Report for Burton Hospitals NHS Foundation Trust

Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England

RAPID RESPONSIVE REVIEW REPORT FOR RISK SUMMIT

July 2013

Contents

1. Introduction

Overview of review process

On 6th February the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Definitions of SHMI and HSMR are included at Appendix I.

These two measures are intended to be used in the context of this review as a 'smoke alarm' for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

1) **Patient and public participation** – these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals and also considered independent feedback from stakeholders, related to the Trust, which had been received through the Keogh review website. These themes have been reflected in the reports.

2) **Listening to the views of staff** – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.

3) **Openness and transparency** – all possible information and intelligence relating to the review and individual investigations will be publicly available.

4) **Cooperation between organisations** – each review was built around strong cooperation between different organisations that make up the health system, placing the interest of patients first at all times.

Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.
- Identify:
    i. Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
    ii. Any additional external support that should be made available to these Trusts to help them improve.

iii. Any areas that may require regulatory action in order to protect patients.

The review follows a three stage process:

- **Stage 1** – **Information gathering and analysis**

This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLOEs). The data pack for each trust reviewed is published at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/burton-KLOEs.pdf.

- **Stage 2 – Rapid Responsive Review (RRR)**

A team of experienced clinicians, patients, managers and regulators (see Appendix II for panel composition), following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and departments, interviewing patients, trainees, staff and members of the Board. The report from this stage was considered at the risk summit.

- **Stage 3** – **Risk summit**

This brought together a separate group of experts from across health organisations, including the regulatory bodies. They considered the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned. A report following each risk summit has been made publically available.

Methods of investigation

The two day announced RRR visit took place at the Trust's main site Queen's Hospital on Thursday 23 and Friday 24 May 2013. A variety of review methods were used to investigate the KLOEs and enable the panel to consider evidence from multiple sources in making their judgements.

The visit included the following methods of investigation:

- **Interviews**

Four interviews took place with members of the Board and selective members of staff based on the key lines of enquiry during the visits. See Appendix III for details of the interviews undertaken.

- **Observations**

Ward observations enabled the panel to see the Trust undergo its day to day operations. They allowed the panel to talk to current patients, and their families where observations took placed during visiting hours. They allowed the panel to speak with a range of staff and observe the quality of care and treatment being provided to patients. The panel was able to observe the action by the Trust to improve quality in practice and consider whether any additional steps should be taken.

Observations took place in twenty five areas of Burton Trusts split across the three hospitals; Queen's Hospital, Samuel Johnson Community Hospital and Sir Robert Peel Hospital. See Appendix IV for details of the observations undertaken.

- **Focus Groups**

Focus groups provided an opportunity to talk to staff groups individually to ask each area of staff what they feel is good about patient care in the Trust and what needs improving. They enabled staff to speak up if they feel there is a barrier that is preventing them from providing good quality care to patients and what actions might the Trust need to consider improving, including addressing areas with higher than expected mortality indicators.

Focus groups were held with fifteen staff groups during the announced site visit. See Appendix V for details of the focus groups held.

The panel would like to thank all those who attended the focus groups who were open with the sharing of their experiences and balanced in their perceptions of the quality of care and treatment at the Trust.

- **Listening events**

Public listening events give the public an opportunity to share their personal experiences with the hospital, and to voice their opinion on what they feel works well or needs improving at the Trust in relation to the quality of patient care and treatment. A listening event for the public and patients was held on the evening of 22 May 2013 at Branston Golf Club near Burton. This was an open event, publicised locally, and attended by c.70 members of the public and patients.

The panel would like to thank all those attending the listening event who were open in sharing of their experiences and balanced in their perceptions of the quality of care and treatment at the Trust.

- **Review of documentation**

A number of documents were provided to the panellists through a copy being available in the panel's 'base location' at the Trust during the site visit. Whilst the documents were not reviewed in detail, they were available to the panellists to validate findings as considered appropriate. See Appendix VI for details of the documents available to the panel.

- **Unannounced visit**

The unannounced out-of-hours visit took place at Queen's Hospital, Burton on the evening of Monday 3 June 2013. This focused observations in areas identified from the announced site visit, see Appendix VII.

Next steps

This report has been produced by Dr Ruth May, Panel Chair, with the full support and input of panel members. It has been shared with the Trust for a factual accuracy check. This report was issued to attendees at the risk summit, which focussed on supporting Burton Hospitals NHS Foundation Trust ("the Trust") in addressing the actions identified to improve the quality of care and treatment.

Following the risk summit the agreed action plan will be published alongside this report on the Keogh review website. A report summarising the findings and actions arising from the 14 investigations will also be published.

2. Background to the Trust

This section of the report provides relevant background information for the Trust and highlights the areas identified from the data pack for further investigation.

Context

Burton Hospitals NHS Foundation Trust is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas including South Staffordshire, South Derbyshire and North West Leicestershire. The Trust serves a population of approximately 360,000 people. Burton Hospitals became a Foundation Trust in 2008 and has a total of 447 beds. In 2011, the Trust took over the running of two Community Hospitals: Samuel Johnson in Lichfield and Sir Robert Peel in Tamworth. It also acquired the Treatment Centre, based on the Queen's Hospital Burton site, providing day case and ophthalmology services to the immediate area and beyond. The Trust's services focus on stroke and rehabilitation and boast a new diagnostic investigation and chemotherapy unit together with a comprehensive women's and children's service, including fertility and IVF services.

Staffordshire is not a particularly deprived region of England. Over 65s in this region constitute a lower proportion of the male population but a higher proportion of the female population, compared to their proportion of the English population as a whole. The population served makes the Trust slightly smaller than the size recommended by the Royal College of Surgeons. 4% of Staffordshire's population belong to non-white ethnic minorities, particularly Indian and Pakistani. A lack of adult physical activity and adult obesity are among the most prominent health problems in Staffordshire. Burton Hospitals NHS Foundation Trust is a medium sized Trust for both inpatient and outpatient activity, relative to the rest of England.

At Queen's Hospital Burton there are a full complement of Accident and Emergency, outpatient and direct access services. The Trust works in partnership with other healthcare providers to offer patients access to more specialist services.

The Trust has a 46% market share of inpatient activity within a 5 mile radius of the Trust sites, however the Trust's market share falls to 30% within a radius of 10 miles, and 24% within a radius of 20 miles. The main competitors in the local area are Heart of England NHS Foundation Trust, Mid Staffordshire NHS Trust, Derby Hospitals NHS Foundation Trust, University Hospitals of Leicester NHS Trust and the Walsall Healthcare NHS Trust (formerly Royal Wolverhampton NHS Trust). The Trust's market share for non-elective admissions is 50% within a 5 mile radius, 41% within 10 miles, and 30% within 20 miles.

Mortality indicators

The Trust has been selected for this review as a result of its HSMR for 2011 and 2012 being above the expected level. The Trust is currently reporting an HSMR of 116 (period between January 2012 and December 2012) meaning that the number of actual deaths is higher than the expected level. This is statistically above the expected range.

The Trust has an overall SHMI of 99 (period between December 2011 to November 2012) meaning that the number of actual deaths as measured by this indicator is within the expected range. For both HSMR and SHMI, non elective admissions are seen to be primary contributing factor to both figures.

Respiratory medicine is flagged within both HSMR and SHMI indicators as an area of concern, as there is a higher than expected number of deaths attributed to respiratory conditions, such as pneumonia and chronic obstructive pulmonary disorder (COPD).

Pneumonia is a recurring concern in the results from the sub-tree of specialties noted in the HSMR review. The RRR visit included observations of the respiratory, general medical and elderly care wards and interviews with patients and staff in these areas.

A specific key line of enquiry in relation to respiratory medicine was also investigated.

Governance and leadership

The Trust's Board of Directors has seven sub-committees including the Governance, Risk and Assurance Committee (GR&A) to oversee quality governance arrangements. This committee receives reports from the Quality & Safety Group, Risk & Compliance Group, Infection Prevention Board, Safeguarding Steering Group, Health and Safety Group and Donation Group. A mortality Advisory Group has recently been established and has held its second meeting.

The current Monitor governance rating is red as the Trust was found in significant breach of its authorisation in November 2011 because it had not fulfilled its general duty to exercise its functions effectively, efficiently and economically or to fulfil its governance duty. In particular, the Trust has significant financial challenges as its income for the 2012/13 period was below planned levels.

Whilst recent CQC inspections do not currently have any concerns in relation to the standards that were tested, an inspection in June 2012 found concerns with medication. The Trust was found to be compliant at the second follow up in December 2012.

There have been a number of changes to the Board over the last 2 years; the most recent changes include a new Director of Operations in September 2012 and a new Director of Nursing in February 2013. The Medical Director role has been strengthened with the appointment of a Medical Director for Surgery, Medical Director for Medicine and a Medical Director for Education.

A high level review of the effectiveness of the Trust's quality governance arrangements was a standard key line of enquiry for the review.

Clinical and operating effectiveness

The data pack did not highlight any concerns for the Trust on the national clinical audit measures.

In terms of operational effectiveness, the Trust has 95.8% of A&E patients seen within 4 hours; which is above the 95% standard, however, the percentage of patients seen within 4 hours was falling over the second half of 2012. (Data for May and June 2013 however suggests that the Trust is back above the national standard.) A recent downturn in performance has meant that only 82.6% of patients are seen within 18 weeks (referral to treatment, RTT) which is lower than the national standard. This is due to the Trust addressing its backlog. The Trust's crude readmission rate is 10.9% and the standardised readmission rate is within the expected range. The Trust has an average length of stay of 3.62 days which is shorter than the national mean average of 5.2 days.

In addition to this, soft intelligence from the local Clinical Commissioning Group highlighted a concern amongst General Practitioners (GPs) around the number of staff available out of hours at A&E. Combined with the short length of stay, a decision was taken to focus on how patients were entering the trust and whether the lack of staff available out of hours in A&E had an impact on the length of stay of patients at the Trust.

Critical care is one of the specialties that is flagged by both SHMI and HSMR. Also, as mentioned previously, for both HSMR and SHMI, non elective admissions are seen to be the primary contributing factor to both figures.

The Trust cancelled 2.4% of elective operations in the third quarter of 2012-13 which is considered to be worse than expected. In the previous six quarters, the Trust's rate was worse or similar to the expected level.

The Patient Reported Outcome Measures (PROMs) dashboard shows that the Trust is a relatively good performer across all aspects of the dashboard.

As well as a key line of enquiry related to clinical and operating effectiveness, the data pack highlighted a specific area to investigate in relation to the urgent care pathway, particularly the time taken to admit or discharge following attendance at A&E.

Patient experience

Of the 9 measures reviewed within Patient Experience and Complaints, the most significant item to be rated as 'red' was the comments recorded via CQC's patient voice system. The number of individual comments was low, but almost two thirds were negative (64%).

In general, however, the Trust performs well on patient experience measures, being around average on the inpatient survey scores and above average on the cancer survey.

The Ombudsman rates the Trust as *A-rated* which indicates a *low-risk* of non-compliance with their recommendations. The Ombudsman investigates complaints escalated to it by complainants who are not satisfied with the Trust's response. It rates Trusts on whether they have implemented the recommendations made at the end of an investigation in a satisfactorily and timely manner, helping to ensure that Trusts learn from mistakes. The Ombudsman rates each Trust's compliance with recommendations and focuses on monitoring organisations whose compliance history indicates that they present a risk of non-compliance.

The following highlights specific areas of note:

- Inpatient Survey Score undertaken in 2012 (published in 2013) – this survey measure uses a pre-defined selection of 20 survey questions to rate the Trust on aspects including access to services, co-ordination of care, information and choice, relationship with staff and the quality of the clinical environment. The average for England is 76.5%; in comparison to this Burton on average scored higher with 76.8%. On average the Trust scores above average on survey questions relating to gaining admission to wards on the planned date, the appropriateness of language used by nurses in front of patients, and staff noise levels at night, but below average on those relating to the length of time required to be allocated a bed on a ward and information provided about medication side-effects.

- Patient Voice Comments were outside the expected range and flagged up as 'red'; via CQC - of 55 comments from patients and public in the two years to 31 January 2013, 35 were negative (64%). Key themes centred on managing discharge safely for elderly patients, some comments about cleanliness and being treated with dignity. There were also several very positive comments.

- High percentage of complaints about clinical aspects of care – of 351 written complaints received by the Trust in 2011/12, 55% of complaints related to clinical treatment (compared to the national average of 47%).

- The Trust's Friends and Family test results did not identify any specific concerns.

Keogh review patient voice comments

The patient voice comments received directly to the Keogh review website (at the time of writing this report) identified the following themes from 16 emails and letters:

Positive	Negative
Excellent care and treatment received	Unsatisfactory hygiene conditions were observed
The Trust strives to provide best possible treatment and care	Patients felt that staff were rude, bad tempered and uncaring
Staff are friendly, caring, compassionate and hardworking	Patients felt there was a lack of care
Good experience on multiple visits	A patient was not cared for on an appropriate ward for their needs and inconsistency in diagnosis observed
Departments work together well	Better communication needed with patients
Matrons were very good	Discharge not managed effectively
Excellent reduction in waiting time for outpatient eye specialists	Poor leadership from ward manager and low staff morale
	The Trust's process for investigating complaints was not adhered to.
	Executives of hospital should walk the wards.
	Incorrect medication doses administered

Key lines of enquiry were included in the review focusing on what patients say about the quality of care and treatment and what the Trust was doing in response to this feedback.

Workforce and Safety

The Trust is 'red rated' in four of the safety indicators;

1. Rate of harm incidents reported as 'moderate, severe or death'
2. 'Harm' for all four safety thermometers indicators (pressure ulcers, falls, urinary tract infection (UTI) and venous thromboembolisms or blood clots (VTE))
3. Pressure ulcers, and
4. Rule 43 coroner reports.

Rule 43 of the Coroners Rules 1984 (as amended) provides coroners with the power to make reports to a person or organisation where the coroner believes that action should be taken to prevent future deaths. The Rule 43 Coroner report for the Trust flagged six items to be considered as follows:

- *To consider use of Bair Huggers to keep patients warm;*

- *To consider clinicians attending autopsies; to consider a review of when patients are given antibiotics after surgery;*
- *To consider the policy on use of bed rails; to consider staff training on dealing with relatives' concerns, including recording such concerns and discharge policy to ensure patients are not discharged early because of bed shortages;*
- *To consider training and levels of staff in the Emergency Assessment Unit;*
- *To consider a review of the protocol and training for staff on the insertion of breathing tubes; and*
- *To consider a review of the systems in place for discharge planning.*

The Trust has a rate of patient safety incident reporting of 9.5 which is very high when compared to the national average for similar sized trusts of 6.5. The Trust has a rate of 1.58 for incidents reported as either 'moderate, severe or death' compared to a national average of 0.43. This means that the Trust has more patient safety incidents per 100 admissions than the median rate for similar small acute Trusts. The panel does however note that organisations that report more incidents usually have a better and more effective safety culture.

Key lines of enquiry were designed for the Trust to address pressure ulcer management concerns and safety issues such as learning from serious incidents causing harm and learning from Rule 43 coroner reports.

An initial review of the workforce data flagged eleven 'red rated' indicators. The Trust has higher than average leaving rates, lower than average joining rates and medical and nursing staff sickness rates are above the Midlands and East regional average. This means that more people are leaving the Trust than are joining and of those working at the Trust, a higher proportion of nurses and doctors are on sick leave than would be expected.

The response rate to the staff survey rate was above average in 2012. While the survey results were higher overall in 2011, all four metrics have dropped below average in 2012. The staff engagement score was slightly above average in 2011 when compared with trusts of a similar type, but dropped below average in 2012. This is mainly due to the fact that the national average improved whereas the Trust's rate remained flat. In 2012, the Trust is significantly below the national average for the percentage of staff that would be happy with the standard of care if a friend or relative needed treatment. This has fallen noticeably in 2012 when compared to 2011.

Key lines of enquiry were included in the review focusing on workforce measures and what staff say about the quality of care and treatment.

3. Key Lines of Enquiry

The Key Lines of Enquiry (KLOEs) were drafted using the following key inputs:

- The Trust data pack produced at Stage 1 and made publically available.
- Insights from the Trust's lead Clinical Commissioning Group (CCG), East Staffordshire CCG.
- Review of the patient voice feedback received specific to the Trust prior to the site visit.

These were agreed by the panellists at the panel briefing session prior to the RRR site visit. The KLOEs identified for the Trust were the following:

Theme	Key Line of Enquiry
Governance and leadership	1. Can the Trust clearly articulate its governance processes for assuring the quality of treatment of care? Are the leadership roles and responsibilities clearly defined for the quality processes? Can staff at all levels of the organisation describe the key elements of the quality governance processes?
	2. How does the Trust assess and monitor the quality impact of CIPs?
Clinical and operational effectiveness	3. What governance arrangements does the Trust have to monitor clinical and operational performance data at a senior level? What processes does the Trust have in place to support monitoring mortality data and clinical effectiveness? Has the Trust data identified any issues? What actions is the Trust taking to address issues noted?
Patient experience	4. How does the Trust review patient experience data and engage with patients to seek views about their experience? What are the key themes from patients on their experiences? What action is it taking to address the key themes emerging? What do patients say about the quality of care in the Trust during our observations/interviews?
Workforce and safety	5. How engaged are staff in the Trust's quality strategy? What do staff groups interviewed (including trainee groups) say are the main barriers in the Trust to delivering high quality treatment and care for patients?
	6. How does the Trust support its staff with adequate training, including safeguarding and other mandatory training?
	7. How does the Trust review and monitor its patient safety indicators? What actions are taken to improve patient safety?
Trust specific – Pressure ulcers	8. What actions is the Trust taking to reduce avoidable pressure ulcers?
Trust specific – Respiratory Medicine	9. What actions is the Trust taking to address issues relating to respiratory medicine?
Trust specific – Urgent Care Pathway	10. How does the Trust manage its Urgent Care Pathway?

4. Review findings

Introduction

The following section provides a detailed analysis of the panel's findings, including good practice noted, outstanding concerns and prioritisation of actions required.

Summary of findings

A number of areas of good practice were identified as part of our review, notably:

- A strong, united team at Executive level;
- A Director of Nursing and Medical Director for Education who were widely praised by their colleagues;
- Ward staff are positive about the Tissue Viability Nurses (TVNs) in the trust and their contribution to pressure ulcer prevention and Pressure Ulcers are on the Board's agenda; and
- Some good Friends and Family scores.

During our visit an issue was identified with relation to incorrect recording of death records. The panel formally escalated this to the CQC during the announced visit. The CQC visited the Trust on 31 May 2013 to perform an inspection into medical record keeping at the Trust. The findings of this inspection are contained in the CQC report.

The main priority areas identified for action in each of the key lines of enquiry themes are below. The priority findings for the Trust specific KLOEs on urgent care and respiratory medicine are included in the workforce and safety section below.

Leadership and governance:

- **There appears to be no systematic approach in place for ensuring collection, reporting and action on information on the quality of services** – The Board should ensure that there is a systematic approach in place for the collection, reporting and acting upon information on the quality of services. This review should include patient and clinician insights and should ensure that the processes include feedback and engagement of staff in learning and service improvement. The Trust should ensure that Clinical Directors are involved in feeding back quality messages.
- **Patients and Staff felt that the Trust Board needed to improve communication with them -** The Trust should review how it communicates with its staff to ensure that it is using the correct methods of communication and is effectively sharing learning from incidents and complaints reporting with its staff. Over the course of the last few years the Trust has received or invited in a significant number of external reviews. Though the Trust has responded to these reviews, it has not consistently

sought to feedback either the outcome or actions taken as a result of the review to its staff. The Trust should also review its handling of patient complaints. The Trust should ensure that it consults appropriately with its staff and patients in advance of any changes to service provision.

Clinical and operational effectiveness:

- **There was an inconsistent understanding of mortality concerns at the Trust and learning was not shared with staff –** The Trust should use a full range of national data measures for reporting mortality and use this data at ward and team meetings. The Trust should disseminate learning from Mortality and Morbidity review meetings to Directorates to improve mortality management. The panel noted that these review meetings are in their infancy and should be embedded further in the organisation.

Patient experience:

- **Patients felt that staff did not always communicate effectively with them –** The Trust should ensure that front-line staff are communicating with patients in an effective and compassionate manner.

- **Resolution of complaints is not systematically fed back to staff teams –** The Trust's Board should review the handling of complaints and the processes whereby complaints can be systematically fed back and used by staff teams to improve service delivery. This should include embedding a culture of ownership of complaints amongst Trust staff.

Workforce and safety:

- **There appeared to be a lack of support for Junior Doctors -** The Trust should consider carefully the support that Junior Doctors receive as part of their training and ensure that delegation and escalation are appropriate. The Junior Doctors did not feel able to raise their concerns about death certification issues within the organisation prior to the Keogh panel visit.

- **Review of medical rotas and discussions at focus groups found that medical staffing levels and skills mix was not appropriate or well managed –** The Trust should consider urgently the staffing levels and mix throughout the Trust, particularly at the middle grades, to address concerns about inappropriate delegation, escalation and lack of decision making. In addition, the Trust should undertake a review of the provision of services at its two community hospitals and satellite wards and whether clinical staffing levels are appropriate and provision of care continues to be sustainable at the current level of service use. The numbers of medical staffing in A&E should also be reviewed to ensure it is appropriate, especially out of hours.

- **The e-rostering system resulted in long shift working patterns and nursing shifts were far from optimally designed –** The Trust should ensure urgently that the working practices of its staff are safe and sustainable and prevent long shifts or a high number of consecutive working days where possible. It should also review the e-rostering system currently in place and make changes so that it better meets staff planning requirements. The number of nurses in certain wards should be reviewed to ensure staffing levels are appropriate, especially out of hours.

- **Equipment safety checks had not been carried out –** The Trust should review all resuscitation trolleys to ensure they are fully stocked, organised and there are no out of date drugs or fluids. Staff should be reminded of the importance of regular resuscitation equipment checking.

The following definitions are used for the rating of recommendations in this review:

Rating	Definition
Urgent	The Trust should take immediate action to respond to these recommendations and ensure improvement in the quality of care
High	The Trust should develop a response and action plan for these recommendations to ensure improvement in the quality of care
Medium	The Trust should implement these recommendations to ensure ongoing improvement in the quality of care

Governance and leadership

Overview

The panel's focus for governance and leadership was on the articulation and understanding of the Trust's governance processes for assuring the quality of treatment and patient care and how well this was embedded throughout the organisation.

Through staff interviews, focus groups and review of governance documentation, the panel tested whether staff at all levels could describe the key elements of the quality governance processes, i.e. policies and procedures, escalation, incident reporting and risk management. The panel also reviewed the Trust's process to assess the impact of cost savings plans on the quality of patient care and its workforce.

Summary of findings

The following good practice was identified:

- Executive Directors were able to articulate a united Board position on the assurance of quality of treatment and patient care and its centrality to the Board's aims and objectives, including the delivery of Cost Improvement Programmes (CIPs).
- The recently appointed Director of Nursing is in the process of reviewing the Trust's governance processes, has identified weaknesses and was able to set out a clear approach to rectify these and a wider vision for clinical and corporate governance of quality across the Trust.
- The large majority of CIPs had been through a Gateway process involving Quality Impact Assessments (QIAs) before being signed off by the Trust's Medical Director and Director of Nursing.
- The Trust recognises the fact that the mortality indicators in certain treatment areas are higher than they should be and has recently established a Mortality and Morbidity Review group to oversee activities in this area. These meetings have an independent chair.

The following areas of concern were identified:

- Staff in frontline roles, including Service Managers and Senior Clinicians, were unable to articulate the governance processes for quality of treatment and patient care and patient safety or the Trust's Quality Strategy.
- The communication within the Trust of issues related to the quality of services, governance processes, CIPs delivery and transformational change was felt by staff to be confused, inaccessible and in a language alien to frontline staff.
- Over the course of the last few years the Trust has received or invited in a significant number of external reviews. Though the Trust has responded to these reviews, it has not consistently sought to feedback either the outcome or actions taken as a result of the review to its staff and other stakeholders, e.g. CCG.
- The engagement of staff and clinicians in the governance processes for assuring the quality of treatment and patient care and the identification and implementation of CIPs is not consistent across the Trust.

- Although there was a process for carrying out QIAs before CIPs were agreed by the Board, there was limited evidence that the Board assured itself of any quality impacts during the implementation of CIPs, with monitoring primarily focussed on financial savings.
- Change within the Trust appeared to be managerially led in many cases, with a lack of staff, patient, public, member and governor engagement on changes.

For some of the above areas of concern, the panel identified a number of improvements already planned or underway at the Trust.

Detailed Findings

Good practice identified
Executive Directors provided a clear vision for the future provision of services in the Trust and a separation of elective and non-elective activity. There appeared to be a strong, united team at an Executive level with all showing clear ownership of the Quality agenda and the potential quality impact of the agreed CIP programme, not just the Medical Director and Director of Nursing.
There were some areas within the Trust, such as Oncology, where clinical leaders and staff were able to clearly articulate governance processes and the quality strategy of the Trust.
The recently appointed Director of Nursing and the Trust's Company Secretary were able to outline a clear vision for Board assurance of the quality of services being provided. They recognised some of the weaknesses in the current governance processes and the inconsistent nature of staff and clinical engagement. The Director of Nursing is in the process of reviewing the governance processes and the current structure in place for quality and patient safety. This work is in its infancy. He outlined to the panel a plan for a development programme for all Ward Managers to improve knowledge, communications, engagement and participation of frontline staff and clinicians in the quality of services including a robust feedback and learning loop back to staff from incidents and reporting. He acknowledged that to date, the work had been based around medical and nursing teams and that a particular focus was required to ensure engagement from allied health professionals, other clinical staff groups and non-clinical staff in the quality agenda.
The Trust recognises the fact that the mortality indicators in certain treatment areas are higher than they should be and has recently established a Mortality and Morbidity Review group to oversee activities in this area. These meetings have an independent chair.
There were some examples of where practice had changed in response to a complaint, e.g. wheelchairs being provided to take Mothers to their transport on discharge following Caesarean-Sections.
The Trust had put clear PMO (Project Management Office) arrangements in place to manage the delivery of the Cost Improvement Programmes.
Executive Directors were able to give some examples of a bottom-up process for the identification of CIPs and outlined a Gateway process using Quality Impact Assessments to inform the sign off of proposals by the Trust Medical Director and Director of Nursing. There were some examples where clinical teams felt engaged in this work and had seen their suggestions result in savings (examples included the Orthopaedic Implants CIP and the active engagement of Paediatric, Maternity and Physiotherapy staff teams).

As part of his review of the governance of quality, the Director of Nursing had personally been in touch with and visited complainants where previous Trust responses had not been felt sufficient by complainants.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Understanding of Trust's quality objectives in the organisation The panel saw and heard evidence from frontline staff, including senior clinicians that there was confusion about the governance structures and processes for quality and patient safety. This included a lack of clarity between divisional and Trust level governance arrangements, a lack of clarity on the feedback mechanisms for complaints and reported incidents. Staff in a number of focus groups, interviews and ward observations were unable to describe a cross-trust, systematic approach to the collection and reporting of data, its use by the Board to assure itself of quality and patient safety and the feedback mechanisms to support learning and service improvement.	The Director of Nursing acknowledged that there are shortfalls in the current processes and is currently reviewing these.	The Director of Nursing should complete his review and along with the Company Secretary, Medical Director and the rest of the Trust Board ensure that there is a systematic approach in place for the collection, reporting and acting upon information on the quality of services. This review should include patient and clinician insights and should ensure that the processes include feedback and engagement of staff in learning and service improvement.	High
(ii) Communication issues A number of communication issues were identified during the review: • There were examples given to the panel from Healthcare Assistants, Junior Doctors and the Outreach Team, where incidents had occurred, staff had reported fully, but had received no feedback or confirmation that the report had been received. • The Director of Nursing and the patient and public listening event both identified that there were many instances where complaints had not been dealt with to the satisfaction of the complainant and that the complaints process was not feeding adequately into the	The Director of Nursing acknowledged that there are shortfalls in the current processes and is currently reviewing these. The Director of Nursing acknowledged that there are shortfalls in the current	The Director of Nursing and Medical Director should review current incident reporting processes and ensure that they include a feedback loop to staff and their active engagement in lessons learnt. The Director of Nursing and the Company Secretary should review the handling of complaints and the processes whereby	High High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
wider governance of assurance for trend analyses, early warnings and feedback to staff. *Complaints are also discussed further in the Patient Experience section of the report.*	processes and is currently reviewing these.	complaints can be systematically fed back and used by staff teams to improve service delivery.	
• Over the course of the last few years the Trust has received or invited in a significant number of external reviews. Though the Trust has responded to these reviews, it has not consistently sought to feedback either the outcome or actions taken as a result of the review to its staff and other stakeholders, e.g. CCG.	None identified.	The Trust should feedback the actions it takes to respond to external reviews to staff members and other stakeholders to share learning and demonstrate the value that is gained from these reviews.	High
• During focus groups, many staff groups felt that communications of issues related to the quality of services relied too heavily on the staff intranet and that other methods of communication including face to face with Board members, face to face cascade through team meetings and other methods would be more meaningful and have greater impact on their practice.	The Trust is starting to consider the use of social media to aid communication to staff and clinical teams.	The Trust should review how it communicates with its staff and to actively respond to staff views in their preferences for communications.	High
• During focus groups, many staff groups (Ward 3, other clinical staff, Non-clinical staff, Senior Doctors, Junior Doctors, community hospital teams) felt that Board Exec and Non-Exec Members did not make themselves available on a regular basis to see the quality of services for themselves. This was echoed in the patient voice feedback.	None identified.	The Trust should undertake a regular programme for all Board members to visit patient care areas.	Medium
(iii) On-going monitoring of CIPs Whilst QIAs had been carried out as part of a Gateway process for the sign-off of each CIP, there was limited evidence of the use of QIAs to assess the impact of CIPs in their implementation. Monitoring of CIPs and reporting to the Board appeared to be primarily financial.	None identified.	The Trust should implement ongoing QIAs for each CIP within the PMO arrangements and should develop QIA KPIs for each CIP and include these in the reporting through to	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
		the Board.	
(iv) Staff engagement in CIP development The engagement of staff and clinicians in the development and agreement of CIPs is inconsistent across the Trust. Whilst there were some examples of strong staff engagement, the panel heard evidence of specific examples where CIPs had been put in place without engagement of key stakeholders or QIAs (these included changes to Pathology Department establishments – where a vacant Band 8A post had been re-banded to a Band 7 without consultation with clinicians in the team or understanding of the impact on the quality of the service being provided, and changes to administrative functions in the Trust such as medical secretaries).	None identified.	The Trust should review the mechanism for the engagement of all those affected by proposed CIPs in their development and agreement. The Board should also assure that it has strong clinical engagement in the development of all CIPs and that QIAs have been carried out in all cases.	Medium
(v) Mortality and Morbidity Review meetings The Mortality and Morbidity Review meetings have only recently been established and do not currently cover all areas of the Trust's services.	The Trust outlined a plan to roll out the remit of the reviews to cover all areas of the Trust's services.	The Trust should undertake and complete the roll out of the reviews of Mortality and Morbidity to cover all areas of the Trust's care and treatment services. The Trust should also consider whether staff members from a range of seniority and departments can attend these meetings to make this as open a process as possible and to share learning.	Medium
(vi) Lack of consultation on decision making A common theme from focus groups was that change within the Trust appeared to be managerially led and that there was a lack of staff, patient, public, member and governor engagement on changes. Examples are: • Staff were not engaged with prior to the introduction of the e-rostering system.	The Chief Executive of the Trust has challenged the Clinical Directors at the Trust to open up debate with CCGs. The CCGs have fed back that there has been an increase in engagement with the Trust	The Trust should ensure it has a robust change management framework that involves consultation with the key stakeholders of the Trust to inform decision making. The Trust should actively engage with public	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
• The Governors' secretary was made redundant without the Governors being consulted. • Patient and Public groups fed back that they struggle to get engagement with senior leadership at the Trust to discuss their concerns and that when they do express their views they do not see action being taken. • Members don't feel they influence the day-to-day running of the Trust. • CCGs are not getting the clinical engagement with the Trust that they desire in order to improve the range of services offered to patients by the Trust.	recently and will request through their Clinical Quality Review Meeting that the Trust now forwards details of CIP schemes for 13/14.	bodies and patient groups to ensure the quality of care delivered to patients is of a high standard.	

Clinical and operational effectiveness

Overview

The panel explored clinical and operational effectiveness, focussing on the actions the Trust is taking to improve mortality performance, particularly in respiratory services, diabetes, cancer care and septicaemia.

Summary of findings

The following good practice was identified:

- There was an awareness of mortality concerns from staff at the Trust from a Board to a Ward level.
- Some good front end processes were observed in A&E and CDU (clinical decisions unit) during our announced visit however it should be noted that recommendations are made elsewhere in this report regarding delegation of clinical decision making at the front end of A&E.
- The Oncology team has developed an action plan to address mortality concerns and have been monitoring this plan.
- Some wards are good at using alternative communication means for interacting with patients.
- The Trust is taking steps to improve its depth of coding.
- The Maternity unit is currently looking to achieve level 2 BFI (breast feeding initiative), with breastfeeding rates at 73%. In addition the Maternity unit appears well staffed with good facilities and appropriate consultant intervention. The midwifery-led birthing unit at Samuel Johnson Community Hospital was noted as being exceptional.

The following areas of concern were identified:

- Infection control, in particular hand hygiene did not appear to be routine on the ward observations.
- Governance, safety and quality not understood by many of the staff and lack of consistency in looking at mortality.
- Nursing handover periods reported by staff to be inadequate.
- Lack of continuity of care.
- The Community Hospitals appear to be under-utilised whilst Queens Hospital is running at a very high capacity.
- Clinical Directors' do not have a thorough understanding of the coding challenges faced by the Trust.

For some of the above areas of concern, the panel identified a number of improvements already underway or planned at the Trust.

Detailed Findings

Good practice identified
Many of the staff members interviewed, from Board members through to clinical staff working on wards, acknowledged that there were mortality concerns within certain specialities within the Trust. Some of them could outline clear plans for addressing these concerns. For example, in ITU (intensive treatment unit), when the Trust became aware of its outlying status it conducted its own review into its practices and identified specific problems, e.g. with its coding. Some of the consultants have also visited other sites to see if there are lessons that can be learnt. The panel felt that the Trust was clearly motivated to improve.
Some good front end processes were observed in A&E and CDU. For example, the booking of beds was clear, the HALO service (Hospital Ambulance Liaison Officer) was good and the alcohol liaison service received praise.
The Oncology team has developed an action plan to address mortality concerns and has been monitoring this plan. The colorectal surgeons have been reviewed by the RCS (Royal College of Surgeons) previously and shown an improvement in their mortality to within normal limits. The colorectal team have employed new surgeons.
Some wards are good at using alternative communication means for interacting with patients. For example, some wards had visible safety thermometer data on notice boards to communicate patient safety information. Other wards had also implemented an “ASK ME” scheme where staff wore badges saying “ASK ME” to encourage patients/ relatives to talk to them. This was in response to feedback they had received that patients didn’t ask staff questions as they thought they were too busy to respond.
The Trust is taking steps to improve its depth of coding and has developed an in house tracker. The newly formed Mortality Group has the Coding Manager as a member and this may prove worthwhile.
The Maternity unit is currently looking to achieve level 2 BFI (breast feeding initiative), with breastfeeding rates at 73%. In addition the Maternity unit appears well staffed with good facilities and appropriate consultant intervention. The midwifery-led birthing unit at Samuel Johnson Community Hospital was noted as being exceptional.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Infection control Infection control, in particular hand washing and ensuring staff are bare below the elbows, did not appear to be routine at the Trust as evidenced on the ward observations. There were a number of concerning observations by panel members and comments from patients, for example: • Staff entering wards without their sleeves rolled up, wearing watches and not sanitising their hands upon entering a ward. There were also instances where panel members notified senior ward staff of this happening and nothing was done about it. • Patients noting that many other patients and visitors did not use hand sanitising facilities when entering a ward. • Hand sanitising facilities were not always available and instructions for use were misleading. • Patients describing nurses that wore their uniforms outside the hospital and didn't change them when they came into work. • Lack of awareness amongst staff of who the lead infection control nurse is on a ward. The panel recognises that the Trust has done lots of work in this area already and that results from infection control audits at the Trust are good. However, given the observations over the visits the panel thinks that more can be done.	None noted	Infection control policies/ training needs implementing and routinely auditing. Some trusts have introduced the concept of 'stop the line' (taken from the manufacturing industry), where ALL levels of staff are encouraged to immediately speak up if they see something unsafe, i.e. a porter is encouraged and expected to ask a consultant to roll their sleeves up.	Medium
(ii) Quality, governance and consistent use of data to improve quality at all levels Governance, safety and quality arrangements at the Trust are not fully understood by many of the staff. There is a lack of consistency in looking at mortality indicators and in developing plans to address concerns. Board	The introduction of the Mortality and Morbidity review group should help to triangulate findings across Directorates.	The Trust should use a full range of national data measures for reporting mortality and use such data at ward	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
members acknowledge that there is work to be done in this regard. An example can be taken from the Critical Care team focus group that felt that the use of SHMI and HSMR was not an appropriate measure of mortality and they focussed on ICNARC (Intensive Care National Audit and Research Centre) figures instead.		and team meetings. The Trust should disseminate learning from Mortality and Morbidity review meetings to Directorates to improve mortality management. The Trust should refresh/re launch quality strategy involving the staff and make it relevant to staff in their workplace.	
(iii) Handover reported as being inadequate Staff groups interviewed across a number of wards and clinical areas reported that the changes to nursing shift patterns had reduced the hand-over time between shifts. The changes in the shift times mean that staff do not have sufficient opportunity to work their contracted hours meaning that staff need to work a longer shift. The reduction in handover time has affected different staff on different wards in different ways therefore a 'one size fits all' approach is not appropriate and the needs of each specialty should be considered.	The Director of Nursing is currently undertaking a review of shift patterns and e-rostering and plans are in place to consult with staff.	The Trust should ensure that this review is completed quickly and actions addressed with urgency.	Medium
(iv) Lack of continuity of care Clinical staff and patients raised concerns about the lack of continuity of staff delivering patient care:	None noted	The Trust should focus on getting the right patient, in the right bed at the right time with appropriate clinical oversight of care.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
• Clinical Directors thought that it was hard to retain and recruit Consultants and this led to problems with patients having to see different Consultants over time if they required multiple outpatient visits. • Patients expressed frustration at having to see different clinical staff as they felt as though they had to communicate their problems several times and were worried over the potential for confusion. • Staff also expressed concern over the amount that patients are moved around with movement of patients preventing effective discharge in certain situations.			
(v) Capacity issues Whilst the Trust has a clear strategy for the future use of the Queen's Hospital, there does not appear to be a clear vision for the Samuel Johnson and Sir Robert Peel community hospitals. Both sites have significant spare capacity in a high quality environment that might assist in the Trust's challenges in urgent care capacity and over occupancy at the Burton site. There appears to be a culture of refer and admit rather than admission avoidance in A&E. It is noted that the Trust has recently been subject to an ECIST review where its action plan and actions taken to date on urgent care were signed off as requiring no further support.	Work in progress to redesign referral criteria for community hospital inpatient services. Trust delivering a programme of work, formally approved by ECIST which supports the move towards a clinical model of short stay care. Increasing short stay capacity is a key planned improvement to meet increasing demand. The CCGs have recognised capacity as a major factor in the A&E 4 hour breaches.	The Trust should fully include the two community hospital sites in the strategic plans for the Trust's services and estates. The Trust should increase the utilisation of existing inpatient and theatre capacity in the community hospital sites in the short and medium-term to assist the urgent care pathway. If this is not feasible the Trust should consider reducing the current services it offers on its Community sites, e.g. theatres. The Trust should consider the issues noted in relation to	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
		admissions and length of stays in conjunction with recommendations made about staffing and appropriate clinical oversight elsewhere in this report.	
(vi) Clinical Directors understanding of coding challenges The depth of coding is below the national average. Given that the Trust has been an outlier with its mortality scores for some time the panel would have expected the Clinical Directors to have more insight into the coding/mortality measures. The ITU Consultants were an exception to this.	The recently formed Mortality and Morbidity Group has the Coding Manager as a member, which should help spread knowledge of coding matters.	The (Payment by Results) PbR audit action plan recommended the following actions: (i) Review the process for coding on wards and consider allowing coders to access the coding systems whilst on the ward to complete coding directly from the case notes as opposed to information copied whilst on the ward. (ii) Review the process for coding on wards and consider allowing coders to access the coding systems whilst on the ward to complete coding directly from the case notes as opposed to information copied whilst on the ward. The Trust should action these recommendations as soon as is reasonably practical.	Medium

Patient experience

Overview

The panel focused on how the Trust understands and responds to patient feedback on their experience through discussing this with patients and staff on wards and at the focus groups and listening events, as well as reviewing board and ward level information on patient experience.

Summary of findings

The following good practice was identified:

- Across a variety of wards, patients provided positive feedback and were pleased with the quality of care.
- There was a great feeling of loyalty to the hospital from patients.
- The Director of Nursing has shown an excellent attitude to complaints, and has been revisiting complaints over the past year that were not satisfactorily resolved.
- Many wards achieved good Friends and Family Test (FFT) scores.

The following main areas of concern were identified for patient experience:

- Patients raised concerns related to communication issues with staff, discharge and flow issues, infection control standards and nursing care.
- The Complaints team is stretched and quality of complaints handling has not been good in the past.
- The Friends and Family Test (FFT) is not fully embedded with staff and patients across the whole Trust.

For some of the above areas of concern, the panel identified a number of improvements already underway or planned at the Trust.

Detailed Findings

Good practice identified
Across a variety of wards patients provided positive feedback and were pleased with the quality of care. In particular the following areas of good practice received praise from patients: • Enforcement of protected eating times • The bus service around the Queen's Hospital site helps elderly patients to be mobile • The speed of treatment for emergency cases was praised • When staff had recognised care has fallen short of expectations, they have worked very hard to rectify the situation for patients
Patients felt very loyal towards the Queen's Hospital. Many of them had received good quality of care there and were very keen not to lose services at their local hospital.
The Director of Nursing has shown an excellent attitude to complaints, and has been revisiting complaints over the past year that was not satisfactorily resolved. Some patients the panel spoke to had been contacted by the DoN and thought this was very good.
Many of the wards that were visited by the panel scored highly on the FFT. For example: • ITU scored 88% based on 44 responses • AFU (acute frailty unit) scored 74% based on 19 responses • Elderly care scored 83% based on 6 responses • Female surgical scored 75% based on 28 responses • Gynaecology scored 82% based on 44 responses • Acute respiratory scored 83% based on 40 responses • General medicine scored 78% based on 38 responses • Elderly assessment unit scored 75% based on 24 responses

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Complaints process The panel observed a number of issues related to the complaints process: • The handling of past complaints has not been good. This was acknowledged by the new DoN who has revisited some complaints that he didn't feel were handled well. There were also a number of complaints raised at the Patient and Public listening event where patients raised concerns that their complaint had not been responded to satisfactorily. • Patients fed back that the Trust had been slow to respond to complaints. • Complaints team feel stretched – they don't feel there is enough staff to support the volume of complaints coming through (35-40 a month). The complaints team also felt they had limited support from some Consultants in answering complaints in a timely manner. • The complaints team do not get feedback on complaints once they are sent on to other departments, which raises a concern over who owns the complaints process. • There is a perceived lack of visibility of complaints methods by patients. It wasn't clear who really had control of the complaints process and therefore a lack of ownership.	The Director of Nursing acknowledged that there are shortfalls in the current processes and is currently reviewing these.	The Director of Nursing and the Company Secretary should review the handling of complaints and the processes whereby complaints can be systematically fed back and used by staff teams to improve service delivery. This should include: • Improving understanding and visibility of complaints methods with staff and patients. • Educate front-line clinical staff to respond more effectively to complaints. • Continue to liaise with and meet patients to ensure their concerns are addressed. • Ensure complaints are responded to promptly. • Review size and structure of complaints team given level of work they have to deal with. • Complaints need to be seen as everyone's responsibility – not just the complaints team / board. Devolve complaints management to Directorate/specialty level rather than a centralised process to improve ownership. • Review the process and person responsible for ensuring a complaint is answered in a timely manner. Review where the complaints/PALS team are situated (currently off main site so not accessible to patients/staff).	Urgent
(ii) Patient experience themes The following themes were gathered through speaking to patients at the Patient and Public listening event and on the			

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
ward observations: **<u>Communication:</u>** There was a lot of feedback relating to communication issues between patients and staff. For example, patients reported: • Having to ask the same doctor/nurse the same question several times due to the doctor/nurse not understanding what the patient wanted. • Being moved several times between different wards without being told why by staff members. • A lack of continuity of clinical staff which meant that situations had to be explained to several staff. The communication between staff members was not thought to be good. • Communication regarding appointment bookings was thought to be poor. The panel also noted that some patient notice boards were too cluttered and had the potential to be confusing for patients.	Board members at the Trust have informed us that communication with patients is one of their quality objectives for 2012/13.	Some wards have used the “ASK ME” scheme to improve communication with patients. The Trust should consider rolling out a scheme similar to this across all wards and sites. The Trust should also ensure it uses notice boards to communicate with patients in an effective way. Improve access to Senior nurses/ward managers to speak to patients and relatives.	High
<u>Patient flow issues:</u> A number of patient complaints were related to patient flow issues. For example, patients fed back concerns over the time taken to be admitted into surgery and being moved to wards not related to their illness due to capacity issues. When the site practitioners (bed managers) were asked about this there did not appear to be a consistent method to decide which	A senior matron has been seconded to deal with capacity and flow to ensure patients identified to move are suitable to be transferred out of specialty.	The leadership team should consider methods to improve flow and discharge to ensure the quality of patient care is high. Increasingly trusts are employing ‘discharge doctors’ at weekends and bank holidays (usually an extra registrar, but even consultants in some cases). The Trust should adopt a consistent approach/proforma on patient moves and discharges to ensure patients are treated fairly.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
patients should be moved and when they should be moved between wards as different practitioners described different criteria. Patients also fed back concerns about the time it takes for them to be discharged. Site practitioners confirmed there was a problem with discharging patients efficiently which led to some of the flow issues. They mentioned that the speed at which patients are discharged is dependent on the Consultant that is on duty, noting variability in practices between Consultants. This point may also link in with the other findings of the panel related to a lack of senior out-of-hours coverage. Other patients raised concerns about being discharged too early, saying that they were discharged when they didn't feel ready to. There was a perception that this was done to meet length of stay standards.		The Trust should monitor 'right patient right bed first time' performance. This should limit non clinical bed moves to < 2 per hospital stay. The Trust should adopt a maximum time patients can be moved to create capacity. The Trust should impose a cut off time to reduce the number of times patients are transferred to outlying wards at night.	
Infection control: Many patients fed back concerns related to the infection control standards at the Trust. For example, patients fed back: • Observing other patients and visitors not using hand sanitizing gel when entering the ward. • Concern over nurses not changing uniform when entering ward when they have worn the uniform outside of the hospital before their shift.	None noted	Infection control policies/ training needs implementing and routinely auditing. If the Trust has done this in the past they need to revisit it as it is clearly not embedded across the Trust.	Medium
Nursing care: Patients fed back concerns over nurse staffing levels and the high level of agency staff used on certain wards and for overnight care. Some patients felt there was a lack of	None noted.	The Trust should review the level of documentation required away from the bedside (registered nurses document care plans on computer at nurses' station)	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
professionalism from some of the agency staff, e.g. use of colloquial language and over familiarity. There was also a common view that nursing staff spent too much time spent on administration and paper-work, rather than providing care, which was a view shared by some of the staff that the panel spoke to.		or consider the use of laptops to increase the time that registered nurses are with patients. The Trust should review the level of agency staff it uses. The Trust should also ensure that the appropriate level of staff conduct the right jobs to ensure senior nursing staff spend time on the most important activities.	
<u>Other concerns:</u> Staff member quoted poor experiences of relatives and even when they complained they were not confident any changes had been made in response. Patients also fed back concerns regarding: • Quality of food: This was sometimes not meeting patient expectations, e.g. portion sizes were too small for adults and staff were not considering patients' conditions before providing them with food. • Car parking: Patients raised concerns about car parking.	None noted	The Trust should continue to monitor patient complaints and act to address the common issues raised by patients.	Medium
(iii) FFT needs to be embedded As indicated in the good practice section above, the Trust has clearly done a lot of good work on the Friends and Family Test (FFT) as many wards scored highly. Trusts in the Midlands and East region have also adopted the FFT earlier than in other regions.	None identified	Display FFT scores in all wards. Ensure all staff are aware of the FFT and the scores within their area. Staff should get patients' families or an independent person to fill in FFT forms if a patient can't do it themselves.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
However, some wards did not display such good practices. For example: • Many staff members on wards couldn't provide the FFT scores for their ward. • FFT scores were not on display in all wards. • FFT was not visible to all patients and many had not heard of it. • Feedback forms were sometimes filled in by staff on behalf of patients. • Some of the wards that did score well had low participation numbers. It is noted that the FFT has not been in-force for that long, however, the Trust should look to embed this across all wards as it is a powerful feedback tool.			

Workforce and safety

Overview

The three KLOEs in the workforce and safety area focused on:

- How engaged staff are in the Trust's quality strategy and staff views of the main barriers in the Trust to delivering high quality treatment and care for patients;
- Whether there is adequate mandatory training for staff, including safeguarding and other mandatory training; and
- How the Trust reviews and monitors its patient safety indicators and what actions are taken to improve patient safety.

Summary of findings

The following good practice was identified:

- The new Director of Nursing has made a positive impact on front line staff.
- Staff generally felt supported by their line managers.
- Midwives felt supported by registrars and consultants.
- The Director of Medical Education received universal positive feedback from Junior Doctors.
- Mentoring system for trainee midwives.
- Evidence was provided that demonstrated action had been taken to address concerns raised through the Rule 43 Coroner's Report.
- Tissue Viability Champions are in place throughout the Trust.

The following areas of concern were identified for workforce and safety:

- A lack of support for junior doctors in some areas, specifically lack of medical Specialty Registrars (SpRs) and the resultant expectation that Senior House Officers (SHOs) should 'act up' on regular occasions.
- Staffing levels and skill mix were not found to be adequate in a number of wards. It was also noted that the Trust has a number of recruitment challenges.
- The Trust has implemented an e-rostering system which has received mixed feedback from staff.
- Training provision was found to be inconsistent across the Trust.
- Student nurse placements are a year-long which means that some students do not feel able to raise a concern if they see a problem.

- Staff highlighted a significant number of agency and bank staff.
- Clinical decisions and tasks being routinely delegated to junior staff. There were a number of incidents identified by the panel during the visits of important safety and equipment checks not being completed adequately.
- Escalation procedures are not clearly defined and documented.
- The outcomes of Serious Untoward Incident (SUIs) reports are not well communicated.

For some of the above areas of concern, the panel identified a number of improvements were planned or already underway at the Trust.

Detailed Findings

Staff matters

Good practice identified
The new Director of Nursing has made a positive impact on front line staff since his arrival in February 2013, staff feel that he has consulted widely with them, for example leading a review of the changes in shift patterns, restructuring the head of nursing roles to provide additional support.
Staff felt supported by their line managers. This was particularly the case in Maternity where midwives felt supported by their line managers.
Midwives felt supported by registrars and consultants.
The Director of Medical Education received universal positive feedback from Junior Doctors as he listens to them and has made positive changes, e.g. the surgical FY1 rota. He is leading by example – the paediatric department appears to be exemplar (he is a paediatrician) in terms of support – if there isn't a Specialty Registrar on the rota, the Consultant will hold the bleep, not the junior.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Support for Junior Doctors Junior doctors highlighted an undermining culture and a lack of senior support both through the Deanery Report and their focus group. There was an observation from the medical team that the 'bleep goes down the chain, not up'. Most concerning was a suggestion that junior doctors were being asked to certify deaths for patients they had not previously treated or seen. In addition, there was an allegation that the Bereavement Office was instructing junior doctors to change cause of death on certificates so that it did not read COPD or pneumonia. The panel formally escalated this to the CQC during the announced visit. CQC visited the Trust on 31 May 2013 to perform an inspection into medical record keeping at the Trust. The findings of this inspection are contained in the CQC report. The Junior Doctors did not feel able to raise their concerns about death certification issues within the organisation prior to the Keogh panel visit. From a surgical perspective, there is only a FY1 and SpR (6 Staff grades and 2 Training grades). This means if the senior doctor is in theatre, then the FY1 is expected to look after the wards as well as see new patients in A&E. The rota has recently been adapted to ensure that there are now 2 FY1's to do this at the weekend, but it means that if the senior doctor is in theatres there is no one able to make decisions about admitting and discharging patients.	None noted	The Trust should consider carefully the support that Junior Doctors receive as part of their training and ensure that delegation and escalation are appropriate. The Trust should consider if any action needs to be taken to respond to the CQC inspection.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(ii) Medical staffing levels and skill mix Our observations, interviews and focus groups during the visit identified a number of issues in relation to medical staffing and skills mix which are summarized as follows: • A lack of middle grade medical staff and qualified nursing staff, especially out of hours, leaving staff very stretched with many working shifts of 14 hours. This also feeds in to the comments above about a lack of support for junior doctors. • Healthcare Assistants (HCAs) performing tasks that should be performed by a qualified nurse e.g. blood observations. • Consultant Medical staffing cover at the two Community Hospitals is limited to one day per week, in addition to specialty level cover. • Ward 44 is only covered by 1 staff grade. Up until recently there was no designated consultant cover which can still be ad-hoc. There is no formal cover for sickness or annual leave. In addition, doctors are expected to travel to the other site if the doctor there is absent. • The Trust needs to undertake further work to affirm its Triage processes. Whilst patients access the ED department receptionist as a first point of entry, the policy for triage on admission is through a registered nurse within the department. The existing policy for triage access requires upgrading to make this explicit, and to ensure this reflects service provision. As a result of a suboptimal staff mix, the panel observed clinical decisions being delegated to an inappropriate level. The symptoms of this could be inappropriate admission decisions and lack of discharge out of hours. Since August 2012 there had been a small number of instances where the Trust had been unable to ensure registrar cover at night.	It was noted that the Trust is looking to recruit newly qualified nurses in some areas in response to shortages of more senior nurses.	The Trust should consider urgently the staffing levels and mix throughout the Trust, particularly at middle grades, to address concerns about inappropriate delegation, escalation and lack of decision making. In addition, the Trust should undertake a review of the provision of services at its two community hospitals and whether clinical staffing levels are appropriate and provision of care continues to be sustainable at the current level of service use. The Trust should ensure that roles and responsibilities are performed by an appropriate member of staff.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(iii) E-rostering and Nursing Shifts The Trust has implemented an e-rostering system which has received mixed feedback from staff. Some feedback is very negative and some staff ignore the e-rostering system completely as they do not believe it delivers the right level of patient care. The change to the shift times and reduction in hand over time has resulted in staff struggling to meet their required hours and can sometimes result in staff working a 14 hour shift to make up these hours. In addition, nursing staff are often working 12 days in a row. Ward sisters do not retain ownership of the rotas, instead this is done by HR.	During the visit the panel chair raised this as an urgent issue that the Trust needs to look into. The Chief Executive of the Trust committed to looking into the system urgently and considering how it can be adapted to address the concerns raised by staff.	The Trust was advised as part of the feedback on the announced visit to consider the functionality of the e-rostering system and whether it was fit for purpose. The Trust should endeavour to prevent long shifts or a high number of consecutive working days where possible. The Trust should consider if it is being sufficiently flexible to attract the best staff and to retain high performers.	Urgent
(iv) Recruitment of Clinicians The panel noted that the Trust has a number of recruitment challenges in relation to clinical staff, particularly at the middle grades, which in itself is having a knock-on impact in recruiting Consultants. Challenges in recruiting radiologists means the Trust is unable to provide sufficient image reporting capacity and are therefore having to outsource elements of this service.	None noted	The Trust should seek to understand what the true barriers are for recruiting appropriately qualified staff at the right level of experience. Once this is understood, a plan to address any concerns can be put in place.	Medium

Workforce planning

Good practice identified
The Trust has a mentoring system for trainee midwives which exposes them to a wide variety of experiences and learning.
Staffing in maternity and paediatrics was considered good.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Training Training provision was found to be inconsistent across the Trust. Student nurses reported episodes of not having worked in a supervisory manner, and not being released from wards for external training. Junior doctors reported being refused the opportunity for training where cover is not sufficient. HCAs also reported challenges related to getting access to training and said that they sometimes have to do it in their own time. A significant amount of the FY1 teaching sessions were cancelled. This is reflected in the GMC and deanery feedback. It should be noted that midwives identified the training as good and followed a good format of mentoring and learning as part of their studies.	The Trust has done some work to address this issue, and continues to monitor the training provision and super numerary status of student nurses alongside university and learning and development colleagues.	Student nurses should be super-numerary from the Trust's establishment. The Trust should ensure wards are sufficiently covered to allow both student nurses and junior doctors adequate protected learning time for training.	Medium
(ii) Agency and Bank Staff Staff highlighted the use of a significant number of agency and bank staff which has led to departments not feeling like 'a team' as agency staff are not part of the permanent structure and culture of the Trust. This was not the case in maternity or ITU/HDU where their permanent staff worked bank shifts to support the unit as needed to avoid use of agency.	None noted	The Trust should consider if there are more appropriate ways to fill gaps in staffing levels in conjunction with its review of the e-rostering system as set out above. This should encompass consideration of how effectively bank staff are used.	Medium
(iv) Student Nurse Placements Student nurse placements are a year-long which means that some students do not feel able to raise a concern if they see a problem because they are worried about how they will be treated by staff.	None noted	The Trust should consider putting in place additional mechanisms to allow student nurses to feed back concerns without fear of repercussions. The Trust should also consider	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
		allowing more flexibility in the placements of student nurses so that learning is maximised during their training period.	

Patient Safety

Good practice identified
Satisfactory evidence was provided that demonstrated action had been taken to address concerns raised through the Rule 43 Coroner's Report. The evidence was reviewed by the panel and identified that appropriate action had been taken against each of the rulings made by the Coroner.
Tissue Viability Champions are in place throughout the Trust.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Equipment safety checks Some areas of the Trust visited were found not to be fully completing relevant safety and equipment checks. In particular, the following examples were noted: • Resuscitation equipment in A&E and paediatrics had not been checked on a number of occasions at the start of May. • Resuscitation trolleys in A&E checked on our unannounced visit (3 June 2013), identified out of date bags of Gelofusine, something that was escalated immediately. It should be noted that these had an expiry date of April 2013 therefore the robustness of the checks is also in question as these trolleys had been signed off subsequent to this date.	None noted	The Trust should review all resuscitation trolleys to ensure they are fully stocked, organised and there are no out of date drugs or fluids. Staff should be reminded of the importance of regular resuscitation equipment checking.	Urgent
(ii) Escalation Procedures Escalation procedures were not always fully understood within the Trust - The Trust has an approved Trust wide and emergency department escalation plan, but staff could not clearly articulate this. There was no defined document on maternity for escalation; however, staff reported confidence in calling on more senior staff to support at times of high activity or acuity. Senior staff were responsive to this request. Staff raised that DNAR procedures were inconsistently followed in the Trust and often DNAR was seen as 'do not escalate' or 'do not treat'.	Escalation procedures are currently being reviewed so that they align to the new ward developments that will be in place in August and also take account of recent changes to medical cover as part of the change to ward based medicine.	The Trust Board should ensure all staff are aware of the Trust's escalation procedures and make sure that they are followed to enable decisions to be made on a timely basis and by the appropriately qualified people.	Medium
(iii) Communication of Serious Untoward Incidents (SUIs) Whilst SUIs are reported, staff felt that the outcome of this reporting was not communicated back to them. Some staff also did not agree that there was a 'no blame' culture at the Trust. The exception to this was maternity where staff felt that appropriate feedback was received on a timely basis.	None noted	The Trust should ensure that the results of all SUI reporting is made available to Trust staff so that the learning is disseminated and staff are encouraged to maintain a reporting culture.	Medium

Pressure ulcers

Overview

Pressure ulcer care and prevention was identified as a key line of enquiry based on review of the data pack and the information submitted by the Trust. Between April 2012 and February 2013, 21 serious incidents had been reported for pressure ulcers that had developed/deteriorated to a Grade 3 or Grade 4 whilst the patient was in hospital, pressure ulcers were also flagged as 'outside of expected range' in the data pack.

To gather evidence in relation to good practice and areas of concern for pressure ulcer care and prevention, the panel observed a number of areas in the hospital with a particular focus on care of the elderly. Observations followed the pathway from admission through to ongoing care on the wards and community hospitals. The panel assessed adherence to guidelines and care pathways as well as availability of equipment, staff were interviewed from Board to ward and patient notes were reviewed for a detailed view of their care.

Generally, processes for the prevention of PU have been rapidly introduced since the IST visit. The Trust has eliminated Grade 4 pressure ulcers. Equipment and documentation are being considered and introduced. The tissue viability nurses (TVNs) have introduced innovative ways of delivering education. It appears that there is little else that needs to be considered by the Trust but where changes are being rolled out or explored, such as with the communication tool or heel protection, it is recommended that this process is accelerated.

The following good practice was identified:

- Ward staff are positive about the Tissue Viability Nurses (TVNs) in the trust and their contribution to pressure ulcer prevention.
- Staff are aware of the process to be followed on pressure ulcer care and prevention.
- Pressure ulcers are high on the Board's agenda and it has demonstrated that it takes action to resolve issues uncovered in this area.
- Equipment library has helped staff to access suitable mattresses in an appropriate amount of time, including out of hours.
- Patients seemed well informed of pressure ulcer prevention care.
- Daily communication tool on ward 3 which has been rolled out to a number of wards now used during the day to communicate which patients have PU's. There is a planned roll out programme to all areas – it is recommended this is expedited.

The following areas of concern were identified:

- Lack of heel protection equipment.

- The trust has been slower to adopt best practice in this area in comparison to other providers. The Trust had a number of actions in place to eliminate grade 3 and 4 avoidable pressure ulcers. These actions were reviewed following an external peer review by the Intensive Support Team (IST) visit in July 2012, in line with the Pressure Ulcer Collaborative and IST recommendations.
- Staff could not communicate the number of pressure ulcer free days they had observed.
- Multiple ward moves were a theme raised from Route Cause Analysis (RCA) and this needs consideration by senior trust management to identify systems to reduce ward moves.
- Possibly an insufficient number of TVNs.

For some of the above areas of concern, the panel identified a number of improvements were planned or already underway at the Trust.

Detailed Findings

Good practice identified
Ward staff are positive about the contribution of TVNs in the trust.
Staff were aware of the process they are required to follow for pressure ulcer care and prevention and could clearly articulate how it happens in practice.
Pressure ulcers are high on the Board's agenda and it has demonstrated that it takes action to resolve issues uncovered in this area.
The level of equipment available did not appear to be an issue; the Trust has a medical equipment library which can still be accessed out of hours. At Samuel Johnson each ward owned its own mattresses. There were no staff complaints about access to equipment and the panel did not identify any patients on an inappropriate mattress during observations.
Patients seemed well informed of pressure ulcer prevention care, patient feedback on a number of wards was that they were aware of the nurses repositioning them and checking their skin and they understood why it was being done.
Daily communication tool on ward 3 which has been rolled out to a number of wards now used during the day to communicate which patients have pressure ulcers. There is a planned roll out programme for all areas – it is recommended this is expedited.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Lack of heel protection equipment A number of examples were identified including; - At Samuel Johnson they used Repose for heels when there were part of a community Trust but as the Trust does not use them they are no longer provided. There is no current alternative. - Wards observed at the Trust provided no heel protection to patients.	The panel was informed by the TVNs that heel protection is being considered.	Process for introducing heel protection needs expediting as a priority.	Medium
(ii) Trust was slow to act on pressure ulcers The Trust had a number of actions in place to eliminate grade 3 and 4 avoidable pressure ulcers. These actions were reviewed following an external peer review by the Intensive Support Team (IST) visit in July 2012, in line with the Pressure Ulcer Collaborative and IST recommendations.	Actions are now ongoing. The TVN was highlighted as being excellent but is only on secondment. The staff's assessment is that two more TVNs are needed.	The Trust needs to continue the good work it has started on pressure ulcer prevention and care and where changes are being rolled out or explored, such as with the communication tool or heel protection, it is recommended that this process is accelerated.	Medium
(iii) Staff could not communicate the number of pressure ulcer free days they had observed Particularly in the community hospitals, staff were unable to identify and communicate the number of pressure ulcer free days they had observed.	None identified	The Board should communicate the progress the Trust has made and encourage all wards to monitor and promote their 'pressure ulcer free' days	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(iv) Multiple ward moves Multiple ward moves hinders pressure ulcer prevention activities.	None identified	RCA theme of multiple ward moves needs consideration by senior trust management to consider systems to reduce ward moves.	Medium

Respiratory Medicine

Overview

Respiratory medicine was identified as a key line of enquiry based on the mortality data in the data pack and the results of two external reviews;

- Pneumonia within the Cardiology, Critical Care and General Medicine specialities shows as an HSMR red flag for 2012 in the data pack. It is also red-flagged for the SHMI non-elective indicator within the Critical Care specialty.

- West Midlands Quality Review on long term conditions: Review team raised an immediate concern on non-invasive ventilation (NIV) - the Medical Director has met with respiratory team to review and agree actions.

- Peer review (March 2012): Inspection of respiratory services for individuals with COPD. Concerns raised that only 25% of COPD patients under care of respiratory consultant, layout of the ward, nurse staffing and nurse training. Recommendations included a move to a ward-based system, review on consultant job plans, education programme, and improvement in palliative care for COPD patients.

To gather evidence in relation to good practice and areas of concern for Respiratory medicine, the panel observed a number of wards within the hospital and held interviews and focus groups with key staff members delivering respiratory services.

The following good practice was identified:

- The Trust has actions in place following external reviews.
- The Trust has ring-fenced beds for NIV and increase nurse training for NIV.
- Investment has been made in nurse staffing levels and education programmes.
- The Trust has moved to a ward based system.
- The Trust has identified a new pneumonia care pathway.
- There are daily (Monday to Friday) Respiratory consultant ward rounds.

The following areas of concern were identified:

- Lack of specialist nursing cover for the ward.
- Lack of community respiratory nurses leading to higher admissions. Clinical engagement with commissioners is required to see how services could be further improved.
- Medical staffing is insufficient.

For some of the above areas of concern, the panel identified a number of improvements were planned or already underway at the Trust.

Detailed Findings

Good practice identified
The review from March 2012 has resulted in a detailed action plan. Many of the actions have been completed since including a dedicated clinical lead that now has protected time in his job plan to fulfil this role. There was clear enthusiasm and determination and openness in accepting that there is always room for improvement.
The Respiratory ward has ring-fenced beds for NIV. Ward 3 has negotiated with the bed management team for 2 of the 32 beds on the ward to be ring-fenced for NIV, leaving a 30 bed capacity. These 2 beds are never used as spare capacity and this was evidenced during the ward observations. The unit has now introduced a rota combining the three respiratory consultants and five ITU consultants so that there is always ready availability of consultant level skills in NIV to ensure this service is safe and well monitored.
Investment has been made in nurse staffing levels and education programmes. The respiratory lead has recently introduced an e-learn education programme for nurses that is accessible both at work and at home. The package has increased knowledge, competition and therefore morale among the nurses. The panel heard that the Trust Post Graduate centre has an excellent Simulation Centre that is well used and links well with the competency training in respiratory care. Sickness rates are very low at less than 2%. Staffing levels are good after a lot of work from the nurse manager within medicine. A high nurse to patient ratio is needed because of the layout of the ward and with the introduction of specific NIV beds.
As a result of the recent quality review, the unit has changed to a ward-based system. That is, instead of a consultant on call continuing to look after everyone admitted on his take wherever they may be in the hospital, they now look after patients who end up on their own ward, ward 3, but not those on other wards unless they are on a surgical out-lying ward. This has allowed more patients with difficult respiratory disease to be looked after in one area and it is clear from everything the panel heard from ward staff and the focus group, that morale has risen markedly from this.
The respiratory department is in the process of producing a care pathway to go on the intranet for patients with pneumonia. The unit has not been able to be part of the British Thoracic Society pneumonia audit and this would be valuable as a baseline with the introduction of the care pathway for pneumonia. The respiratory team cannot look after everyone with pneumonia, but should oversee excellence in care by all teams, and regular audit of the care pathway will ensure appropriate diagnosis, suitable rapid antibiotics and the correct antibiotics as outlined in guidelines.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Lack of specialist nursing cover There are 1.5 Whole Time Equivalent (WTE) respiratory nurses at the Trust. The part time nurse spends all of their time on oxygen assessments for community patients and therefore does not support the care delivered in the hospital. The full time nurse is therefore the only specialist nurse working in the hospital. With only one respiratory specialist nurse in the team who is not reliably covered when away on holiday, study leave, maternity leave or sickness, the consultant team is left very exposed in terms of providing a quality service.	None noted	Serious consideration should be given to increasing the number of specialist respiratory nurses on the respiratory team to allow cross cover and enhance the ability to identify and treat all non-elective patients with respiratory diseases admitted to the trust. In the context of difficulties recruiting middle grade medical staff, this becomes a really important way of potentially building in stability of approach for the patients and useful support for the consultants, JDs and nursing staff. This is an increasing problem in many hospitals which used to be partly solved by appointing non career middle grades, which is proving more difficult now. Nurses must be appropriately trained.	High
(ii) Lack of community respiratory nurses leading to higher admissions - clinical engagement with commissioners is required to see how services could be further improved Arrangements for community care for respiratory patients are limited with those the panel spoke to not being aware of any specialist respiratory nursing in the community. Therefore there is little support for patients resulting in those with long term conditions coming into hospital for care they could receive in a community setting.	The panel is not aware of any current plans to change this arrangement.	This should be looked at jointly by the commissioners, GPs and acute trust. Similarly the development of further Oxygen assessments would best be developed within the community with links with the respiratory department at Queens hospital.	Medium
(iii) Medical staffing There are three WTE Consultants and one part-time; this is low for the	The Trust has agreed to additional funding and is out to recruitment for a 4th Consultant and is	The Trust should increase Consultant cover following this agreement and continue to monitor the situation.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
population served. There is one middle grade career post. This does not provide satisfactory stability of input. There is one trainee registrar post but this post is vacant for at least 25% of the time and is not being filled by the Deanery, with numerous adverts failing to attract appropriate locum staff. This lack of middle grade cover increases the workload of the Consultants considerably, although the cover from the Consultants is considered excellent in terms of accessibility. The Trust is at risk of failing to attract high calibre candidates onto its establishment.	interviewing 31st July 2013.		

Urgent Care Pathway

Overview

The Urgent Care Pathway was chosen as a KLOE due to the high HSMR values for non-elective admissions and concerns raised about senior out-of-hours cover in the Accident and Emergency department.

The following good practice was identified:

- The Trust is committed to recruiting and developing high quality staff in the Accident and Emergency Department.
- ICU had positive patient feedback.
- One of the nursing managers introduced a new paper-based admittance, triage and discharge form whilst a new system was being built. This has helped to track a patient through the hospital and leaves a clear audit trail as to the assessments and decisions taken.
- Neutropenic sepsis pathway operating via the Accident and Emergency Department.
- The Trust is delivering a comprehensive programme of work, approved by ECIST to improve its non-elective pathway and improve the flow of patients through the hospital.

The following areas of concern were identified:

- Staffing levels and skill mix were not optimal.
- Escalation processes were not fully understood.
- A&E equipment and fluid checks were not taking place.
- Concerns were noted with respect to junior doctors/middle grades.
- Activity levels and flow challenges.

For some of the above areas of concern, the panel identified a number of improvements were planned or already underway at the Trust.

Detailed Findings

Good practice identified
The Trust is committed to recruiting and developing high quality staff in the Accident and Emergency Department. The department is finding that it is able to recruit, and receive multiple applicants for each available post (38 applications for 9 vacant posts), whilst the other wards are struggling to recruit.
ICU had positive patient feedback.
One of the nursing managers introduced a new paper-based admittance, triage and discharge form whilst a new system was being built. This has helped to track a patient through the hospital and leaves a clear audit trail as to the assessments and decisions taken.
The Trust is delivering a comprehensive programme of work, approved by ECIST to improve its non-elective pathway and improve the flow of patients through the hospital.

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(i) Staffing levels and skill mix The panel had a concern over staffing levels in A&E. A number of staff members spoken to regularly had to work very long shifts (14 hours) which the panel thought were unsustainable. There was also a concern from staff about the level of Consultant and nursing out-of-hours coverage in the department. It was noted that a high level of bank staff is used in A&E (30%).	The panel is not aware of any current plans to review these is arrangements	The skills mix and staffing levels should be addressed to ensure experienced clinical staff are used effectively and no single person is required to work at an unsustainable and unsafe level.	Urgent

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
(ii) A&E equipment and fluid checks The panel made a number of concerning observations in A&E: • Resuscitation equipment in A&E had not been checked on a number of occasions at the start of May. • Resuscitation trolleys in A&E checked on the unannounced visit identified out of date bags of Gelofusine, something that was escalated to the Charge Nurse immediately. It should be noted that these had an expiry date of April 2013 therefore the robustness of the checks is also in question as these trolleys had been signed off subsequent to this date. • Paediatric airway trolley was documented as missing equipment on 3 consecutive days, with no action to remedy or restock.	No evidence of plans to address this.	Develop and monitor clear professional accountability to check, restock and remedy deficiencies every day.	Urgent
(iii) Concerns with junior doctors/middle grades There appeared to be a disconnect between the views of A&E senior team members and junior members with regards to the working conditions in the department. Junior doctors fed back that they did not feel supported and did not feel that Consultants are responding to them about their concerns. The Deanery has raised concerns about the treatment of junior grades at the hospital and along with the reports from current junior staff, recruitment was thought to be difficult at this grade.	None identified.	A&E could set up regular meetings with the other specialities, providing a 'safe' feedback opportunity for both parties. This would also encourage and facilitate junior doctors and middle grades to follow up on patients they have seen, providing fantastic learning opportunities for everyone, and help break down the barrier.	High

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
The level of support from consultants was thought to be inconsistent, with junior doctors saying that some consultants provided good support and others did not. While some consultants provided an “extra pair of hands” at times of peak pressure, there was a lack of evidence of leadership and managing pressures on a department or Trust basis – see comments on escalation policies below.			
(iv) Escalation process As with other areas of the Trust, escalation procedures were not always fully understood within the Trust. The Trust has an approved Trust wide and A&E escalation plan, but staff could not clearly articulate this. This is particularly important for this Trust given that senior out-of-hours coverage is also a concern. There did not appear to be a clear process to decide on the prioritisation of patients in A&E, and the panel observed a number of breaches of the 4-hour waiting time standard to which all Trusts in England are expected to deliver for patients (the national standard for Trusts in England is for 95% of A&E patients to be discharged, admitted or transferred within 4 hours of arrival).	Escalation procedures are currently being reviewed so that they align to the new ward developments that will be in place in August and also take account of recent changes to medical cover as part of the change to ward based medicine.	Develop, communicate and implement escalation plans/policies with objective metrics to address • Potential 4 hour breeches • Exceptional demand for A&E care • Critical bed capacity	Medium
(v) Activity levels and flow challenges The A&E department has high activity levels. The panel spoke to a number of patients and staff groups about this and the general themes as to why this was happening were: • Many patients go to A&E as they don’t know where else to go. There appeared to be a lack of public awareness of	Trust delivering a programme of work, formally approved by ECIST which supports the move towards a clinical model of short stay care. Increasing short stay capacity is a key planned improvement to meet increasing demand.	Implement action, with the CCGs, to improve discharge from the hospital – the “back door” - and reduce admission conversion rate from A&E. Monitor KPIs and quality impact.	Medium

Outstanding concerns based on evidence gathered	Key planned improvements	Recommended actions	Priority – urgent, high or medium
alternatives of going to A&E. The Trust should consider how this can be addressed. • Staff commented that the overnight closure of the Staffordshire Hospital A&E department has caused a greater than expected strain on Queen's Hospital A&E department. These high activity levels are thought to contribute to other concerns described in this section, such as staff being over-stretched, and the Trust needs to consider the best way to respond to these challenges.	The CCGs have recognised capacity as a major factor in the A&E 4 hour breaches. The Trust and the 3 CCGs have recognised capacity and delayed discharge have an impact on non-elective patient flow. The Trust has agreed a CQUIN with the CCG and Community Trust to improve discharge and support admission avoidance.		

5. Conclusions and support required

The review identified a number of good areas of practice across the Trust, with some great examples of excellent care being delivered to patients. Some staff groups and particular individuals at the Trust also received praise. The review also identified a number of areas of outstanding concern across all ten key lines of enquiry which will require urgent or high priority action to address as identified in the detailed findings section. The Trust recognises that there are steps it needs to take to address the concerns raised by the review. Some improvement plans are already in motion, and the review team thinks these should be expedited. Other things may be areas that the Trust has not yet considered and the panel recommends the Trust quickly develops action plans to address these concerns. A number of these areas were recommended for discussion at the risk summit to consider what support may be required from the Trust to address these concerns.

Urgent and high priority actions for consideration at the risk summit

Problem identified	Recommended Action for discussion	Support required by the Trust
1. Understanding of Trust's quality objectives in the organisation - there was confusion amongst staff about the governance structures and processes for quality and patient safety.	The Board should ensure that there is a systematic approach in place for the collection, reporting and acting upon information on the quality of services. This review should include patient and clinician insights and should ensure that the processes include feedback and engagement of staff in learning and service improvement.	
2. The Trust's Board needs to improve communication with its front line staff and with patients	The Trust should review how it communicates with its staff to ensure that it is using the correct methods of communication and is effectively sharing learning from incidents and complaints reporting with its staff. The Trust should also review its handling of patient complaints and ensure that front-line staff are communicating with patients in an effective and compassionate manner.	
3. Support for Junior Doctors – Junior Doctors fed back a number of concerns which reinforced the findings of the Deanery report.	The Trust should consider carefully the support that Junior Doctors receive as part of their training and ensure that delegation and escalation are appropriate.	
4. Medical staffing levels and skills mix – there was a concern over staffing levels of middle grades in particular. The Nursing staffing levels and skills mix was also found to be suboptimal in places.	The Trust should consider urgently the staffing levels and mix throughout the Trust, particularly at the middle grades, to address concerns about inappropriate delegation, escalation and lack of decision making. In addition, the Trust should undertake a review of the provision of services at its two community hospitals and whether clinical staffing levels are appropriate and provision of care continues to be sustainable at the current level of service use.	Staff review support

Problem identified	Recommended Action for discussion	Support required by the Trust
5. e-rostering and Nursing Shifts (page 40) – the e-rostering system is causing a number of problems for staff, in particular, some nurses having to work very long shifts.	The Trust should ensure that the working practices of its staff are safe and sustainable and prevent long shifts or a high number of consecutive working days where possible. It should also review the e-rostering system currently in place and make changes so that it better meets staff and clinical requirements.	
6. Equipment safety checks (page 43 & 55) – equipment safety checks were not complete on a number of observations.	The Trust should review all resuscitation trolleys to ensure they are fully stocked, organised and there are no out of date drugs or fluids. Staff should be reminded of the importance of regular resuscitation equipment checking.	

Appendices

Appendix I: SHMI and HSMR definitions

HSMR definition

What is the Hospital Standardised Mortality Ratio?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

How does HSMR work?

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific groups (CCS groups); in a specified patient group. The expected deaths are calculated from logistic regression models taking into account and adjusting for a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

How should HSMR be interpreted?

Care is needed in interpreting these results. Although a score of 100 indicates that the observed number of deaths matched the expected number; in order to identify if variation from this is significant confidence intervals are calculated. A Poisson distribution model is used to calculate 95% and 99.9% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

SHMI definition

What is the Summary Hospital-level Mortality Indicator?

The Summary level Hospital Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the general standardised mortality ratio; a measure based upon a nationally expected value. SHMI can be used as a potential smoke alarm for potential deviations away from regular practice.

How does SHMI work?

1) Deaths up to 30 days post acute trust discharge are considered in the mortality indicator, utilising ONS data
2) The SHMI is the ratio of the Observed number of deaths in a Trust vs. Expected number of deaths over a period of time
3) The Indicator will utilise 5 factors to adjust mortality rates by
    a. The primary admitting diagnosis
    b. The type of admission
    c. A calculation of co-morbid complexity (Charlson Index of co-morbidities)
    d. Age
    e. Sex

4) All inpatient mortalities that occur within a Hospital are considered in the indicator

How should SHMI be interpreted?

Due to the complexities of hospital care and the high variation in the statistical models all deviations from the expected are highlighted using a Random Effects funnel plot

Some key differences between SHMI and HSMR

Indicator	HSMR	SHMI
Are all hospital deaths included?	No, around 80% of in hospital deaths are included, which varies significantly dependent upon the services provided by each hospital	Yes all deaths are included
When a patient dies how many times is this counted?	If a patient is transferred between hospitals within 2 days the death is counted multiple times	1 death is counted once, and if the patient is transferred the death is attached to the last acute/secondary care provider
Does the use of the palliative care code reduce the relative impact of a death on the indicator?	Yes	No
Does the indicator consider where deaths occur?	Only considers in hospital deaths	Considers in hospital deaths but also those up to 30 days post discharge anywhere too.
Is this applied to all health care providers?	Yes	No, does not apply to specialist hospitals

Appendix II: Panel Composition

Panel role	Name
Panel Chair	Ruth May
Lay representative (Patient/public representative)	Leon Pollock
Lay representative (Patient/public representative)	Alan Keys
Lay representative (Patient/public representative)	Norma Armston
Junior Doctor	Ester Kwong
Junior Doctor	Bethan Graf
Doctor	Richard Dent
Doctor	Mike Lambert
Doctor	Daren Forward
Doctor	Balraj Appadu
Student Nurse	Nicola Hendrick
Board Level Nurse	Suzie Loader
Board Level Nurse	Sylvia Knight
Senior Nurse	Michelle Rowley
Nurse	Tonia Dawson
Nurse	Anne Thomas
TV Nurse	Heidi Guy

Panel role	Name
CQC representative	Debbie Widdowson
Senior Trust Manager	Erica Loftus
Coding Specialist	Trudy Taylor
Senior Regional Support	Gareth Harry
Senior Regional Support	Trish Thompson
Senior Regional Support	Shelley Bewsher
CCG Observer	Charles Pidsley
CCG Observer	Tony Bruce
CCG Observer	Heather Johnson

Appendix III: Interviews held on announced visit

Interviewees	Date held
Chief Executive, Chair and Non Executives	23 May
Craig Stenhouse, Medical Director, and Brendan Brown, Director of Nursing	23 May
Mark Powell, Director of Operations, Tony Waite, Director of Finance and Jackie Jones, Director of Strategy	23 May
Coding team: Celine Barrett (Head of Clinical Coding), John Whitehouse (Information Manager)	23 May

Appendix IV: Observations undertaken

Observation area	Date of observation
Acute Respiratory (Ward 3)	22 May
Care of Elderly ward	23 May
Cardio respiratory	23 May
Samuel Johnson Community Hospital, Lichfield (various clinical areas)	23 May
Acute Respiratory (Ward 3)	23 May
Paediatrics (Ward 1 & 2)	23 May
AFU (ward 9)	23 May
Maternity (Ward 15 and 16)	23 May
Male surgical unit (Ward 4)	23 May
Adult Medicine (Ward 7)	23 May
EAU (Ward 8)	23 May
ED (Ward 5)	23 May
General Medicine (Ward 6)	23 May
Rehabilitation (Ward 44)	24 May
Accident and Emergency (A&E)	23 May
General surgery	23 May
Orthopaedics (Wards 19 & 20)	23 May

Observation area	Date of observation
Acute medical (ward 12)	23 May
Antenatal	23 May
ITU	24 May
SCBU	24 May
Gynaecology (Ward 14)	23 May
Chemotherapy outpatients unit	24 May
Sir Robert Peel Community Hospital, Tamworth (various clinical areas)	23 May
Neonatal Unit	23 May
Theatres	23 and 24 May
General Surgery (Ward 30)	23 May
A&E	3 June
Maternity (Delivery Suite)	3 June
Maternity (Ward 16)	3 June
Acute Respiratory (Ward 3)	3 June
Coronary Care	3 June
Critical Care Unit	3 June
General Medicine (Ward 6)	3 June

Appendix V: Focus groups held

Focus group invitees	Focus group attendees	Date held
Trainee Nurses	18 registered attendees	23 May
Senior Doctors	8 registered attendees	23 May
Health Care Assistants	16 registered attendees	24 May
Senior Nurses	20 registered attendees	23 May
Governors	9 registered attendees	23 May
Non-clinical staff	14 registered attendees	23 May
TV Nurses, Matron and Head Nurse	11 registered attendees	23 May
Junior Doctors	9 registered attendees	23 May
Union representatives	7 registered attendees	23 May
Clinical Directors	8 registered attendees	23 May
Accident and Emergency Team	8 registered attendees	23 May
Critical Care Team	6 registered attendees	23 May
Cancer team	11 registered attendees	24 May
Other clinical staff	9 registered attendees	24 May
Respiratory Team	4 registered attendees	24 May

Appendix VI: Information available to the RRR panel

1_Quality Strategy BHFT 2012 to 2014.pdf	6_Chief Executive CV.pdf	7_Nomination Committee ToR.pdf
2_Assurance Framework - March 13.pdf	6_Director of Finance CV.pdf	7_People Committee ToR.pdf
2_Chief Executive.PDF	6_Director of Finance Personal Statement.pdf	7_Remuneration Committee ToR.pdf
2_Director of Finance.PDF	6_Director of Nursing CV.pdf	7_People Committee ToR.pdf
2_Director of Nursing.PDF	6_Director of Operations CV.pdf	7_Remuneration Committee ToR.pdf
2_Director of Operations.PDF	6_Director of Strategy CV.pdf	7_Trust Committee structure.pdf
2_Director of Strategy.PDF	6_Executive Chart.pdf	8_Board Papers Closed Session - 28 March 2013.pdf
2_Medical Director.PDF	6_Executives Chart.pdf	8_Board Papers Open - 28 March 2013.pdf
3_Clincal Audit and Effectiveness Annual Report 11-12.pdf	6_Medical Director Appendix to CV.pdf	8_Closed Board Papers - 7 March 2013.pdf
3_Clinical Audit Forward Plan 2013-14 Working draft.pdf	6_Medical Director CV.pdf	8_DRAFT Minutes Board of Directors CLOSED 7 March 2013.pdf
4_CIP Dashboard 12 13.pdf	7_Audit Committee ToR.pdf	8_DRAFT Minutes Board of Directors OPEN 28 March 2013.pdf
4_CIP Dashboard 13 14.pdf	7_Charitable Funds ToR.pdf	8_DRAFT Minutes Board of Directors OPEN 7 March 2013.pdf
4_CIP Gateway processes.pdf	7_Finance & Investment Committee ToR.pdf	8_Open Board Papers - 7 March 2013.pdf
5_Quality Governance Self Assessment.pdf	7_Governance Risk Assurance Committee ToR.pdf	8_Tabled - Att 8 - Assurance Framework - March 13 -

		BoD OPEN 7 March 2013.pdf
8_Tabled - Burton Enforcement Action - cover letter - re sig breach verbal update.pdf	10_PDF MoRAG - 17.04.13.pdf	13_Enc 8 - Mortality Review Template 4 15.12
8_Tabled - Burton Section 106 Undertaking re sig breach verbal update.pdf	11_Medicine IPR 12 13.pdf	13_Enc 9 - Inspection of COPD at Queen.pdf
8_Tabled - FI Meeting Summary - BoD OPEN 28 March 2013.pdf	11_Surgery IPR 12 13.pdf	13_Enc 9a - COPD Business Case.pdf
8_Tabled - Future Ownership of the Community Hospitals - BoD CLOSED 28 March 2013.pdf	11_Trust IPR 12 13.pdf	13_Imperial College London - Mortality Outliers 16.04.10.pdf
8_Tabled - GR&A Summary Report - BoD OPEN 28 March 2013.pdf	13_CQC Alert - septicaemia.pdf	13_Response to CQC - 21.12
9_AGREED Minutes GR&A 22 February 2013.pdf	13_CQC Mortality Alert - Pneumonia.pdf	13_Response to CQC Alert Pneumonia - 04.03.pdf
9_DRAFT Minutes GR&A 21 March 2013.pdf	13_Enc 1 - CQC alert Pneumonia.pdf	14_Burton Acute Oncology EMCN 2013 Draft.pdf
9_GR&A Papers - 21 March 2013.pdf	13_Enc 2 - HSMR dataset and relative risk.pdf	14_IMD Report 20 December 2012.pdf
9_GR&A Papers - 22 February 2012.pdf	13_Enc 3 - pneumonia HSMR 12mnths.pdf	14_Inspection of Respiratory Services for individuals with COPD at Queen.pdf
10_Appendix 1 - low pred mortality deaths Jan to Jun 2012 and July - Sept 2012.xls	13_Enc 4 - pneumonia by age.pdf	14_National Cancer Peer Review Internal Validation Process Report 2012.pdf
10_Appendix 2 Copy of Unit Self Assess Tool Burton 16 January 2013 WITH ACTION PLAN.xls	13_Enc 5 - pneumonia day of admission.pdf	14_PWC Report on CIP process.pdf
10_Critical Care mortality report.pdf	13_Enc 6 - pneumonia comorbidity.pdf	14_RCS Colorectal Review Report - July 2012.pdf

10_DRAFT MoRAG Minutes - 17 April 2013.pdf	13_Enc 7 – CQC Analysis of J18 patients.pdf	14_Royal College of Radiologist - initial feedback.pdf
14_Staffordshire Cluster CIP assurance stage 1 report for BHFT.pdf	Heatmap - Trust.pdf	Routine Observation Chart.pdf
14_WMQRS Critical Care - confirmation email.pdf	MG Rota (A&E).pdf	Suggest Report 12-13 and 13-14 numbers.pdf
14_WMQRS Critical Care Review.pdf	Minimum Observation Standard.pdf	Trends in Colorectal 30 day Mortality after Colorectal Cancer Surgery.pdf
15_Clinical Networks.pdf	Minutes of Mortality Note Analysis Group held on 4th April 2013.pdf	Trust Committee Structure (Feb 2012).pdf
15_Local Providers.pdf	Minutes of Mortality Note Analysis Group held on 15th May 2013.pdf	Update on quality concerns - Feb 28th 2013.pdf
15_Review of SSOTP BHFT joint working.pdf	Minutes of Mortality Note Analysis Group held on 16th January 2013.pdf	Critical Care Nursing Off Duty.pdf
A&E Attendances (based on discharge date).pdf	Modified Early Warning Observation and Fluid Balance Chart.pdf	Critical Care Nursing Staff Levels.pdf
A&E Patient information.pdf	Mortality Review - April 2013.pdf	Work Roster - 206 Nursing Midwifery L5.pdf
Burton Hospitals - Areas of Concern Nov 2012.pdf	Objectives - Quality and Governance.pdf	Work Roster - 206 Nursing Ward 6 L5.pdf
Complaints.pdf	Peri Operative Care Theatre Documentation.pdf	Work Roster - 206 Nursing Ward 12 L5.pdf
CSP Report Template (v1).pdf	Position statement on the governance of patient quality and safety within the organisation.pdf	Work Roster - 206 Nursing Ward 14 Gynae L5.pdf
Emergency Department Nursing Documentation.pdf	Quality Concerns - BHFT April 2013.pdf	Work Roster - 206 Nursing Wd 11 L5.pdf
GML Report.pdf	Quality Improvement Action Monitoring Report -	Work Roster (4 weeks) - 206 Nursing Ward 3 L5.pdf

	April 2013.pdf	
Work Roster (4 weeks) - 206 Nursing Ward 14 Gynae L5.pdf	Work Roster (4 weeks) - 206 Nursing Ward 20 L5.pdf	1 - Helen Joan Walker.pdf
2 - Margaret Rose Jefferies.pdf	3 - Raymond Thomas Neville.pdf	4 - Janet Eileen Lamb.pdf
5 - Margaret Ann Jee.pdf	6 - Harold Edward Redfern.pdf	

Appendix VII: Unannounced site visit

Agenda item
Panel pre-meet
Entry into Queens Hospital and announced arrival to site manager
Observations undertaken of the following: • Accident & Emergency • Acute Respiratory Ward (Ward 3) • Talk to clinical site practitioner (bed manager) • Maternity Wards (Wards 15 and 16) • Coronary Care unit/Acute ward (Ward 6) • Critical Care Unit • Stroke ward • Accident & Emergency (second visit)
Meeting held with site manager to understand current staffing and patient levels
Panel left Trust and announced exit