Overall October was the worst month because qualified day levels were low at 96.54% (97% rounded up). The unqualified rate was below 90% for nights (at 89%); this was with a high bed occupancy for that month (568 occupied bed days).
- As of June 2017, nursing and midwifery staff mandatory training compliance fell below the target with 85% compliance overall. Nursing and midwifery staff working within maternity met the target for six of the 13 modules. Training modules with the lowest compliance included mental health act and mental capacity training (25%), neonatal resus (83%) and adult resus (84%). We discussed low training compliance rates for some modules with leaders of the service during the inspection. The department had an action plan in place to help ensure staff conducted mandatory training in a timely manner. This included cancelling training only when this was unavoidable and the practice development midwife arranging training well in advance.
- Medical and dental staff working within maternity failed to meet the trust's safeguarding training target of 90% for both children's safeguarding modules. Nursing and midwifery staff working within maternity failed to meet the target for safeguarding adults or safeguarding children level 3, with 163 of the 211 eligible staff members (77%) completing adults safeguarding and 166 of the 210 eligible staff members (79%) completing level 3 children's training. Senior staff coordinated with the practice development midwife to put measures in place in response to where safeguarding training compliance did not meet the trust target. This included staff being allocated training on their off duty to attend training and planning training well in advance to ensure required staff could complete training. A process had also been implemented to notify staff members and their line manager if they have had two non-attendances to training. Despite this, all of the staff we spoke with were aware of how to recognise and escalate concerns of abuse relating to children

Is the service effective?

Requires improvement 

We rated effective as requires improvement because:

- From April 2016 to March 2017, the total number of caesareans at 1,389 (32.8%) was higher than the England average at 27.4%. For the same time period, the standardised elective caesarean section rate was higher than expected. There were 14.7% (622) elective caesareans compared to an England average of 11.9%. As of 29 September 2017 there was an active maternity outlier which related to higher than expected rates of elective caesarean sections, specifically among women with a single pregnancy with a normal presentation, with and without a previous caesarean section and for single pre-term pregnancies with a normal presentation. The trust were acting on this by conducting audits of numbers of caesareans per consultant and an audit of 30 notes in response to CQC alert. De-brief discussions were held following caesareans to check if the procedure had been appropriate. The service also held daily reviews of emergency elective sections.
- In the 2016 National Neonatal Audit, Russells Hall Hospital performed worse than the national average for the number of babies in this unit who had their temperature measured within an hour of birth where the temperature measurement was between 36.5°C and 37.5°C; the amount of mothers who delivered babies from 24 to 34 weeks gestation who were given antenatal steroids and the proportion of babies at below 33 weeks gestation at birth receiving any of their own mother's milk at discharge to home from a neonatal unit.
- In the 2017 MBRRACE audit, the departments stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was much worse than their comparator group at 5.7. This was more than 10% higher than their comparator group. This is a deterioration from the previous publication, where they were "up to 10% higher" than the comparator group, and for the year before that when they were "up to 10% lower" than the comparator group.

Maternity

- The trust reported as of June 2017 Mental Capacity Act (MCA) and Mental Health Act (MHA) training had been completed by 17% of staff within maternity. This did not meet the trust target of 90%. As of December 2017, staff training compliance had reduced further to 15%. The service had plans in place to ensure staff training compliance was at 90% for MCA training by the end of March 2018. In addition, the trust had relaunched the vulnerable women's study day, which included MCA and Deprivation of Liberty Safeguards training. As of December 2017, 25 midwives had completed this training.
- During this inspection, we found the service still had eight guidelines requiring review or amendments. We had concerns maternity staff may not be able to access all of the most up-to-date guidelines needed to support and evidence their clinical and professional practice. This had the potential for staff not delivering evidence-based care to women. However, we discussed this with senior staff during our inspection and they told us they ensured staff were sighted on any changes of guidelines or procedures that affected their practice despite some guidelines still requiring review. Senior managers told us they were ensuring these were dealt with as a matter of urgency by all involved and no further extensions would be given to staff. The service had plans to improve the process for the management and review of procedures in maternity and demonstrated they understood the importance of review and update of these guidelines to ensure the service was providing women with safe and evidence based care.

However:

- We saw the service ensured women received care in line with NICE guidelines and quality standards for maternity.
- Maternity staff had appropriate qualifications, skills, knowledge and experience to do their job.
- We saw there was good multidisciplinary (MDT) relationships between the maternity service and other services at the trust. This ensured the needs of women and their babies were met.
- In our previous inspection, we identified that monitoring information on the performance dashboards was inaccurate. During this inspection, we saw the quality of the maternity dashboards had improved and the information displayed was now consistent throughout the department.
- Maternity services had been UNICEF Baby Friendly accredited since 2002. We saw maternity infant feeding assistants supported women in their choice of baby feeding method. All staff in maternity received infant feeding training.
- We saw there was good communication between the maternity service and other services at the trust to ensure the needs of women were met. During the inspection, we observed a handover, which community midwifery staff attended to ensure all staff within the maternity service remained updated and to provide continuity of care for women.
- Appraisal rates within the department were higher than the trust target and had improved from the previous year. As of June 2017, 92% of staff within maternity had received an appraisal compared to a trust target of 90%. We saw there was a robust process within the department to monitor and arrange appraisal dates for staff. Staff told us their appraisals were a useful way of raising any concerns or training and development requirements.
- Women told us they received pain relief in a timely manner. Staff offered a choice of pain relief methods and some staff had received training in complimentary therapies.
- The midwifery led unit (MLU) contained equipment to support active births. Women told us active birth classes were offered to them and their partners from 34 weeks of pregnancy to demonstrate how the equipment can be used.
- In the 2016 National Neonatal Audit, for the maternity department performed better than the national average as 100% of babies had their temperature measured within an hour of birth. This was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Maternity

- The maternity department had a slightly lower rate of non-interventional deliveries at 57.3% (2,424) than the England average at 59.8%.
- Student midwifes told us they were well supported in their role and arrangements had been made to ensure they could stay at the trust as permanent staff members.
- The service held handovers in a structured manner and away from patients. However, we saw handovers were not consistent in their content and format and did not follow a Situation Background Assessment Recommendation (SBAR) model. SBAR is a technique that can be used to help standardize and prompt communication. Senior staff told us there were plans in place to implement consistency and evidence effectiveness of handovers.
- We saw improvements had been made in the clinical audit programme conducted for maternity services since our last inspection. However, we saw this was not yet fully embedded. Despite this we saw evidence that the leaders of the service regularly reviewed the effectiveness of care and treatment staff provided through local and national audit and benchmarking with other maternity units within the Black Country region.
- Action plans we reviewed showed measurable improvements were made in response to the findings from audits. Clinical leads reviewed audit results and monitored progress made in response to the audits which was documented in associated action plans we reviewed.

Is the service caring?

Good

We rated caring as good because:

- All feedback we received from patients and their families was positive regarding the care they had received. Patients told us staff were friendly and we saw thank you cards from women to staff thanking them for all their support.
- Easy Read format patient satisfaction questionnaires had been sent to patients with a learning disability to obtain their views on the care and treatment they received in the maternity department.
- Women and their partners told us staff kept them informed and involved them in their care and treatment. We saw staff interacted well with patients and were reassuring when necessary.
- We witnessed good care and saw staff treated women with dignity and respect. Women we spoke with told us staff pulled curtains around when performing more intimate procedures.
- Each ward had an identified area away from the wards to discuss patient handover so that patient's details could not be overheard. Staff and patients told us discussions would be held in private for discussing confidential and personal matters.
- Leaders of the service were supportive. Staff told us they arranged debriefs following bereavements and staff were offered counselling.
- Telephone support was available to women before and following their appointment at the Early Assessment pregnancy Clinic (EPAC) and colposcopy appointments. The EPAC is a dedicated nurse led team providing support to women experiencing difficulties during the early stages of their pregnancy.
- The unit provided assistance to women who were between 6 and 20 weeks gestation, had a positive pregnancy test and are experiencing bleeding, pain or other complications in early pregnancy.
- The friends and family tests results from October 2016 to September 2017 for all areas of the maternity department were in line with or better than the England average.

Maternity

- The trust performed about the same as other trusts for all 16 questions in the CQC Maternity survey 2015.

However:

- The maternity service did not have a dedicated bereavement room or specialist bereavement midwife. However, we saw the service had developed plans to convert some delivery rooms on the labour ward to accommodate a dedicated bereavement suite. However, the service currently had two midwives with a specialist bereavement interest to provide bereavement support but this was in addition to their main midwifery roles.

Is the service responsive?

Good

We rated responsive as good because:

- From Q4 2015/16 to Q1 2017/18 the bed occupancy levels for maternity were generally lower than the England average, with the exception of Q2 2016/17 where occupancy levels were slightly higher. The trust had 56.3% occupancy in Q1 2017/18 compared to the England average of 58.9%.
- The department held specialist clinics for diabetes, vulnerable women and substance misuse for example. The service also had some specialist midwives for these clinics.
- We saw women were allocated a named midwife for their antenatal care, which provided continuity of care for women.
- Women could access antenatal and postnatal mental health support via the trust's mental health team. During the triage process, we saw documentation included three questions relating to a woman's mental health.
- Staff in maternity were responsive to the individual needs of women. Staff described how they could arrange translation services for patients whose first language was not English. A new telephone was kept in the Matron's office for staff to access translators for patients.
- The Lead Community Midwife was working with health visitors from the Black County Partnership to provide a clinic specifically tailored to the needs of Romanian women and children with face-to-face interpreters to ensure pregnant women were receiving regular antenatal care. This clinic had a drop in facility and was proving very popular with increasing numbers of women attending regularly.
- We saw signs displayed advertising chaperones were available for women if they wished to have support. Patient notes confirmed where women had a chaperone accompany them to an appointment.
- We saw maternity infant feeding assistants supported women in their choice of baby feeding method. All staff in maternity received infant feeding training. Maternity services had been UNICEF Baby Friendly accredited since 2002.
- Patients told us they could have timely access to appointments throughout the clinics in maternity. It was possible to change appointments to best suit patients' requirements.
- It could take women a maximum of four hours to complete their antenatal appointments. However, this was to ensure women could have their scans and tests all on one day to save returning on a number of different days. We saw the appointment letter warned women in advance of the potential waiting times so they could make necessary arrangements. We reviewed an audit of the average waiting times in all clinics in the maternity outpatients department. The service had conducted this audit between 6 November 2017 and 10 November 2017 in response to complaints and negative feedback received in the Friends and Family test. The audit found the average time between

women arriving in the department and being seen for their ultrasound scan appointment was 12 minutes. However, the audit identified the average time between women's scan appointments and being seen in the clinic room was 42 minutes. The service recognised this was not an acceptable time for women to have to wait and identified recommendations to help improve waiting times with an associated action plan.

- Between August 2016 to July 2017, there were 27 complaints about maternity (9% of total complaints received by the trust). However, not all complaints were investigated within the trusts agreed timescales. Clinical treatment and communication were the subjects complained about most frequently, accounting for 70% of all complaints.

However:

- The Early Assessment pregnancy Clinic (EPAC) was not available to women at the weekend. During out-of-hours women were advised to contact their GP.

Is the service well-led?

Good

We rated well-led as good because:

- The strategy within maternity took into consideration the Black Country maternity care arrangements to meet the needs of the local population and to continually drive to improve the service. The maternity team had strong links with other maternity services in the region and shared good practice and learning from incidents and reviews.
- Governance meetings were held each month. We saw senior staff shared learning regarding incidents with staff at team meetings and via the governance newsletter.
- During our inspection, we observed plans were in place for the service to cope with the severe weather conditions the local region was experiencing. This included plans to cover maternity services in the community.
- We saw the risk register for the department accurately reflected the main risks to the department. Senior staff reviewed the risk register each month both at a divisional and local level.
- The senior maternity team had been strengthened by the implementation of a consultant governance lead role and allocated medical leadership time had been increased for the service.
- We found a positive culture in the maternity department. Staff felt supported and told us their leaders were visible and approachable.
- The maternity service held an employee of the month award scheme to reward staff for their contributions to the service.
- Staff felt engaged with the strategy, told us they understood there was a clear vision for the service, and knew their role in achieving them.
- Staff we spoke with told us they received specific feedback regarding incidents they had raised and discussed learning points with them.
- Senior staff had a robust recruitment plan, which included offering eight student midwives permanent positions in the trust to increase the midwifery staffing establishment.

However:

Maternity

- The service did not have a Non-Executive Director with responsibility for maternity services. However, the HoM and clinical director attended monthly clinical quality safety meetings to discuss the maternity improvement action plan. This demonstrated joint working within the directorate and updates from this meeting were shared with the senior trust executive team and the board.

Outstanding practice

We found three areas of outstanding practice in this service, see the outstanding practice area of the report.

Areas for improvement

We found six areas for improvement in this service. See areas for improvement section of the report.

Services for children and young people

Requires improvement 

Key facts and figures

- The trust has 26 inpatient peadiatric beds, three high dependancy unit beds, five beds within the paediatric assessment unit and six seated spaces.The trust had 6,900 spells from August 2016 to July 2017.
- Emergency spells between August 2016 and July 2017 accounted for 91% (6,310 spells), 4% (310 spells) were day case spells, and the remaining 4% (280 spells) were elective.
- The paediatric department at Russells Hall Hospital is set up to care for babies, toddlers and adolescents up to the age of 16 years. The paediatric department is located adjacent to the maternity department; with direct access onto the neonatal ward. The neonatal ward also has capacity for level 2 patients (with its own intensive care and high dependency beds).
- The children's ward has separate bays for younger children and adolescents where possible. There is also a separate mixed-age bay for under 18s attending the unit for surgery. There are two high dependency beds on the unit which can be increased to three according to demand. There is a paediatric assessment unit (PAU) operational from 8am until 8pm every day, situated within the department.
- There is an outpatient department for paediatrics situated on the ground floor of the hospital.
- During our inspection we spoke with 26 members of staff including consultants, junior medical staff, nurses from band 5 to band 8, student nurses, speech and language therapists, administration and domestic staff and two members of the executive team. We spoke with two patients and 11 family members visiting patients. We reviewed nine sets of patient records.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- We identified concerns about the robustness of delivery of the safeguarding service. Whilst ward staff demonstrated a good understanding of safeguarding, and we saw evidence of referrals and actions made and taken, medical staff cover did not meet national guidance.
- We saw both medical and nursing staffing levels did not meet requirements consistently. Concerns surrounding medical staffing were recorded on the trust risk register and actions had been taken to mitigate this risk. Similarly nursing staffing did not consistently meet required levels; actions had been put in place to mitigate this however the concerns over staffing were longstanding.
- We saw that the neonatal units did not have enough hand wash basins per cot area to meet hygiene regulations.
- There was no transition policy to manage young people transitioning to adult services. Unless a child was already known to paediatric services or children and adolescent mental health services; any 16 to 18 year old went straight onto an adult ward upon admission to the hospital. Therefore, they may not receive specialist paediatric support as required.
- We saw the children and young people's service did not undertake a full range of national audits. Patient outcomes and audit results varied. For example, data for the National Paediatric Diabetes Audit in the 2015/16 showed that Russells Hall Hospital performed worse than the England average.

Services for children and young people

- We saw the paediatric outpatient department had a large backlog of patients awaiting appointments for specific services. This waiting list was 90 weeks long for specific services at the time of inspection. The trust had actioned some changes to help manage this such as Saturday clinics.
- During the inspection, we found the children and young people's service was not represented at board level. This may have impacted upon highlighting and addressing risks to the service in a timely manner. We saw some risks on the trust risk register had been identified for significant periods of time before action had been taken.
- We saw medical staff did not consistently attend clinical governance meetings leading to gaps in sharing of information.
- However, we also saw evidence of good practice.
- Incidents were reported and acted upon. Staff were aware of the incident reporting procedure and gave examples of incidents that had been reported and investigated.
- We saw that staff monitored patients in case of deterioration in their condition using the National Early Warning Score (NEWS) and Paediatric Early Warning Score (PEWS).
- We saw multidisciplinary working was improved since the last CQC inspection. Allied health provision such as speech and language therapists were more embedded into the service.
- Another improvement since the last CQC inspection was that of appraisal completion rates. We saw at the time of the inspection, 95% of staff within the children and young people's service had received an appraisal.
- We saw consistently good examples of care provided to patients throughout our inspection. Staff strove to be kind and compassionate, and we saw new indicatives to promote a calm and caring atmosphere such a garden area designed to engage with patients with learning disabilities; although all children could access this.
- We saw the service placed emphasis on being responsive to individual needs. A staff member trained to support patients with learning disabilities supported staff, patients and parents and carers with advice and guidance. A sensory room was well equipped to enable children with learning disabilities or difficulties to engage with staff. Interpreters could be sourced for patients and parents who did not speak English.
- We saw that local leadership of the children and young people's service was supportive; with staff confident to raise concerns and questions. We saw local management shared information and learning with staff through a variety of mediums and encouraged staff to be directly involved with local projects.
- We saw that the children and young people service at the trust was part of a neonatal network with other trusts within the Black Country and Staffordshire and Shropshire which met every three months. Therefore, shared learning and continuous development was enabled and encouraged.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Nursing staff had a good understanding of safeguarding; and we saw evidence of appropriate safeguarding assessments and referrals. However, medical staff received no safeguarding supervision as required by trust policy and the Royal College of Paediatrics and Child Health (RCPCH) standards. In addition, some medical staff were declining to provide safeguarding cover during office hours. Therefore we were not assured that medical cover met the Facing the Future standard that required this.

Services for children and young people

- We saw paediatric medical staffing was highlighted on the service's risk register as a significant risk to clinical care and service demands, particularly overnight. We saw that actions had been taken to mitigate this risk such as recruiting three consultants; two of whom had commenced work at the time of our inspection.
- Nursing staffing was not always compliant with the Royal College of Nursing (RCN) and the British Association of Perinatal Medicine (BAPM) requirements. Bank and agency staff were used to fill gaps in staffing; however there were occasions when the nurse staffing levels fell below required numbers. We saw these incidents were recorded and actions were planned to meet the shortfall including the recruitment of four trainee associate nurses; due to commence employment in March 2018.
- Mandatory training compliance for medical staff was poor. Medical staff were below the trust training target in seven out of 11 required modules within 2017.
- The neonatal ward did not have enough hand wash basins per cot to meet hygiene regulations. This was on the risk register for the service; however at the time of inspection there were no specific plans to add additional hand washing facilities. However, staff we spoke with on the ward were aware of this concern and described how they worked to mitigate this risk such as maintaining high standards of handwashing techniques.
- We found the children and young people's service was not compliant with the Facing the Future standard of providing consultant cover during the hours of peak activity (5-10 PM). The trust had recruited three new consultants; two of whom were already in post at the time of our inspection.
- We saw there had been an outbreak of Enterobacter within the children and young people's service within 2017, in addition to other concerns regarding infection prevention being raised throughout the trust. However, we saw that regular hand hygiene audits were conducted with results and action plans discussed with staff. During our inspection, we noted the environment appeared clean and clutter free and staff regularly washed and gelled their hands.

However, we also saw evidence of good practice.

- We saw staff were aware of the trust electronic incident reporting procedures, and incidents were discussed and shared via a variety of communication methods, including ward huddles, team meetings and handovers.
- Medicine management was safe, with fridge and ambient temperatures being recorded daily, medicine checks being completed at regular intervals, and waste medication appropriately disposed of. However, staff were not consistently recording allergies for all patients.
- We saw patient records were generally well maintained; with risk assessments completed for each patient. Entries were clear and dated and timed. We noted that some entries did not always have the printed name of the member of staff completing this, which may make it difficult to identify who made the entry.
- Play equipment was well maintained and in good supply on the wards. We saw a cleaning policy was in place for toys on the ward areas; although this did not cover the cleaning of toys in the children's outpatients department.
- We saw that staff used recognised tools to identify deterioration within patients. For example, the children's ward routinely used a paediatric early warning score (PEWS) and the neonatal unit used the neonatal early warning score (NEWS) in order to enable the nurses in recognising and responding to signs of deterioration, thereby preventing serious adverse events.
- We saw ward security was good; entry and exit to the ward had to be gained by being 'buzzed' in or out. Entry and exit points were locked at all times and had CCTV to monitor enable visual identification of individuals.

Services for children and young people

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- We saw that apart from a transition policy for children with diabetes, which incorporated monthly clinics with adult medicine; there was no process or policy within the trust Therefore if a child aged over 16 was admitted for either physical or mental health reasons; they were placed on an adult ward unless already known to children's services.
- We saw that the trust did not undertake a full range of national audits. For example, the trust had not undertaken a 'You're Welcome' audit which is the Department of Health (DH) 'Quality criteria for young people friendly health services'. However, we did note that the children and young people's service were working towards accreditations such as the Bliss Baby Charter scheme (an accreditation scheme which measures the level of family centered care provision within a unit).
- We saw patient outcomes varied for children and young people's services. Most recently available data for the National Paediatric Diabetes Audit in the 2015/16, Russells Hall Hospital performed worse than the England average. For example, psychological assessment for children with diabetes was inadequate due to lack of psychology services as part of the paediatric team. An action was set for March 2018 to address this therefore a gap in the service had been recorded as existing since this audit and throughout 2017 with no action taken.
- From April 2016 to March 2017, the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and worse than the England average for epilepsy patients.
- In the 2016 National Neonatal Audit Programme (NNAP), Russells Hall Hospital performance was the same as or below similar neonatal units. For example; No babies died post discharge at Russells Hall Hospital, in line with rates for similar neonatal units. However, an initial patient consultation following admission occurred within 24 hours for only 86% of the patients within the audit. This was below the national average where 90% of eligible patients had the first consultation within 24 hours of admission.
- The CQC children's survey 2016 results had identified concerns with specific areas such as staff attitude and communication with parents and patients. Overall, the trust was one of nine in the country to score 'worse than expected' overall for 2016.

However:

- We saw the service had created action plans to address areas of improvements as identified within audits. For example, as a result of the 2016 CQC children's survey; a children's communication charter had been developed as a way to effectively communicate with patients. We saw this was displayed frequently within the ward areas; and had been cascaded to the emergency department and to the children's outpatients department to support shared learning.
- We saw evidence of good practice. We saw the premature infant pain profile (PIPP) and the neonatal infant pain score (NIPS) were used to assess pain in babies. Pain relief measures offered to neonates included sucrose, kangaroo care (skin to skin contact) and IV and oral paracetamol. Parents and patients told us, with one exception, that pain and discomfort was well identified and managed by staff.

Services for children and young people

- We saw evidence that multidisciplinary working had improved since our last inspection in 2014. Speech and language therapist (SALT) availability to the service was much improved. Children and adolescent mental health services (CAHMS) and community nurses attended the hospital regularly to manage children with either mental health conditions or additional needs that may require support post discharge. We saw play worker staff were employed and actively worked within a multidisciplinary team both on the ward and within outpatients.
- Staff were aware of their requirements around consent; we saw evidence that consent was gained appropriately prior to undertaking clinical or care related activity with babies and children. We saw evidence that the parent or carer's ability to consent was considered in specific cases.
- Staff were competent to fulfil their roles within the service. We saw that 95% of staff within children's services at the trust had received an appraisal compared to a trust target of 90%. This was higher than the previous year where 86% of staff received an appraisal; and an improvement from our previous inspection in 2014 whereby 81% of staff within the directorate had received an appraisal.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Patients and parents we spoke with consistently spoke highly of staff within the hospital with regards to care and compassion. We were told that staff of all grades within the children and young people's service treated parents and patients with respect; and made an effort to protect the dignity of both patients and parents. We saw examples of where staff had relocated children to an alternative bay to ensure a child's comfort.
- Families told us they felt involved in their child's care; and that both medical and nursing staff listened to their opinion and questions. Parents told us their personal decisions regarding care for their child had been respected. For example, we were told about how staff discussed feeding options with new mothers including breastfeeding and the benefits of this. However, once the mother had made a decision, this was both respected and supported.
- Bliss champions, volunteers who support parents of ill or premature babies, were prominent within the neonatal department to provide emotional support. We saw evidence of charity fund raising and events being publicised. We also saw other hospital volunteers distributing gifts free of charge to children during our inspection. We saw these volunteers engaged with children and parents to identify gifts the child would like to receive.
- The chaplaincy team were available to support children and parents, and we were told members of the team regularly attended the inpatient areas.
- Play leaders worked with anxious children to aid clinical tests and treatments, such as blood tests. Various techniques were used including distraction techniques and relaxation strategies.
- We saw evidence that Pets as Therapy (PAT) dogs attended the unit to provide emotional support to inpatient children.

However:

- We saw that the trust performed worse than other trusts in 6 out of 12 (50%) questions relating to compassionate care in the CQC children's survey 2016. This means that the trust's performance has declined quite significantly related to caring for children since the previous survey in 2014.

- We saw management had planned and taken actions to address the results of the CQC children's survey. As mentioned in 'effective' a children's charter to enable age appropriate communication had been created by staff to address concerns raised around communication

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- We found that the paediatric outpatient department had a large backlog of patients; specifically there was a 90 week wait at the time of the inspection for patients awaiting assessment for attention deficit hyperactivity disorder (ADHD) and autism under the neuro-disability service. The trust had put plans in place to mitigate this; such as Saturday clinics and the recruitment of new staff.
- We saw that children between the ages of 16 to 18 years of age did not necessarily gain access to the children's ward or paediatric facilities. If a child was over 16 and not known to a paediatric consultant or to the child and adolescent mental health services (CAMHS) they were automatically admitted to an adult ward. As a result, the children and young people's service were not aware that there may be patients within the hospital who may benefit from tailored support. This also removed the choice of children in this age bracket to be placed on either an adult ward, or a children's ward as per best practice guidelines.
- We saw reported incidents showed the neonatal ward was regularly at capacity, or almost at capacity, which led to episodes of ward closure to new admissions throughout 2017 (except for emergency admissions). However, we saw that actions taken at these times demonstrated staff strove to be flexible where possible to enable safe care to be delivered to all admissions. In addition, when capacity was limited; the trust worked with network partners to ensure mothers and babies could be seen at other units.

However, we saw evidence of good practice.

- For example, we saw education provision for inpatient children was regular and viewed positively by staff, patients and parents.
- Patient's individual needs were met. We saw provision for patients with learning difficulties and disabilities were provided for, with a well-equipped sensory room in place. Play leaders, parents or nursing staff could accompany children into the sensory room as a means to interact and engage with children, to reduce emotional distress or to promote child development. We saw that learning disability staff had created specific information folders to disseminate learning more widely within the children's ward in terms of caring for children with learning disabilities.
- We saw children were given a varied choice of food from a trolley. Children were encouraged to choose which food they wanted at the time of their meal, rather than select from a pre-prepared menu. Vegans, vegetarians and other dietary requirements were catered for. Although only breast feeding mothers were formally provided with meals, we saw that where available, other parents staying with their child could also access food from the ward. Alternatively, there was provision for parents to buy food within the hospital, or to bring their own and use kitchen facilities such as a microwave.
- We saw interpreters were available and used for patients and families that did not speak English. Staff told us; of an initiative in the process of becoming actioned whereby communication cards were being made for everyday communication in commonly used languages such as food and drink choices. This involved a picture of a common item, with the English word for this written alongside the word in the language used by the patient or parent.

- A flat for parent and sibling use was available within the neonatal unit. This was used to house parents and siblings staying overnight; and was also used for new parents to familiarise themselves with caring for their baby prior to discharge, if required.
- We saw that community paediatric nurses worked closely within the inpatient children and young people's service at the trust in order to promote positive discharges home; and to provide support for parents making this transition.
- We saw that over the 12 months prior to the inspection, 16 complaints had been made via the Patient Advice and Liaison Service (PALS). Themes ranged from waiting times for patients to be seen, and communication problems between patient/ parents and staff. We saw complaints were discussed at clinical governance meetings and learning was shared with local staff.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- We saw that overall leadership of the children's and young people's service was not robust which had impacted upon the safety, effectiveness and responsiveness of the service. We found that the children and young person service was not represented at board level. These meant risks to the service may be overlooked; during our inspection we identified areas of risk which had not been specifically identified on the service risk register. For example, the children and young people's service highlighted medical staffing as a risk, and within that identified safeguarding duties was part of a consultant's role. However, it was not identified that consultants were not all consistently fulfilling their safeguarding duties, and that there were gaps to the service as described in 'safe'. We raised this with the executive team during our inspection visit who stated they would take steps to address these concerns and gaps in provision. Action plans to address key issues of risk were not in place and therefore risks were not mitigated effectively.
- We saw on the service risk register, which covered 'women's and children's services'; therefore included maternity services, that risks had actively been identified. However we saw, and we were told, that some risks had been long standing with no proactive action taken for significant periods of time. For example, a lack of psychological support for paediatric diabetic patients was identified as a risk; and was highlighted as a concern in the National Paediatric Diabetes Audit in the 2015/16. An action was set to recruit new staff to mitigate this risk; however was not due for action until 2018 as highlighted in 'effective'. Safeguarding was also identified as a risk with regards to placing extreme pressure on the service following a raised number of concerns. However, no specific action had been taken at the time of our inspection visit. Plans were in place to increase the specialist safeguarding nurse provision; including recruiting into a head of safeguarding vacancy. However, new members of safeguarding staff were not in position at the time of inspection.
- Medical attendance at clinical governance meetings was identified as poor which resulted in clinical updates not being completed to schedule. Also, medical presentations to these meetings were delayed impacting on shared learning at the management level. The children and young people's service did not hold separate mortality and morbidity meetings to discuss patient deaths; however, we saw a trust wide mortality surveillance group was in place. In addition, paediatric and neonatal deaths were clearly discussed and documented within clinical governance meetings.

However, we saw evidence of good practice.

- Local leadership was strong. All staff we spoke with were aware of who the local management team was; and reported regular contact. We saw evidence of regular team meetings, huddles and learning days which enabled staff to be updated on incidents, clinical updates, complaints and service development.

Services for children and young people

- The culture within the children and young people's service was positive. Staff reported job satisfaction and enjoyment in caring for babies and children. We saw staff were concerned about nursing staffing levels and the impact this had on more senior nurses ability to complete their roles, however this was presented in a supportive way with effective teamwork evident throughout the time of our inspection.
- We saw staff were familiar with the trust vision and strategy, and also plans for the children's department specifically. Staff were able to access regular updates from the executive team via the intranet if they chose to do so.
- We saw that the children and young people service at the trust was part of a neonatal network with other trusts within the Black Country and Staffordshire and Shropshire which met every three months. Therefore; the network were able to share policies and updated guidance to ensure a consistent approach to treating children.

Areas for improvement

We found eight areas for improvement in this service. See areas for improvement section of the report.

Community health services

Background to community health services

The trust provides adult community health services including sexual heath across a multitude of locations. We did not inspect end of life community services as part of our inspection.

Summary of community health services

Good

See community section of the report for full details of our findings.

Community health services for adults

Good

Key facts and figures

The Dudley Group NHS Foundation Trust operates a community nursing/multidisciplinary service for adults, across the boroughs of Dudley and Wyre Forrest. These services provide clinical care to patients who are acutely, chronically or terminally ill in their own homes, GP practices or health centres. The services are multidisciplinary and include both nursing and allied health professionals who interlink with each other through networking pathways.

Community adult's services:

Dudley Rehabilitation Services provides rehabilitation and clinical management for the following pathways:

• Long term neurological conditions

• Stroke (including Early Supported Discharge)

• Rehabilitation following illness or a fall

The pathways are made up of specialist clinicians (run from Stourbridge Health and Social Care Centre)

Intermediate Care; a team of occupational therapists and physiotherapists work across the Dudley Borough providing therapy and rehabilitation to patients in stepdown inpatient beds. This service aims to improve transfers, mobility and functional ability and facilitate safe, timely and effective discharges into a community setting.

Chiropody and orthotics departments both have dedicated resources which provide a full complement of services. These work in close partnership and often make cross-referrals between the services. There is also a "rheumatoid foot" clinic and a computerised gait analysis system provided at the rheumatology day-case unit.

The podiatric surgery service offers access to a consultant in podiatric surgery for consultations, assessments and diagnosis of foot problems. They are trained to provide surgical interventions of the foot, specialising in day case surgery and primarily local anaesthesia. Referrals are received from GPs, consultants and fellow health professionals by letter. This service is run from the Brierley Hill Health & Social Care Centre.

The community dietetics department provides dietetic and nutritional support to people in the community including patients attending GP surgeries and health centres, residents of residential and nursing homes and in patients in their own homes. This service is run from the Stourbridge Health and Social Care Centre.

Speech and language therapy is also provided in the community services by a team of therapists and assistants. They provide a service to patients in both an acute and outpatient setting. The team specialise in the assessment, diagnosis and treatment of patients with a wide range of communication, voice and/or swallowing difficulties. The therapy is provided on an individual basis or in groups. The team also provide training to the multidisciplinary team (MDT) at Russells Hall Hospital.

There is also a community nursing service which includes district nursing consisting of five locality teams working across the Dudley borough to provide an integrated nursing service. This is in conjunction with the out of hours community nursing service which operates between the hours of 17.30-08.15 hours to provide a 24 hour service, seven days a week from the Brierley Hill Health & Social Care Centre.

Community health services for adults

In addition the community services also provide a dedicated community sexual health service. These community based clinics offer a range of contraception services including; contraception advice and provision, condoms, HIV rapid testing (one minute result), emergency contraception, implants, contraceptive pills, depo injections, IUS or IUD (coils), pregnancy tests, chlamydia screening programme and referrals to sexual health clinic or other services where appropriate.

Information about the sites, which offer services for community adults and sexual health services at this trust, is shown below:

Location Address	Teams that work from the Location Address
Brierley Hill Health and Social Care Centre Venture Way Brierley Hill West Midlands, DY5 1RU	• Kingswinford, Amblecote and Brierley Hill Community Nurses • Sexual Health • Community Response Team • Care Co-ordinators • Assertive Case Managers • Out of hours community nurses • Care home practitioners • IV therapy team
Halesowen Health Centre 14 Birmingham Street Halesowen West Midlands, B63 3HN	• Halesowen Community Nurses • Quarry Bank Community Nurses
Ladies Walk Clinic Priory Lane Sedgley Dudley West Midlands, DY3 3UA	• Coseley Community Nurses • Sedgley and Gornal Community nurses
St James Medical Practice Malthouse Drive Dudley West Midlands, DY12BY	• Dudley and Netherton Community nurses
Stourbridge Health and Social Care Centre John Corbett Drive	• Stourbridge, Lye and Wollescote Community nurses

Community health services for adults

Stourbridge

West Midlands, DY84JB

(Source: Community routine provider information return (RPIR) – CHS Context)

Summary of this service

We rated it as good because:

- 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.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- We saw excellent innovative multidisciplinary team working. Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- The trust planned and provided services in a way that met the needs of local people.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However

- Community staff were not fully compliant with mandatory training or appraisal rates.
- Whilst we were confident patients were receiving person centred care, we found patient care plans were generic and not person centred.
- People could not always access services when they needed it. Waiting times for treatment were not always in line with good practice.

Is the service safe?

Good

- 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.
- The service used monitored safety information and used the results to improve the care delivered to patients. This was shared it with staff, patients and visitors.

Community health services for adults

- The service controlled infection risk well. They undertook audits of their practice and used the results to plan and implement improvements. Equipment and premises were clean and well maintained. We saw that staff used control measures to prevent the spread of infection during interactions with patients.
- The service had suitable premises and equipment and maintained these well. The management team had put measures in place to ensure that staff were able to request equipment for patients such as hospital beds, pressure relieving mattresses and commodes and delivery staff delivered them quickly. The service kept a number of items frequently requested items at bases. This meant that the service aimed to deliver emergency equipment within four hours, 24 hours a day every day including public holidays. Access to equipment was 24 hours a day including banks holidays and Christmas day.
- The service managed risk well and there were clear and established processes to deal with any patients who deteriorated or required escalation. There were robust and standardised risk assessments undertaken for every patient and these included pressure area, multifactorial falls and mobility risk assessments. We found these were consistently completed and in place.
- The service had sufficient numbers of suitably qualified staff deployed to deliver a safe and effective service. We undertook a review of staffing information for a three month period and found that the service was staffed with the appropriate number and mix of clinical professionals required. The community nursing teams used a recognised capacity tool which took into consideration the number of staff on duty on a daily basis, how many hours the staff worked and the number of hours available to work taking.
- Staff kept appropriate and comprehensive records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. The service undertook regular documentation audits and compliance was high.
- Medicines were managed well and the service had specialist pharmacy input who provided regular medicines management visits to 25 community areas across 12 sites. Each area that stored medicines received a monthly visit by a pharmacy technician with completed training competencies. There were a number of nurse prescribers who used patient group directives (PGDs) and received competency based training.
- 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.
- The service planned for emergencies and staff understood their roles if one should happen.

However

- Apart from sexual health, community staff were not fully compliant with mandatory training. However in most subject areas the level of staff trained was close to the trust 90% target and also had plans in place to improve compliance.
- Podiatry did not complete infection prevention control audits; however managers assured us they had identified this as a risk and had included it on the podiatry action plan for imminent implementation.
- There were high turnover and vacancy rates within the service and this had resulted in high bank usage. However the leadership team had plans in place to address this issue and had implemented an ongoing retention of staff programme.

Is the service effective?

Good

Community health services for adults

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. For example policies and procedures reflected relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), and professional bodies.
- The community dietitians provided nutritional support and dietary information to a variety of patients. Community services included outpatient services, including dietitian-led clinics across the Dudley borough and a service to patients at their own homes, nursing and care homes. Staff completed malnutrition universal screening forms (MUST) forms for new patients. The MUST is a simple five step screening tool which will help to identify adults who are underweight and at risk of malnutrition and audited compliance with this screening tool.
- There were effective systems in place to manage patient's pain. There was a community specific pain service which provided a multi-disciplinary approach to help people referred with chronic pain problems.
- The service participated in national audits and monitored patient outcomes. Some patient outcomes were monitored and the services results showed that patients received good care and treatment. The service also compared local results with those of other services to learn from them.
- Most staff received appraisals and the service had a comprehensive ongoing action plan to continuously improve the appraisal rate. All new members of staff completed a full and comprehensive induction programme which included speciality training. For example, the sexual health service had a tailored induction package for new staff. All new members of staff had a period of four to six weeks being supernumerary with preceptorship.
- There were progression programmes in place for staff including a mix of university, practice and study days. These offered development and learning opportunities not only offered staff continued professional development but encouraged staff retention.
- All nursing staff completed community clinical competency workbooks specific to their areas of practice. There were also good processes in place to monitor and facilitate revalidation.
- There were excellent examples of multidisciplinary working and the trust were working with partner organisations to develop new roles, capabilities and different ways of working across the multispecialty community provider model. For instance, this included expanding the advanced care practitioner workforce by investing in a "grow your own" model of skill mix development for existing staff.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment and all staff had access to an electronic records system that they could all update.
- Staff across community services told us that they promoted self-care. Advice included encouragement to relieve pressure areas, dietary intake, and education around control of diabetes, smoking cessation, fire safety and falls prevention.
- 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.

However

- Whilst we were confident patients were receiving person centred care, we found patient care plans were generic and not person centred. This was not in line with NHS England recommendation that staff should offer everyone with a long-term condition a personalised care plan.

Community health services for adults

- In some areas of the service appraisal rates were lower than the trusts target, however action plans were in place to address this.

Is the service caring?

Good

- Staff cared for patients with compassion and kindness. We saw that patients and their relatives were treated with compassion and communication was approached in an open and caring manner.
- Feedback from patients and their relatives both prior to the inspection and during the inspection was consistently positive. They told us that staff treated them well and with kindness.
- We observed lots of interactions between staff and patients and we saw that staff were respectful and friendly to patient. They offered emotional support in all of their interactions we observed.
- Staff gave us examples of when they provided emotional support. This was particularly evident when staff were caring for patients at the end of their lives. The trust employed named clinical nurse specialists within the community for continence, diabetes, Parkinson's disease, multiple sclerosis and heart failure. Macmillan offered specialist support for patients and carers needing it. Staff could refer patients and carers to a Macmillan psychologist for extra psychological or emotional support.
- The service scored similar or above the national average for 29 out of 35 standards in the National Cancer Patient Experience Survey 2016 results relating to community patients. Some of the areas looked at included 'patient thought they were seen as soon as necessary', 'possible side effects explained in an understandable way', 'hospital staff gave information about support groups', given clear written information about what should/should not do post discharge'.
- There were community patients experience champions in place who used patient feedback to support the development of accessible and high quality services that offered value to local people.
- When patients experienced pain or physical or mental discomfort staff responded in a compassionate and timely manner. Staff also considered the need for referrals to other services such as palliative care support charities. Staff also referred to these services where patient's relatives required additional support and care.

Is the service responsive?

Requires improvement

- We found that people could not always access services in a timely way when they needed to. Waiting times for treatment were not always in line with good practice.
- Referral to treatment times varied greatly across the community teams we visited. For example, between 1 April 2017 and 31 December 2017, these times varied between 18 and 26 minutes from the time of arrival across different clinics.
- In the podiatry department the waiting time for seeing initial patients was 3.2 weeks. However, this had improved from the year prior to the inspection where the wait was 42 weeks. There had been significant problems with waiting times and high number of complaints in the podiatry department; although interim managers assured us they were addressing these issues effectively. A high volume of patients had resulted in staff deferring visits being until the next day if the service was up to full capacity.
- The service did not see any patients referred to community stroke rehabilitation for dietetics within the target time from April 2017 to June 2017.

- In the community stroke rehabilitation department compliance with the one week waiting time target to see patients for dietetics treatment was inconsistent and ranged from zero to full compliance.
- In the first quarter of 2017 to 2018 the Dudley rehabilitation team completed 5518 contacts and were contracted for 4575. This meant they over preformed on activity, however increased referral rates saw waiting times rise. The trust reported that patients waited for up to 143 weeks for rehabilitation appointments, up to 25 weeks for neurology, 3 weeks on average for stroke and up to 10 weeks for speech language therapy appointments.
- The Community Patient Experience survey 2016/17 showed that podiatry services patient and liaison services (PALS) received 45 concerns from patients where the majority had reported difficulty in contacting the service regarding their appointments. This is more than double the amount received in Q3 (18) and significantly higher than the 4 concerns received about podiatry services in Q2.
- Staff of all grades told us that there was insufficient therapy staff including physiotherapists in Dudley rehabilitation service to manage the increasing numbers of referrals. This meant patients waiting times were increasing.

However

- The community service offered a clinical single point of access (SPA). This worked by directing patients to the most suitable sites of care or providing safe, timely advice to manage their health at home which reduced unnecessary emergency department and GP visits.
- There were good arrangements for responding to the needs of people living with a learning disability and dementia.
- There was a large amount of printed information available to patients across the community adult services we visited and staff were involved in the accessible information standard task and finish group.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, managers did not always deal with complaints in a timely manner.

Is the service well-led?

Good

- The trust had managers at all levels with the right skills and abilities to run the service effectively. Leaders were visible, credible and engaged with staff groups.
- All managers and senior leaders had competent deputies who had the relevant skills and knowledge to undertake the role effectively.
- There were good arrangements for the development of leaders throughout the service. An example of this was that the interim podiatry services manager had introduced a leadership programme for team leaders in podiatry.
- Managers across the community promoted a positive culture that supported and valued staff which was also supportive and enthusiastic. Staff were proud to work in the service and of the quality of service they delivered.
- There was a system of robust governance which included a schedule of meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff.
- There were also effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. We saw the risk register for community and noted managers had identified a range of risks relating to the community. We saw that trust had taken appropriate actions to address or manage the risk, there were action plans in place, a responsible person was named to monitor the risk and review dates were regularly reviewed.

Community health services for adults

- Community Services performance information formed part of the trust integrated performance report and this report flagged areas of risk resulting from poor performance. There was a data standard group which reported to the Caldicott and Information Governance Group a formal group of the Audit Committee which oversaw the quality of the trust's data used internally and reported externally.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. This included 'breakfast with the boss' which were informal sessions with directors over breakfast to listen to staff concerns, 'Healthcare Heroes', monthly recognition awards, ' Listening into Action' which saw staff come together to discuss how to make improvements to specific areas or services.
- The trust engaged with the public through various medium such as Facebook and Twitter, charitable events and listening into action events. The service also undertook local surveys to engage with the public and understand patient's experiences of the service.
- There were areas of innovation within the service including the service was chosen to be 'vanguards' for the new care models programme, with the aim to improve health and wellbeing for local people through more closely linked health and care services, based around GP practices, which allow easier access to care that is consistent and better co-ordinated. Another example was that the sexual health team were taking part in a large scale international observational study looking at women's experiences with use of intrauterine devices.

Outstanding practice

There were two areas of outstanding practice in this service, see outstanding practice area of the report.

Areas for improvement

We found six areas for improvement in this service. See areas for improvement section of the report.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Katherine Williams inspection manager led this inspection.– Tracey Halladay and Carolyn Jenkinson Head of Hospital Inspections supported our inspection of well-led for the trust overall.

The team included eleven inspectors, one executive reviewer, nineteen specialist advisers, and one expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.