Sheffield Teaching Hospitals NHS Foundation Trust

Inspection report

Northern General Hospital
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Date of inspection visit: 5th October 2021 to 11th November 2021
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Sheffield Teaching NHS Foundation Trust provides acute and community health services to a population of 640,000 people in Sheffield and the surrounding areas. The trust provides specialist services for the populations of Yorkshire & Humber, parts of Mid-Yorkshire and North Derbyshire. The trust operates from five sites:

- Northern General Hospital
- Royal Hallamshire Hospital
- Jessop Wing Maternity Unit
- Weston Park Hospital
- Charles Clifford Dental Hospital

We carried out this unannounced inspection of Sheffield Teaching Hospitals NHS Foundation Trust of the acute and community services provided by this trust as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the trust overall as good. Our inspection was prompted by concerns about the quality and safety of services. We also inspected the well-led key question for the trust overall.

We inspected urgent and emergency care, medicine and surgery at the Northern General Hospital and the Royal Hallamshire Hospital, maternity services in the Jessop Wing and community health services for adults at Beech Hill from 05 October to 07 October 2021. We undertook a further inspection of urgent and emergency care, medicine and surgery at the Northern General Hospital and the Royal Hallamshire Hospital, and maternity services in the Jessop Wing on 09 to 11 November 2021. We also conducted an inspection of the trust's leadership and governance on 09 to 11 November 2021.

Whilst we inspected during the COVID 19 pandemic the risks and concerns identified by CQC during the inspection were not the result of the immediate pressures faced by the trust as a result of the COVID pandemic. The number of beds

Our findings

occupied during this period by patients diagnosed as COVID positive was a rolling average of 7.9%, the trust have reported the long lasting impact of the COVID 19 pandemic for the preceding 20 months. These included the significant impact on staffing, including sickness and the identification and redeployment of clinically vulnerable staff, the prolonged period of command and control arrangements and service remodelling.

We did not inspect critical care, end of life care, outpatients or diagnostics at either the Northern General Hospital or the Royal Hallamshire Hospital. We also did not inspect community services for adults, community end of life care, community dental services or the Sheffield dialysis unit. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

At this inspection we found the core service ratings for urgent and emergency care, medicine, surgery had deteriorated since our previous inspections in 2016 and 2018. The maternity core service remains rated as inadequate since the March 2021 inspection and the overall provider well-led rating has deteriorated from good in 2018 to requires improvement at this inspection.

Following our inspection of core services in October 2021, we formally wrote to the trust under our section 31 powers to share our concerns about our inspection findings. We asked the trust to take immediate action to improve the quality and safety of services. The trust provided details of the immediate steps taken to ensure patient safety and a further action plan to ensure and embed improvements. During our inspection of the trust's leadership and governance in November 2021, we reviewed the action taken by the trust to improve the quality and safety of care patients were receiving on the inpatient wards. Our return visit found that the trust had not made significant improvement in some of the areas of concern identified in our October inspection which resulted in continued breaches of several regulations. As such we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008. The warning notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided. The principles we use when rating providers requires CQC to reflect enforcement action in our ratings. This means that the warning notice we served has limited the trust's rating in the core service and well-led inspections.

Our rating of services went down. We rated them as requires improvement because:

- We rated safe as inadequate and effective, caring and responsive and well led as requires improvement.
- We rated urgent and emergency care, medicine at the Royal Hallamshire hospital and Maternity services as inadequate overall. We rated the medicine at the Northern General hospital, surgery at both sites and community adult inpatients at Beech Hill as requires improvement.
- In rating the trust, we took into account the current ratings of critical care, end of life, outpatients and community services including community nursing, end of life, dental and the Sheffield dialysis unit services which were not inspected this time.
- The trust did not have enough staff to care for patients and keep them safe. Staff were not always up to date with training in key skills. The trust did not always control infection risk well. Staff did not always assess risks to patients, however, when they did, they were not always act on them and care records were not always up to date and contemporaneous. Staff did not always manage medicines well. The trust did not always manage safety incidents well and actions were not always robust.
- Staff did not always provide good care and treatment. Pain relief was not always given on time. Staff worked together for the benefit of patients, but they did not advise them on how to lead healthier lives. Staff did not always support patients to make decisions about their care and access to information was not always easy. Not all key services were available seven days a week

Our findings

- Staff mostly treated patients with compassion and kindness, but they did not always protect their privacy and dignity when providing care. Staff did not always help patients to understand their conditions. Staff did not always provide emotional support to patients to minimise their distress.
- The trust did not always plan care to meet the needs of local people, which, took account of patients' individual needs, and made it easy for people to give feedback. People could not always access services when they needed it and experienced long waits for treatment.
- Senior and executive leaders did not always operate effective governance systems to manage risks and issues within the service. Not all staff felt respected, supported and valued although. The trust not always engaged well with staff, patients and the community to plan and manage services.

However:

- Staff understood how to protect patients from abuse. The service-controlled infection risk well.
- The trust had enough medical staff to care for patients and keep them safe. Staff worked well together for the benefit of patients and advised them on how to lead healthier lives.
- Staff treated patients with compassion and kindness.
- Local leaders ran services using information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were committed to improving services.

How we carried out the inspection

The team that carried out the well led inspection service comprised a CQC head of hospital inspection, three inspection managers, two inspectors and an inspection planner. In addition, there was an executive reviewer and three specialist advisors experienced in executive leadership of NHS trusts. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:
We told the trust that it must take action to bring services into line with 86 legal requirements. This action related to five core services and trust wide.

Trust wide

- The trust must ensure it implements effective systems to ensure staff assess and manage the risks to service users in relation to their mental health. (Regulation 17 (1)(2))

Our findings

- The trust must ensure it implements effective systems to identify, assess and manage risks in relation to care environments including the risks related to infection prevention and control. (Regulation 12 (2)(d)(b))
- The trust must ensure it implements effective systems to ensure staff consistently assess and manage risks in relation to falls. (Regulation 12 (2)(a)(b))
- The trust must ensure it implements effective systems to ensure staff consistently assess and manage risks in relation to service users who may be deteriorating. (Regulation 12 (2)(a)(b))
- The trust must ensure there is enough suitably skilled nursing and midwifery staff to ensure patient safety. (Regulation 18 (1))
- The trust must ensure it implements effective systems to ensure staff adhere to the Mental Capacity Act. (Regulation 12 (2)(a)(b))
- The trust must ensure effective operational oversight of risk, issues and performance. (Regulation 17 (1)(2))
- The trust must ensure it implements effective systems to monitor incidents involving restrictive interventions including restraint and rapid tranquilisation. (Regulation 12 (2)(f)(g))
- The trust must ensure it implements effective systems to ensure incidents are reported consistently and to ensure reports are categorised appropriately to reflect harm sustained by service users. (Regulation 17 (1)(2))
- The trust must ensure that all board members have been subject to all the appropriate fit and proper person checks and that these are recorded. In addition, the trust should comply with its own FPPR policy by ensuring that there is evidence of the qualitative assessment and values-based assessment directors had undergone as part of the recruitment process. (Regulation 5 (3)(b)(c)(d))

Northern General Hospital Urgent and Emergency Care

- The service must ensure that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. (Regulation 9(1)(a)(b)(c))
- The service must ensure that service users are treated with dignity and respect, ensuring the privacy of service users. (Regulation 10(1)(2)(a))
- The service must ensure that it is effectively assessing the risks to the health and safety of service users of receiving the care or treatment. (Regulation 12 (2) (a))
- The service must ensure that assessments of the risks to the health and safety are carried out in line with national guidelines and mitigate risks posed to patients. (Regulation 12 (2)(a)(b))
- The service must ensure that care and treatment is provided in a safe way to patients, including actions is taken when issues are identified in audits. (Regulation 12 (2))
- The service must ensure that patients who are streamed away from the emergency department are reviewed in line with the systems and process in place, by staff who are suitably trained and competent to do so. (Regulation 12(2)(a)(b))
- The service must ensure that the nutritional and hydration needs of service users are met. (Regulation 14 (1))
- The service must ensure that all premises and equipment used by the service provider is fit for use and cleaned in line with trust and national guidelines. (Regulation 15 (1)(a))
- The service must ensure they maintain appropriate standards of hygiene. (Regulation 15 (2))
- The service must ensure that systems or processes are established and operated effectively. (Regulation 17 (1))

Our findings

- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (Regulation 17 (2)(b))
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulation 17 (2)(c))
- The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in line with national guidance. (Regulation 18 (1))
- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Regulation 18 (1)(2)(a)(b))

Northern General Hospital Medical Care

- The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks (Regulation 12 (2)(b))
- The service must ensure the proper and safe management of medicines (Regulation 12 (2) (g))
- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (Regulation 17 (2)(b))
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (Regulation 17 (2)(c))
- The service must have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to comply with the fundamental standards (Regulation 18(1))
- The service must ensure areas used to store hazardous and biological waste are locked at all times. (Regulation 15 (1)(b)(e))

Northern General Hospital Surgery

- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. This includes the completion of mandatory training. (Regulation 12(2)(c))
- The service must ensure that all staff receive safeguarding training for adults and children, as necessary which includes PREVENT, to evidence that systems and processes are operated effectively to prevent abuse of service users. (Regulation 13(2))
- The service must ensure that all premises and equipment used by the provider must be clean, secure and properly maintained. This must include the secure storage of cleaning chemicals. Regulation 15(1)(a)(b)(e)
- The service must ensure there is a safe and effective system for the storage, administration and reconciliation of medicines, including medical gases. (Regulation 15(1)(a)(b)(e))

Our findings

- The service must ensure all medical gases are stored safely and pose no fire or health and safety risks. Storage information and guidance must be clearly
documented in the medicines' management policy. (Regulation 15(1)(a)(b)(e))
- The service must ensure there are fire safety risk assessments in place for the premises, which include the storage of medical gases. Regulation 15(1)(a)(b)(e))
- The service must ensure that assessments of risk to the health and safety are carried out in line with national guidelines and mitigate risks posed to patients. Regulation 12 (1)(2)(a)(b))
- The service must ensure that there are enough nursing staff to provide safe care and treatment. (Regulation 18(1))
- The service must ensure that surgical patients have their individual needs assessed and that care planning is personalised to meet their individual needs. This must include the assessment of mental capacity and cognitive impairment assessments and emotional needs. (Regulation 11(3)(5))
- The service must ensure that medicines are stored safely. (Regulation 12(1)(2)(g))
- The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this. This must include the management and investigation of incidents and the learning following incidents. (Regulation 17(2)(a))
- The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This must include the implementation of staffing risk review, which reflects the acuity of patients. (Regulation 17(2)(b))

Jessop Wing Maternity Services

- The service must ensure effective risk and governance systems are implemented that supports safe, quality care. (Regulation 17(1))
- The service must improve the monitoring of the effectiveness of care and treatment. Timeliness of reviews and implementation of change. (Regulation 17(1))
- The service must ensure audit information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. (Regulation 17(2)(c))
- The service must ensure correct processes are in place for investigating complaints, recognising incidents from complaints and improving complainants' responses. (Regulation 17(2)(e))
- The service must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing women and babies to the risk of harm. (Regulation 18(1))
- The service must ensure systems are put in place to ensure that midwifery staff were suitably qualified, skilled and competent to care for and meet the needs of women and babies within all areas of the maternity services, including areas where women were waiting to be seen. (Regulation 12(2)(c))
- The service must ensure risk assessments and risk management plans are completed in accordance with national guidance and local service policy and documented appropriately. (Regulation 12(2)(a))
- The service must ensure that delays to induction of labour is significantly reduced. (Regulation 12(2)(a))
- The service must ensure that the CTG monitoring of women and their babies are undertaken in line with national guidance and best practice. (Regulation 12(2)(a))

Our findings

- The service must ensure correct processes are in place for investigating serious incidents that reduce delays and accuracy of investigations. (Regulation 12(2)(b))
- The service must improve lessons learned and the sharing of lessons learned amongst the whole team and the wider service. (Regulation 12(2)(b))
- The service must ensure improved infection control. (Regulation 12(2)(h))
- The service must ensure safe systems and processes to prescribe, administer, record and store medicines are in place and applied. (Regulation 12(2)(g))

Royal Hallamshire Hospital Medical Care

- The service must ensure that patients have their individual needs assessed and that care planning is personalised to meet their individual needs. This must include the assessment of mental capacity and cognitive impairment assessments and emotional needs. (Regulation 11(3)(5))
- The service must ensure service users are treated with dignity and respect. Ensuring the privacy of the service user. (Regulation 10(1)(a))
- The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks Regulation 12(2)(a)(b)
- The service must ensure the proper and safe management of medicines Regulation 12(2)(g)
- The service must ensure that staff complete mental capacity and best interest decisions, and they must clearly document the assessment and decision making-making process. (Regulation 12(2)(a))
- The service must ensure that a service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. (Regulation 13(5))
- The service must ensure that all premises and equipment used by the provider must be clean, secure and properly maintained. This must include the secure storage of cleaning chemicals. (Regulation 15(1)(a)(b)(e))
- The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this. This must include the management and investigation of incidents and the learning following incidents. (Regulation 17(2)(a))
- The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This must include the implementation of staffing risk review, which reflects the acuity of patients. (Regulation 17(2)(b))
- The service must have enough suitably qualified, competent, skilled and experienced persons deployed to comply with the fundamental standards (Regulation 18(1))

Royal Hallamshire Hospital Surgery

- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. This includes the completion of mandatory training. (Regulation 12(2)(c))
- The service must ensure that all staff receive safeguarding training for adults and children, as necessary which includes PREVENT, to evidence that systems and processes are operated effectively to prevent abuse of service users. (Regulation 13(2))

Our findings

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- The service must ensure that assessments of risk to the health and safety are carried out in line with national guidelines and mitigate risks posed to patients. (Regulation 12 (1)(2)(a)(b))
- The service must ensure that there are enough nursing staff to provide safe care and treatment. (Regulation 18(1))
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Beech Hill Community Health Inpatient Services

- The trust must ensure that medicines are administered safely in line with best practice. (Regulation 12 (2)(f)(g))
- The trust must ensure staff administering medicines are offering patients as and when required pain relief. (Regulation 12 (2)(f)(g))
- The trust must ensure staff receive appropriate supervision. (Regulation 18 (2)(a))
- The trust must ensure they have sufficient numbers of staff to respond to patient requests for support in a timely manner. (Regulation 18 (1))
- The trust must ensure the mental capacity of patients is assessed appropriately in conjunction with the Mental Capacity Act 2005 Code of practice principles. (Regulation 11(3)(5))
- The trust must ensure they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users by ensuring robust governance arrangements are in place. (Regulation 17(1)(2))
- The trust must ensure patient risk assessments for specialist equipment are reviewed regularly to reduce risks to patients. (Regulation 12(2)(a)(b))
- The trust must ensure that the care and treatment of service users meets their needs and preferences. (Regulation 9(1))

Our findings

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider the recruitment to the freedom to speak up guardian to ensure it is open to all staff who express an interest in the role.

Northern General Hospital Urgent and Emergency Care

- The service should consider formalising the frequency and attendance of mortality and morbidity meetings to facilitate regular learning and discussion.
- The trust should continue to embed assurance processes and mechanisms in the department to make improvements to patient care and experience.
- The service should have a vision and strategy in place to set out achievable aims and objectives for the department to work towards.
- The service should consider implementing training for staff in the emergency department on mental health, learning disabilities, autism and dementia to support staff to care for patients in the most appropriate way for their needs.
- The service should consider strengthening meeting documentation to monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress is not achieved as expected.

Northern General Hospital Medical Care

- The service should consider if the needs of patients with a dementia are currently met, within the current environment.

Northern General Hospital Surgery

- The service should review the consistency of decision-making processes for administering medication that controls patient's behaviour, such as rapid tranquilisers.
- The service should consider if complaints information is widely displayed so that patients know how to complain.
- The service should consider implementing the audit of safe management of data, including the storage of patient records and display of patient information.
- The trust should consider if the needs of patients with a dementia are currently met, within the current environment.

Jessop Wing Maternity Services

- The service should implement electronic recording as per MBRRACE UK guidance.

Royal Hallamshire Hospital Medical Care

- The service should review the consistency of decision-making processes for administering medication that controls patient's behaviour, such as rapid tranquilisers.
- The service should consider if complaints information is widely displayed so that patients know how to complain.
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Royal Hallamshire Hospital Surgery

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- The service should consider implementing the audit of safe management of data including the storage of patient records and display of patient information.
- The trust should consider if the needs of patients with a dementia are currently met, within the current environment.

Beech Hill Community Health Inpatient Services

- The trust should ensure that all equipment is labelled after it has been cleaned.
- The trust should ensure food items stored in fridges contain open date labels and any out of date items are disposed of.
- The trust should ensure clinic room temperatures are checked and recorded daily.
- The trust should consider conducting regular monitoring of patient call bell wait times.
- The trust should consider reviewing fire safety practices and ensure risk assessments and regular fire drills are carried out in line with the trusts policy.
- The trust should consider reviewing and updating the environmental risk assessment at Beech Hill.

Is this organisation well-led?

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

Leadership

Executive leaders demonstrated the necessary experience, knowledge and ability to lead effectively. They understood the priorities and issues the trust faced, however, the devolved leadership structure meant that executives were not always fully sighted on the operational challenges and they did not intervene quickly enough to improve the quality and safety of care provided to patients. Staff reported the executive team were not always visible and approachable in the service for patients and staff.

Following our previous inspection in 2018 there had been several changes in the executive leadership including chief executive officer, chief nurse, medical director and trust chair.

The chief executive officer (CEO), joined the trust as Director of strategy and planning in 2011, they took the post of interim CEO in August 2018 and was substantively appointed to the post in 2019. The role of the CEO was to develop local partnerships; however, the two most comprehensive ones were identified as the accountable care partnership (ACP) and the integrated care system (ICS).

Our findings

The chief nurse was appointed to post in October 2018 from another NHS trust, however prior to this was also deputy chief nurse at Sheffield teaching Hospitals NHS foundation trust. There were two medical directors in post one for development (appointed 2019) and one for operations (appointed on an interim arrangement from February 2020 and substantively from December 2020). Both medical directors had worked at the trust prior to their appointments.

The appointment of chair was approved by the council of governors in November 2020 and their four-year term began in January 2021. They had a significant experience working with local health care system in South Yorkshire and was previously a non-executive director and deputy Chair at the trust.

The diversity had improved from the previous inspection, however, it remained limited. Of the executive board members none were from a British minority ethnic group (BME) and 63% were male, of the non-executive directors 14% were from a BME background and 57% were male. Of the whole board 7% were from a BME background and 60% were male. This was recognised within the workforce race equality standard draft action plan dated August 2021, however, was not identified as a specific concern by the CEO and Chair in our well-led inspection. The trust had in place an equality diversity and inclusion (EDI) board to drive forward the development of an inclusive, fair and diverse organisation through the EDI strategy and implementation plan.

There were clear priorities for ensuring sustainable, inclusive and effective leadership; there was a multi-layered approach to leadership development within the trust which includes succession planning. There was a workforce strategy “Making it Personal 2017 - 2022” and evidence of development programmes for staff. All staff groups and bands had supported access to leadership and development opportunities. The leadership/management development opportunities included a well-established nationally recognised Level 3 accredited award in Leadership & Management, an ‘Effective Management Series’ programme, and bespoke work on psychometrics preferences for leadership styles and team working. The ten People Strategy workstreams had been refreshed considering the challenges, pressures and impact of COVID-19 on services, patients, staff and all aspects of life. The refreshed work programme was governed through the People Strategy Programme Board and delivered through close working between workstream leads and key stakeholders and supporting forums.

The board understood the broader health challenges locally and nationally and were aware of the risks. There was active inclusion in the developing health and social care landscape through the leadership and involvement of directors and other staff in the South Yorkshire and Bassetlaw Integrated Care System (ICS) and its working groups.

The immediate structure below the board was the board sub-committees which were all chaired by non-executive directors. Below this sat trust executive group (TEG), this group undertook executive work on behalf of the board of directors and was responsible for managing the trust and holding those with delegated responsibilities for performance of elements of the trust’s work to account. TEG was supported by the clinical management group (CMB).

Operationally the trust had a devolved leadership structure which was run through 11 clinical care groups; Acute and Emergency Medicine (AEM); Combined Community and Acute Care (CCA); Head and Neck; Obstetrics, Gynaecology and Neonatology (OGN); Medical Imaging and Medical Physics and Laboratory Medicine (IMPEL); Medicine and Pharmacy Services (MAPS); Musculoskeletal (MSK); Operating Services, Critical Care and Anaesthesia (OSSCA); Specialised Cancer, Medicine and Rehabilitation (SCMR); South Yorkshire Regional Services (SYRS); Surgical Services. Each individual care group had a triumvirate management structure which consisted of clinical director(s), operations director and nurse or midwifery director. Below the care groups sat 27 clinical directorates. These arrangements were supported by ten Corporate Directorates.

Our findings

The chief pharmacist was working his notice period to move to another Trust. An interim chief pharmacist was being recruited to start on the 19 November 2021 until a permanent appointment had been made

In March 2021, CQC sent a letter of intent to the trust raising concerns that patients experiencing mental health concerns may or would be exposed to the risk of harm and the trust were required to provide a response as to how they would improve the quality and safety of care for these patients. The trust had formed a mental health action plan to address concerns in relation to meeting the needs of patients with mental health conditions. The action plan included; audit programmes, development of a mental health strategy and suicide prevention plan, the addition of patients wishing to leave to the mental health risk assessment, estates work to reduce ligature risks and training plans.

To monitor the action plan and make progress, in May 2021, the mental health committee was reformed to become the mental health steering group. The group met monthly and followed a set agenda which included the trust's mental health action plan, the quality and safety monitor dashboard, the learning, training and education and audits. The trust's clinical director for therapeutics and palliative care and the medical director (development) were responsible for mental health oversight across the trust and chaired the steering group. The quality and safety monitor dashboard gave clearer oversight of mental health care across the trust and we saw that the inclusion of near miss incidents of harm to patients via self-harm was positive. However, several key areas were not included such as; the use of restraint and rapid tranquilisation, and the presentation of patients with learning disabilities and autism.

The trust had completed an audit of the application of the Mental Capacity Act in services which had identified low compliance with the trust's policy. The results of this audit were presented to the Mental Health Steering Group which decided to undertake a further audit of compliance with the Mental Capacity Act in a year's time. The minutes of the meeting did not identify interim actions to improve compliance.

Oversight of this area at executive level was improving, however, plans remained in their infancy and progress was slower than expected.

The non-executive directors each chaired subcommittees of the board. They reported the use of virtual technologies meant that meetings continued. However, all of the non-executive directors we spoke with reported they had stepped back from their oversight during the pandemic to enable the executive directors to focus on frontline clinical care.

The council of governors (CoG) were aligned to the board and involved in various activities. The use of virtual technology during the pandemic had meant more opportunities to attend meetings. However, visiting restrictions had meant they were unable to visit patients on wards as they had done prior to the pandemic, plans were being put in place to restart the visits when pandemic restrictions were completely lifted.

Fit and proper persons requirement

We found that the trust's policy for fit and proper persons requirement (FPPR) was in date and met the requirements of the regulation, however, it did not detail how often disclosure and barring service (DBS) checks would be repeated for directors. We saw all files contained DBS certificates, however, of the nine files we reviewed seven did not contain evidence they had been repeated after three years. Both executive and non-executive directors completed annual self-declaration forms to confirm that they complied with the regulation, however, the self-declaration forms did not include information pertaining to declaration of interests such as directorships and conflicts of interest. During the factual accuracy process the trust provided evidence which showed declarations of interest were made in line with the Trust's

Our findings

Standards of Business Conduct Policy (October 2021). Board members interests were captured on appointment and reviewed and updated annually (as a minimum) and in year as required in response to any changes. In addition, declarations of Interest were recorded in an electronic system used by the Trust to record and publish Declarations of Interest, which was available to the public.

We reviewed five non-executive director and four executive director FPPR files. We found there was an inconsistency with the information held in executive files, specifically in relation to occupational health checks and professional body checks. In addition, there was no documented dates of the disqualified directors and insolvency checks, therefore, we could be assured when these had been completed and if they had been repeated.

We found that none of the files we reviewed contained evidence of a qualitative assessment and an assessment on the alignment of the individual's values against the Trust PROUD values. This was not in line with the trust's own policy. This was also found in our previous inspection and a requirement notice was issued.

Vision and Strategy

The trust had a vision and a strategy, developed with relevant stakeholders and staff. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, the focus on vision and strategy had been delayed due to the pandemic and all directorate strategies were delayed due to this.

The trust had a five-year trust strategy (Making a Difference Corporate strategy 2017–2020) however, this had not been refreshed since our last inspection due to the COVID-19 pandemic and was due to be relaunched in 2022. The strategy had originally been developed in 2012 and was refreshed following consultation with staff and wider stakeholders. The vision and values had remained the same with some changes to the strategic objectives. It had five strategic aims: deliver the best clinical outcomes, provide patient-centred services, employ caring and cared for staff, spend public money wisely and deliver excellent research, education and innovation. We were informed there would be an additional focus on environmental sustainability within the trust.

The trust had set a clear cohesive vision and values (PROUD) that were at the heart of all the work within the organisation.

- Patient-first
- Respectful
- Ownership
- Unity
- Deliver

The vision was "*To be recognised as the best* provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and health city region". Staff were able to articulate the vision and values were and their role in achieving them.

There were underpinning and enabling strategies in place which were trust-wide, at group/directorate and service level. However, several strategies had also not been refreshed due to COVID for example the estates strategy 2017 to 2020 had had its timeline extended, also work was commencing on a new Quality and Safety Strategy, the previous strategy covered 2017 to 2021.

Our findings

The corporate strategy and its operational plans were monitored and reviewed by TEG and then progressed through to board sub committee's and then board. However, we were concerned that TEG would was acting as a "gatekeeper" and not all relevant information for the whole board to see was in the papers which were later presented to the subcommittees and subsequently the board. We were aware the non-executive directors received the minutes of TEG; however, we also saw examples where reports were noted and accepted. This meant that non-executive directors did not see the entirety of the report. This meant the non-executive board members may not have seen all the relevant information to enable them to discuss and challenge on pertinent risks within the organisation.

There was an agreed governance process, which included the ward to board escalation, however, during our core service inspection we identified that not all wards were holding meetings and safety huddles and key safety risks had not been escalated through this mechanism. We saw a continued theme from our 2018 inspection that implementation plans were not always well developed, the monitoring of the implementation was not as robust as it should be, and improvements were often slow and not in track with timelines in the plan. For example, the trust had completed an audit which looked at whether patients with mental health needs had received a specific assessment of the risks posed by their mental health. The audit found good compliance with completed risk assessment documentation. However, the audit did not examine whether the measures as described in the risk management plan within each risk assessment were effectively and consistently implemented by staff. Our inspection found that whilst patients did receive an assessment of their mental health risks, the risk assessments did not inform the ongoing provision of care and did not result in appropriate action from staff to manage patients' risks in relation to their mental health.

The quality board was chaired by the medical director (operations) and fed into the healthcare governance committee. The role of this board was to oversee the Trust's overarching quality strategy. Membership included trust governors, local Healthwatch and voluntary sector representation.

The corporate strategy and its supporting strategies were linked into the wider health economy of the South Yorkshire and Bassetlaw Integrated Care System which had five place-based partnerships operating within it, one being Sheffield local authority area – the Sheffield health and care partnership (HCP). The ICS five-year plan 2019-2024 planned to build of the work already achieved and identified four key ambitions:

1. Developing a population health system.
2. Strengthening our foundations
3. Building a sustainable health care system
4. Broadening and strengthening our partnerships to increase our opportunity.

At the time of the inspection there were very few specific examples the board could give to articulate what difference the ICS had made to improve care for patients. The Board members we spoke with were aware of the national, regional and local challenges and opportunities for the health care system and how they saw the trust operating within it.

The trust had strategies in place for meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis, however, these were city-wide strategies that the trust had developed and signed up to with partner organisations. We wrote a letter of intent to the trust in March 2021 identifying significant and repeated concerns with patients with mental health concerns including suicidal ideation, the trust had provided regular updates as directed on the work they were undertaking to mitigate the risks to this patient group. However, the trust recognised, and we also saw during our core service and well-led inspection that the care of patients with mental health needs in the acute setting remained a significant concern. This was not limited to adults but also included young people aged 16-17 who were being cared for in the emergency department. We wrote to the trust and the two other NHS trusts in the

Our findings

Sheffield area under our section 64 powers to understand the current pathway provision for young people. During our inspection we found patients being cared for long periods of time in an unsuitable environment, with fragmented care provision from all the NHS trusts and no clear plans of care. In response to our information requests, system partners described new and substantial action with further planned actions to improve pathways for young people with mental health needs. We will continue to monitor progress and actions through our engagement with the trust to ensure the risks to young people have been mitigated and they are protected from harm.

There was an executive director board lead for mental health and since the last inspection the trust had developed and was implementing a Mental health strategy 2020 – 2022, however, the replacement strategy was already in draft form. During our previous inspection we saw mental health was highlighted as a corporate risk with appropriate mitigating actions identified to reduce the risk. However, during this inspection there was minimal reference to mental health risks within the integrated risk and assurance report which incorporated both board assurance framework and corporate risk register.

The pharmacy team had a 24-hour service for some areas of the Trust. The medicines reconciliation rates for the whole trust during the inspection were at 63.3% medicines reconciled within 24 hours; this is significantly below NICE national guideline of 90% within 24 hours. The chief pharmacist said the department had nearly 500 pharmacy staff working within the team, although we were not assured these were being used effectively at ward level to improve medicines reconciliation rates.

Culture

Most but not all staff felt supported, respected and valued by their local leaders. All staff we met were focused on the needs of patients. Senior leaders were confident there was a positive, open and transparent culture, however, this was not replicated throughout all core services.

The trust's strategy, vision and PROUD values underpinned a culture which was articulated as patient centred, however, our core service inspection identified that patients' health care needs were not always at the forefront of the care they received.

Most staff we spoke with during inspection were proud to work for the trust, with a shared loyalty to the communities the trust served, and a commitment to providing good care and positive experiences for patients. During our inspection we observed many examples of how staff continued to work with a caring approach, often under demanding and challenging circumstances. However, despite staffing working hard to deliver care to patients there were times when staff told us, and we observed the culture was not in line with the trust values. For example, in maternity services there was a significant number of staff who reported a negative culture and within urgent and emergency care services staff told us they felt unsupported by senior leaders and the wider organisation.

There was a relatively stable workforce. Both the non-executive and executive board members appeared to work well together. However, we were concerned, with the management of information and escalation of risks within the devolved leadership model namely ward, directorate and care group management teams and within the unitary board.

Senior leaders described a culture of openness and felt that staff were not afraid to raise concerns without the fear of retribution. However, during the core service inspection we heard mixed views from staff about their confidence to raise concerns and that action would be taken. A significant number of staff told us they no longer reported incidents due to a lack of action or improvement, or they did not have the time to report incidents and therefore escalated their concerns to their immediate manager to report. We were also informed by staff in the surgical core service where incident reporting was discouraged as it was a weakness.

Our findings

Overall, there were positive results from the 2020 staff survey. Of the 10 themes four were in line with the national comparison these included health and wellbeing, quality of care, safe environment – violence and staff engagement, five were better than the national comparison these included Equality, diversity and inclusion; immediate managers; Morale, safe environment – Bullying and harassment and safety culture, however, one theme was identified as worse than the national comparison and this was team working.

The trust performed much worse than the national comparison for staff engagement and motivation:

- Q2a I look forward to going to work – 53.4% (national comparison 58.5%)
- Q2b I am enthusiastic about my job – 68.8% (national comparison 73.1%)
- Q2c Time passes quickly when I am working – 72.5% (national comparison 76%)

The trust performed worse than the national comparison for staff engagement and ability to contribute to improvements:

- Q4b I am able to make suggestions to improve the work of my team/ department – 69.8% (national comparison 73%)
- Q4d I am able to make improvements happen in my area of work – 51.4% (national comparison 55.4%)

The trust performed worse than the national comparison for team working:

- Q4i The team I work in often meets to discuss the teams effectiveness – 49.6% (national comparison 56.7%)

The trust continually scored worse than the national comparison in all NHS staff surveys between 2016 and 2020 for the above highlighted questions.

Despite the trust performing better than the national comparison for equality, diversity and inclusion. We saw a theme where the trust deviated (negatively) from the national comparison in the 2020 NHS staff survey for the following questions:

- Q15c.1 On what grounds have you experienced discrimination? – Gender 25.4% (national average 19.9%)
- Q15c.5 On what grounds have you experienced discrimination? – Disability 11.2% (national average 8.2%)
- Q15c.6 On what grounds have you experienced discrimination? – Age 21.1% (national average 18.9%)

Therefore, we were concerned the board was not fully sighted on all the detail within the 2020 NHS staff survey as we saw evidence in board papers there was only discussion surrounding the high-level results. A trust-wide staff survey action plan 2021/2022 had been formulated to address key themes at organisational level and these covered all the themes in the 2020 NHS staff survey.

The implementation of the equality diversity and inclusion (EDI) strategy 2021-2025 was led by the EDI team. The executive lead for this work was the CEO. The trust had developed four staff networks:

- Prouder LGBTQ+
- Women
- STHAbility
- Race, equality and inclusion.

Our findings

Freedom to speak up guardian

The trust had a raising concern at work policy and procedure (2015-2019) the review of this policy had been delayed due to COVID. The trust had four freedom to speak up guardians (FTSUG). However, the FTSUGs did not have protected time to carry out their role, therefore, worked flexibly within their current role. This meant that staff who did not have this flexibility in their role may not be supported by the systems and processes in place to effectively undertake the role. As part of the national FTSUG job description, it is expected that FTSUGs "should be supported with the resources they need, including ring-fenced time, to ensure that they meet the needs of workers in their organisation". FTSUGs in the trust did not monitor time spent dealing with contacts, therefore it would be difficult to quantify how much protected time might be appropriate across the four roles. This had not been identified as a concern that needed addressing by the trust board.

We were told the FTSUG roles were only open to current staff governors by expressing an interest in the role and then holding informal interviews from those interested. National guidelines for the recruitment of FTSUG roles identifies "Appointments should be made according to local policies, fairly, openly and transparently". Staff had to be an elected staff governor before they could express their interest in the role, therefore not all staff had the opportunity to apply for or be recruited to the FTSUG role. This meant there was a risk that there was no diversity of staff members undertaking this role and there may be a risk to the FTSUG provision if a member/FTSUG was not re-elected. We were told the trust mitigation was to increase the provision to four guardians. However, this process of recruitment was not documented in the raising concerns at work policy and procedure therefore causing concern on transparency within FTSUG process.

The trust had approximately 40 FTSU advocates who were based across the care groups and divisions. National guidelines for FTSU recommends the term "advocate" is not used as the term "can create confusion and a false expectation that there is a personal representative element to the role. There was annual training in place for FTSU advocates and the guardians considered gaps in the directorates when new ambassadors were being recruited. We did not see or hear during our inspection that the trust had considered this.

The FTSUGs did not personally report to the board. They were able to review reports before they were presented, however reports were developed and delivered to board by the executive and non-executive lead for FTSU. The FTSUGs attended board meetings in their capacity for other roles they held in the organisation but did not attend specifically relating to FTSU. All the FTSUGs described an open culture with the executive team and felt they could approach any executive team member with concerns, which would be addressed promptly. They had good links with HR and HR business partners and encouraged staff to make their own contact with managers and senior managers to escalate their concerns.

The guardian of safe working

The guardian for safe working supported junior doctors in their role and facilitated meetings to discuss, support and raise concerns with good representation from all relevant areas in the hospital. The pandemic had meant that more meetings were able to be attended via a virtual platform rather than needing to take time out of busy work schedules to travel to face to face meetings. The guardian worked closely with the medical director and had support from human resources with the reporting requirements. The junior doctors forum was active in the trust and had been instrumental in the development of a website for new medical trainees to access before they arrived at the trust which not only told them about the trust, it's policies and processes but also Sheffield as a city and the local area.

Accessible Information Standard

Our findings

Since 01 August 2016, all organisations that provide NHS care and / or publicly funded adult social care have been legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The trust was beginning to implement the standards and had developed an action plan following the EDI audit in July 2021, due to absence no action was undertaken between July and September 2021. During the factual accuracy process the trust provided additional evidence which showed there was an action plan and flow chart were developed in August 2019, however, this was put on hold due to the COVID-19 pandemic. The trust did not provide evidence that the AIS had been considered prior to this despite this being a requirement since 2016. However, there were some measures in place, the trust website had links to an accessibility 'side bar' enabling the fonts, colours and lighting to be adapted. There was no single AIS policy in place as the trust planned to consolidate the interpreter services policy and alternative formats policy into a single ASI policy, however this was not due to be completed until March 2022.

Governance

There were clear arrangements for governance, however they did not always operate effectively. The trust had a devolved leadership model and we were not assured the board had sufficient oversight and focus on the operational risks within the trust.

Actions were often limited and did not fully address the concerns as such the actions taken did not always reduce the risks to patients and improve the quality of care they received.

Not all staff in leadership roles were clear about their roles and accountabilities. Processes were not always effective and completed in a timely manner.

There were six sub committees of the board:

- Acute federation committee in common
- Healthcare governance committee
- Finance and performance committee
- Human resources and Organisational development committee
- Audit Committee
- Board of directors' nominations and remuneration

Each of the board committees had a non-executive chair. Four of the six board committees included executive and non-executive board members on their membership. Two of the six committees; the audit committee and the board of directors' nomination and remuneration committee did not have executive member in their membership in line with the NHS Foundation Trust Code of Governance (July 2014).

Under each of the board committees there were a number of groups which provided assurance to the committee and were accountable to the trust executive group (TEG). For example, the mortality governance committee and patient experience committee which were accountable to TEG and provided assurance to the healthcare governance committee.

However, all papers from the working groups were presented and discussed at the TEG, prior to being escalated to the subcommittee. We saw papers from groups and committees were discussed or noted at TEG, were not always discussed

at the board committee to which they were required to provide assurance. For example, the minutes of the May 2021 safety and risk committee were noted during TEG on 04 August 2021, however, there was no evidence of them being noted or reviewed in the healthcare governance committee. Therefore, we were not confident the board committees received full assurance by the groups aligned to them.

The trust had a devolved system of governance with almost fifty programme boards, committees, teams and other working groups each focussing on specific areas including equality and diversity, infection prevention and control, safeguarding, and serious incidents.

The Trust's 'Board Assurance and Reporting Arrangements' showed that working groups within the trust were accountable to the TEG. These groups were also aligned to the most relevant board committee depending on the group's specialist area for the purposes of assurance.

The trust's governance structure made the trust executive group the primary forum for operational accountability, assurance and for reporting and escalation to the subcommittees of the board.

The requirement for working groups to be accountable to the trust's executive group and to assure the trust's sub-board committees meant that it was not clear whether the trust's systems for internal control and management of risk were effectively overseen by the trust's sub-committees. The primacy of the trust's executive group over sub-board committees reduced opportunities for independent scrutiny and challenge of quality and performance by the board subcommittees and ultimately the unitary board.

For example, the trust had commissioned an external governance review following the unannounced inspection of the Jessop Wing in March 2021. We saw this review was approved by TEG in June 2021, was added to the IRAR and noted at board in July 2021 and discussed at the healthcare governance committee in November 2021. However, this decision was not articulated by any of the board members we interviewed.

There was a trust-wide systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. Actions identified from clinical audits were monitored by the clinical effectiveness committee which reported to the board's healthcare governance committee. Actions from internal audit were monitored by the trust's governance team and audit committee to ensure implementation and review.

The senior leadership pharmacy team told us that nursing staff were responsible for undertaking and submitting the medicine management audits. Concerns found around the storage of medicines and access to medicine rooms were not always known to the pharmacy team as they were not fully involved at ward level.

Despite these meetings and governance processes we were not assured the trusts internal governance was sufficiently robust to identify key patient safety concerns and monitor progress to ensure improvements were made to the care patients received. In the last twelve months CQC have identified a number of key patient safety concerns within the trust and have requested and required the trust to take actions to mitigate the risks to patients.

Throughout our inspection we found a number of key policies and procedures that had not been updated in line with their review dates, dating back to 2016. It was unclear the mechanism to extend the policy period and whether this had

been done in the policies we reviewed. The pandemic had further exacerbated the issue regarding out of date polices. During the factual accuracy process the trust informed us the controlled documents policy was ratified by the board on 28 September 2021 and stated existing controlled documents would remain in force until they are updated on the intranet or withdrawn, even if the review date has been passed.

Management of risk, issues and performance

Leaders and teams were not always able to use systems to manage performance effectively. Although some risks were identified and escalated identified actions were not always implemented in a timely way to reduce the impact. There was a lack of operational oversight at all levels to effectively manage and reduce risks to patients.

Risk

There were systems in place to manage risks, however, there was a lack of operational oversight and timely action at board and senior levels in the trust to effectively manage concerns and reduce the risks. For example some of the issues which we identified at inspection such as mental capacity assessments, falls, deteriorating patients and pressure ulcers were known to senior leaders and the board despite some actions we found there were significant concerns in the care patients received and actions taken had not reduced the risks.

The trust did not have a separate board assurance framework and corporate risk register, it had in place an integrated risk and assurance report (IRAR) which incorporated both. We found that recorded risks were mostly aligned with what directorate staff said were on their 'worry list'. We found that not all "extreme" operational risks were identified as such by the IRAR. We saw staffing was continually identified as a significant risk at the directorate level, however, on the IRAR we saw staffing / skill mix had with a current risk score of 12. The IRAR referenced seven directorate risk registers which were scored between 15 to 20 for staffing.

Senior leaders did not have a consistent understanding of the definition of risks on the IRAR. The IRAR included a risk '3.4 Extended length of the pandemic recovery and uncertainty around next phase(s) places additional pressures on leadership of business continuity planning and delivery of core business, resulting in impact on service delivery, staff engagement and health and well-being'. This had a score of 25 which was the highest scoring risk, and higher than the risk related to operational staffing. Senior leaders described this risk as referring to the pressures on board leadership resulting from the pandemic. However, following the review of CQC's draft report, the trust clarified the meaning of this risk as 'reflecting a further growth in inpatient admissions for Covid-19, alongside high levels of community infection, which have placed considerable pressure on non Covid-19 patient pathways, with the impact on staff wellbeing evident.'

We also found the risk of ineffective healthcare governance arrangements which would identify potential regulatory intervention and loss of public confidence scored 15. Given the issues in maternity services including the imposition of urgent conditions on the trust's registration, a letter of intent regarding mental health and the recent letter of intent issued following the core service inspections this risk did not appear to reflect the seriousness of our concerns and the significant patient safety concerns within the trust. Therefore, we were not assured the IRAR accurately or adequately reflected the significant operational risks which could impact on the trust.

The internal audit report (May 2021) provided an opinion of "significant assurance" of the trust risk processes, however, the full report was only reported to the executive members of the board at TEG and the audit committee quarterly which implied the full IRAR was only reviewed in its entirety four times a year. Individual board committees undertook deep dives on their relevant strategic risks. However, the internal audit report, also identified the significant number of risks which were overdue in all areas of the trust including some risks rated as extreme. This was raised as a medium risk by the internal auditor as they identified:

Our findings

- Several open risks which was recorded on the COVID-19 risk logs may not have been recorded on the trust's risk register.
- Minimal evidence actions received enough attention at directorate governance meetings to ensure they are appropriately monitored
- Governance arrangements in corporate directorates were not in line with the risk management framework.
- There was a significant percentage of risks (42%) which were overdue for review.
- Auditors were unable to evidence the current project risk logs.

We raised this during our well led interviews and were advised the IRAR was reviewed appropriately and in line with trust policy. However, we remained concerned that the IRAR was reviewed in its entirety four times a year by the board, giving concern the board may not be sighted on the overall risk within the trust. The framework for risk management (July 2020) and the associated "Guidelines to identify, assess, action and monitor risks" document identified that new extreme risks were to be reported to safety and risk committee and to trust executive group and board of directors via the IRAR. We continued to see no evidence these guidelines had been followed in terms of reporting to the board of directors. For example, we saw the safety and risk committee had reported to TEG, however, there was no evidence of discussion within the minutes of the meetings held in March and June 2021. These minutes were identified as received and noted, we further reviewed board minutes following this and there was no evidence of discussion.

The trust carried out annual reviews of each directorate using the performance management framework (PMF), each directorate was scored out of ten in the following areas for performance:

- Deliver the best clinical outcomes.
- Provide patient centred services.
- Employ caring and cared for staff.
- Spend public money wisely.
- Deliver excellent research, education and innovation.

The directorates were then also scored out of ten in the following areas for assurance:

- A talented leadership triumvirate that plays to individual strengths as well as operating as a team.
- Good collective and individual understanding of what is driving current performance.
- A clear diagnosis that is shared throughout the Directorate of the key challenges in the year(s) ahead.
- Confidence in systems, processes and structures to deal with unanticipated events.
- A robust plan for the future that has been subject to wide engagement both within the Directorate and beyond and has comprehensive ownership.

Dependant on the scores the oversight category was assigned, and this could be highest priority, watching brief or standard. Each review was approved by TEG and then confirmation letters were sent to each directorate by the CEO. In the 2021 review there were Four directorates which were identified as requiring the highest priority of support, anaesthesia and operating services; vascular; acute and emergency medicine; Obstetrics, gynaecology and neonatal, Critical care were to remain in the highest priority until early 2022 following winter. From the information provided we were unable to determine specific criteria which assigned each directorate a category. All five of the directorates who were identified as requiring the highest priority of observation the criteria had also been identified in in this category

during 2020 although their individual directorate scores had improved within this banding. Therefore we were not assured this process was as robust as it could be in ensuring improvement or what specific support had been put in place. The letters sent to directorates provided the overall scores and several qualitative comments from members of TEG, however, there was no detailed explanation of the scoring so the directorate could explicitly identify how they required improvement.

Following the maternity inspection and the imposition of urgent conditions on the trusts registration the trust was required to submit an action plan and evidence of the actions they had taken to mitigate the risks. Despite the action plan and submissions from the trust which indicated that the majority of actions had completed and the board had reviewed this, we found many of the process parts of the action may have been completed but there was little evidence actions had been embedded, sustained and improvements made to the care patients received.

Operational oversight

At all leadership levels in the trust including the board there was a lack of operational focus, oversight and action to mitigate the risks to patients receiving care in frontline services. There was a number of patient safety concerns CQC have found during the last 12 months through our engagement, monitoring and inspection processes. This has included the use of our urgent enforcement powers to impose conditions on the trust's registration, two further considerations of the use of our urgent enforcement powers and repeated requests for information and assurance. We identified through this close monitoring that governance systems and operational oversight and grip at the trust were not mature and did not adequately assess, monitor and manage risk in frontline services. The trust has required significant guidance from CQC to enable them to provide the required regulatory assurance that immediate risk to patients has been addressed. For example, we wrote to the trust in June 2020 and again in July 2020 requesting assurances the trust had implemented actions in relation to the increasingly high numbers of never events we had observed being reported. The trust provided CQC with a written action plan on how they would improve the safety of patients and reduce the number of never events.

Our review of the National Reporting and Learning System and the Strategic Executive Information System identified the trust had declared 11 never events between September 2020 and May 2021. Following the trust's review of CQC's draft report, the trust stated there were five never events in the same period. Our further review of the incident reporting systems maintained there were 11 never events in the period. The trust did not provide the detail required to show that two incidents (ID 31728307 and 62206536) had been declassified as never events which meant we could not be assured as to the correct number of incidents declared by the trust.

CQC identified significant patient safety concerns at the focussed inspection of maternity services in March 2021 which saw the rating of the service deteriorate to inadequate. We re-inspected the maternity services as part of this inspection and found there was little or no improvement to the quality of care patients received, in some areas the service had deteriorated further. For example, there was significant concerns about the assessment of patients in the labour ward assessment unit, maternity staffing and delays in induction of labour.

We found in the other core services significant patient safety concerns during this inspection. Many of the areas were known to senior leaders but actions taken had not been reviewed to see if they effectively mitigated risks to patients. For example, despite a letter of intent relating to care of patients with mental health concerns and actions taken there were still concerns. We found patients without appropriate assessment or plans of care to reduce the risks. This also included patients where a deprivation of liberty safeguard was being applied for without an appropriate assessment of the person’s mental capacity.

Our findings

Following our inspection, we formally wrote to the trust under our section 31 powers to share our concerns about our inspection findings. We asked the trust to take immediate action to improve the quality and safety of services. The trust provided details of the immediate steps taken to ensure patient safety and a further action plan to ensure and embed improvements. During our inspection of the trust's leadership and governance in November 2021, we reviewed the action taken by the trust to improve the quality and safety of care patients were receiving on the inpatient wards. Our return visit found that the trust had not made significant improvement in some of the areas of concern identified in our October inspection which resulted in continued breaches of several regulations. As such we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008. The warning notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided.

We found that the medical director (operations) had issued patient safety message to staff in relation to falls and falls prevention which indicated a number of actions for staff to take. However, during our inspection we found that falls was a significant issue in that patients were not always assessed for falls risks and actions were not always implemented to mitigate risks. So, despite actions being identified in the message there was no formal processes in the organisation to ensure the actions had been implemented, sustained and had improved the care to patients. The board and management teams were reliant on staff taking the requisite actions without governance or operational oversight to ensure this happened. This was replicated in a number of areas and concerns that we have identified through our engagement, monitoring and inspections in the last 12 months.

During our interviews at core service through to the board staff described robust plans to improve service delivery for example elective recovery. However, despite requests for copies of these plans were not provided with the information so we could not see the clinical prioritisation, timeliness of actions, responsibilities for action and monitoring information to ensure the plans improved the services.

Within the emergency department we saw significant challenges with access and flow through the department. We saw and heard local leaders taking the appropriate actions to try and improve flow through the department and escalating these concerns when the department was extremely busy. Staff described to us that flow through the department was not seen as a whole organisation issue and they were often left to manage this without additional support. We saw senior leaders including board executives at our inspection supporting staff to improve flow through the department however, staff described they did not often see senior leaders outside of their department on a day to day basis and this had only happened as we were inspecting.

During our unannounced onsite inspection, we escalated a number of patients in both the medical and surgical core service who were at risk. This included one patient who was at high risk of leaving the ward, which had been escalated to staff by inspectors and we asked them to review the care of the patient. We later returned to review this patient and found they had absconded and been found off the hospital site and the review we had requested had not been undertaken.

In addition, on ward G2 a patient was not given Oxycodone for six days despite the patients notes saying they were in pain. This was raised with a nurse in charge who said this would be reviewed, the following day the patient had still not had the medication nor a review. This was raised with the chief nurse on the last day of our inspection and we then saw evidence that appropriate action was taken.

Security

We saw the annual security report which was presented to TEG in November 2021. Within this report we saw, the trust assessed itself as meeting the requirements of the standard NHS provider contract in terms of security standards.

Our findings

However, it did not identify, information we were given during our onsite inspections in relation to security guards being used to provide 1:1 observations of patients. Ward staff informed the inspection team that security guards had training in terms of MCA and DoLs, dementia restraint, in addition the report stated 92% of the security department had received training in MCA. However, we spoke with security staff who informed us they had not received training which they felt met the needs of patients. In addition, there was no training on appropriate physical restraint, all techniques that were used was shared between the team and based on knowledge from roles (police and armed forces) prior to working for Sheffield teaching hospitals and common sense. We were told some security officers had attended security industry for supervisors training, however, staff felt this was not fit for purpose in the roles they currently had in terms of 1:1 supervision of patients. In the report there was also no mention of the security team being short staffed, as there was a team of up to two security officers to cover each site, there was no robust lone working system in place for security officers.

The trust used closed circuit television (CCTV) and security guards were issued with body worn video cameras to detect and deter security incidents with the ultimate aim of protecting patients, staff, visitors and assets. We saw in the annual report that the trust believed it adhered to all relevant codes of practice in the operating of both the CCTV and body worn video. However, we were not assured consideration had been given to the use of body worn video cameras when providing 1:1 supervision of vulnerable patients in terms of their privacy, confidentiality and human rights.

Finances Overview

Finances were reviewed monthly at the finance and performance committee and an in depth and comprehensive report was provided to TEG on a monthly basis. A high-level overview was included in the board's integrated performance report.

The board understood the current financial position and the challenges and risks to it both in this financial year and going forward for the next two to five years. The trust was not reliant on any external cash support. We were told that cost improvement/efficiency plans were developed from the directorates upwards and were clinically driven.

Performance

There was an integrated performance report (IPR) gave an oversight of the trust performance in a range of objectives and performance indicators; the report was used to cover areas related to the strategic objectives. From the November 2021 board papers, the IPR moved to using statistical process control (SPC) charts to show variation and assurance using icons and included actions to recover performance.

The trust performance was reported between April and October 2021 for the following:

- Hospital onset methicillin-susceptible staphylococcus aureus (MSSA) reported as being higher than the same quarter in the last two financial years - 22 cases against a target of 16. The actions to improve the performance included – themes and trends from RCA's being considered by the infection prevention and control team.
- Hospital onset clostridium difficile (c.difficile) was reported as being above the threshold for the second quarter 2021/2022 – 42 cases against a target of 34. The actions to improve performance included – review of new treatment guidance by the microbiology team.

- Percentage of incidents approved within 35 days based on approval date, was reported the target had not been met in any month within the last two years – 83.8% against a target of 95%. The actions to improve performance included – the launch of the safety and risk quality dashboard launched in September will help directorates to monitor their own performance against the target and focus their efforts on how to improve.

However, in terms of incident reporting, directorates were required to write a paper identifying the incident for it to be reviewed by the serious incident group (SIG) which met once a week. Decisions around the reporting of serious incidents were made by the patient safety team within two working days following the identification of the incident.

As with all other trusts the COVID-19 pandemic had had a negative impact on emergency care standards and referral to treatment times and clinical care pathways and these were included within the IPR.

Staffing

The trust developed a workforce planning tool to proactively understand what nurse staffing would be required in coming years. It was used to identify risks in terms of nurse staffing in the future and was helpful in developing business cases for funding additional Registered Nurse recruitment. The workforce planning tool has supported the trust to secure national and internal funding to fill the registered nurse vacancy.

The trust completed bi-annual strategic staffing review including all nursing areas using the safer nursing care tool (SNCT). Due to the COVID-19 the last full review of staffing had not been undertaken since January 2020, however, this review had not been reported to TEG and human resources and organisational development (HR and OD) committee until February and March 2021 respectively. This paper identified there was a positive difference against the acuity and dependency of patients.

We found nurse staffing reviews were paused as a result of the COVID-19 Pandemic in June 2020 and January 2021. We found there was no discussion in public or private board papers which reflected the staffing concerns found during our onsite inspection.

The trust published safe staffing information on the trust website, the average fill rate for registered nurses and midwives during the day for all wards was reported to be 92.3% and ranged between 68.5% on the Burns Unit and 122.5% on the Pulmonary vascular disease ward M2. The average fill rate for care staff for all wards was reported to be 103.2% and ranged between 50.9% on the cardiac progressive care unit and 270.8% on the neonatal intensive care. During the night the average fill rate across all wards for qualified nurses and midwives was 86.7% and ranged between 67.7% on the high dependence unit and 113.1% on wards N1 and N2 and for care staff 105% and ranged between 21% on the cystic fibrosis unit and 271.7% on Osborn 4. This meant the gaps in registered nurse and midwife staffing were backfilled with care staff. During our core service inspection we observed a bed meeting led by the duty matrons which looked at staffing and capacity across the trust. However, we were not assured the number of staff moves made during the day were recorded accurately by the trust to maintain effective and dynamic oversight of staffing on all wards. Therefore, we were not assured staffing assessments in the immediate term were based on the safest options as no objective tool was used for each inpatient area nor were, they reported accurately. During the inspection, we requested evidence from the trust to provide assurance that there was appropriate planning in the short and medium term for staffing establishments in response to the changing use of wards in response to the pandemic. The evidence submitted by the trust did not provide this assurance at the time of inspection. However, following the trust's review of CQC's draft report, the trust submitted further evidence detailing the process used to undertake reviews of establishments and a sample showing this process in action.

Our findings

During our inspections we found a number of wards where the actual numbers of staffing were below the planned levels. This was managed on a day to day basis through ward managers and matrons. We found in the majority of cases staff were working hard to try and deliver safe care to patients however staffing levels were consistently having a negative impact on the safe and timely delivery of care.

Medicines

The Medicines Safety Officer (MSO) reported to the Medicine Safety Committee. The MSO did not routinely look at incidents rated at low harm to check whether they have been rated correctly or to check for any themes for future learning. We saw a medicines management and therapeutics committee (MMTC) activity report which was presented to TEG, we noted the MMCT met on nine occasions in the previous year, however, one meeting was not quorate, it was also noted that membership from the pharmacy team was good, however membership and attendance from prescribers was static and could be improved.

Information Management

The trust did not always collect reliable data, analyse and use it to make improvements. Staff accessed data on multiple electronic and paper platforms. This meant that, for some services, information was difficult to access promptly and may provide limited or false.

Although information technology systems were used to record and monitor the quality of care, we found there were multiple systems which did not communicate with each other and meant records were fragmented and hard to follow.

The inconsistencies and significant variation found in the nurse staffing data meant we were not assured the data collected was accurate or timely.

This information was not always used to drive improvement where needed. The trust used electronic systems including an electronic patient record (EPR), monitoring of early warning scores, medicines management and incident management systems. Some information was in paper format and staff often needed to navigate multiple systems to view information. We saw during inspection staff struggled to access systems and developed work arounds; however, these were different for each staff member which meant we were not assured that data was accurately being captured.

We were told a new electronic patient records system was in the process of being procured and was likely to go live in 2022/2023.

Electronic Prescribing and Medicines Administration (EPMA) had been rolled out across the Trust. We found some critical medicines were not available to give at ward level. During the inspection, the Trust was unable to provide a report to identify missed doses to make the necessary improvements. An example of a missed doses report was provided following the trust's review of CQC's draft inspection report.

As part of the inspection we had a number of examples where CQC requested information which the trust was unable to provide in a timely way. We found some of the data responses did not correlate with the original request on occasions was only part of the information or a narrative rather than the actual document itself. Hence this led to a number of further information requests.

Our findings

Engagement

Leaders told us that they engaged with patients, staff, equality groups, and the public, although we frequently heard from staff that leaders were not visible. The trust was participating in the developing new health and social care landscape of the ICS.

The trust had engaged with staff in identifying updating their strategy, however the launch had been delayed due to COVID 19. During the core service inspections, we frequently heard from staff that senior leaders including directorate, care group and executives were not always visible in services.

Actions had been identified to support staff during the COVID-19 pandemic, with an emphasis on staff well-being. Staff were encouraged to access a range of available support, including occupational health services, risk assessments, counselling for both staff members and their families and different therapies.

There were regular newsletters to inform staff of what support was available for them and providing additional information including "you said we did" and identifying support days for example world menopause day on 18 October 2021.

In the trusts quality report 2020/2021 it identified the priorities for 2021/22 with patient experience highlighted as a quality objective in terms of developing and improving individualised end of life care for patients and their carers. This was a two-year objective with the initial pilot due to begin in December 2021.

Monitoring patient experience was delegated to a patient experience committee which met monthly. The committee reported to the trust executive group, we reviewed meeting agendas for the six months prior to our inspection and saw the executive group only received minutes from the patient experience committee in October and November 2021. The trust executive group noted the minutes without further action. We reviewed health care governance committee agendas for the last six months and did not see evidence of output or reporting from the patient experience committee to the trust's healthcare governance committee. The limited output from the committee meant it was not possible to evidence a commitment from the trust to monitor and improve patient experience. We saw the last patient experience report which was published on the trust website was dated 2018, and the strategy for involving patients and the public was dated 2015. We also saw there was limited involvement of maternity groups including the maternity voices partnership. This meant we were not assured the trust was as open and transparent with the public as it could be.

We saw evidence of a patient story was presented at the safety and risk committee and was planned to be a standing agenda items at future meetings. The trust board included clinical updates as a standing agenda item which allowed frontline staff to present case studies to the board which included examples of patients' experiences using services. However, the trust board did not regularly hear patient stories from patients themselves and as such we were not assured the board was fully sighted on the entirety of the lived patient experience at the trust, in line with the PROUD values.

We saw that trust governors had a limited role in talking to the public but up to the time of our inspection were openly invited to observe board and subcommittees of the board. We spoke with governors who stated they felt very engaged with the trust and the executive team being given opportunity to ask questions following meeting to gain a greater context of the discussion. This was not usual in the role of the governor and during our interviews this level of engagement an oversight by the council of governors was being reviewed.

Our findings

Learning, continuous improvement and innovation

Complaints process overview

There was a complaints system in place and overview was delegated to the patient experience committee. One of the priorities for 2020/22 was to undertake end to end review of the complaints process to identify good practice and areas for improvement. The rational for this was to ensure a more personal approach to resolve concerns in a timely manner. Progress towards this priority was delayed due to operational pressures as a result of COVID-19. Most complainants were responded to in a considerate manner. The trust worked to a response time usually 25 days and this was reported within the Integrated performance report which was received by the trust executive group monthly. Complaints timescales were agreed with each complainant depending on the complexity of the complaint, since the start of the pandemic, a timescale of 40 working days had been agreed for most complaints and 60 working days for more complex complaints. The Trust target was to respond to 90% of complaints within the agreed timescale. We saw evidence that from January 2021 82% of complaints were responded to within the agreed timescale. Actions and monitoring were put in place with directorates and this position improved to 92% by July 2021.We reviewed four complaints, there was evidence all four of these had been responded to in line with the trust target. All the complaint responses were signed by the chief executive and contained information about PHSO and a complaints feedback survey. All the complaint responses we reviewed had evidence of clinical involvement and contained contact details for staff who would be willing to speak with and/or meet the complainant. None of the four complaints were upheld which meant it was not possible to evidence how the trust identified lessons learnt from complaints and shared these with frontline staff. Following the trust's review of CQC's draft inspection report, the trust provided an example of a complaint which had resulted in learning for staff. This had been presented at the trust's patient experience committee in July 2021.

Serious incident review process

There was minimal evidence of learning from incidents. The majority of staff we spoke with at the unannounced inspection were unable to tell us about learning which occurred from incidents. There was a formal process for reporting serious incidents, which were discussed and signed off by the medical director or chief nurse at the trust's serious incident group.

The serious incident group met weekly; each directorate was required to submit a Paper A which should include all information known as to why an incident was suspected it was a serious incident. These reports were expected to be submitted to the patient safety team within 24 hours of identifying the incident. Within a further 24 hours the patient safety team reviewed the incident and if it met the serious incident criteria it would be reported on to strategic executive information system (StEIS). The Paper A would then be discussed the serious incident group for sign off. If the incident was deemed not to meet the serious incident criteria it was still discussed at the serious incident group to decide what level of investigation was required. Following our inspection of maternity services in March 2021 we raised concerns with the trust regarding this process as Maternal Deaths and pressure area damage were not properly reported to StEIS. During this inspection we found similar processes throughout the core services, so we were not assured directorates were given the autonomy to report incidents

Between November 2020 and October 2021, we saw the trust were not timely in their reporting of incidents. Evidence showed the trust reported a total of 79 serious incidents to StEIS of these 25% [20] were reported over 90 days. We also saw the trust reported 22,512 incidents to the national reporting and learning system (NRLS) of these 9% [2,031] were reported over 90 days.

We reviewed six incident reports and found they were effectively investigated, and the reviews focussed on the learning. However, whilst there were terms of reference for each investigation there was no evidence in at least four files that the

patient or their family/carers had helped to set the terms of reference and in four files there was no evidence that there was a support plan in place if they needed one. Where incidents were reported and investigated, we found no concerns with the implementation and carrying out of duty of candour. All six incident reports had recommendations and action plans in place although we were concerned that the recommendations from serious incidents were not as robust as they should have been. The trust maintained oversight of all planned actions resulting from serious incident reports. The data provided showed a slight increase in actions overdue for completion from August to September 2021. The data showed the trust was not consistently taking timely action in response to serious incidents in order to reduce the risk of repeat incidents.

Where incidents were reported and investigated, we found no concerns with the implementation and carrying out of duty of candour. All six incident reports had recommendations and action plans in place although we were concerned that the recommendations from serious incidents were not as robust as they should have been. The trust maintained oversight of all planned actions resulting from serious incident reports. The data provided showed a slight increase in actions overdue for completion from August to September 2021. The data showed the trust was not consistently taking timely action in response to serious incidents in order to reduce the risk of repeat incidents.

We were told that any never events were managed through a central action plan. Our review of the National Reporting and Learning System and the Strategic Executive Information System identified the trust had declared 11 never events between September 2020 and May 2021. Following the trust's review of CQC's draft report, the trust stated there were five never events in the same period. Our further review of the incident reporting systems maintained there were 11 never events in the period. The trust did not provide the detail required to show that two incidents (ID 61728307 and 62206536) had been declassified as never events which meant we could not be assured as to the correct number of incidents declared by the trust.

Mortality, Learning from deaths

Since April 2017, the national ‘learning from deaths’ framework has stipulated that trusts must collect and publish, via quarterly public board papers, information related to deaths of patients.

We met with the medical director (operations) who was the executive lead for mortality. We also met with two medical examiners who had been instrumental in setting up the trust’s mortality review process and was instrumental in leading the regional structured judgement review process. The trust had 12 medical examiners in total who had been trained to independent scrutiny of non-coronial deaths in the trust.

We reviewed seven structured judgement reviews carried out after patients had died. We found two difficult to analyse, however, quality assurance processes had been implemented where 10% structured judgement reviews were sampled regardless of scoring. The review form was being re-designed to streamline the process and adding a cover sheet too support the identification of themes.

There are two main measures used nationally; the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI). The HSMR is worked out according to observed deaths divided by expected deaths, multiplied by 100. A score of 100 means that the number of deaths is similar to what would be expected. A higher score means more deaths; a lower score, means fewer. Mortality data at the trust between April 2020 and March 2021 showed the HSMR was 108.8 which was higher than expected. The latest data that was shared by the Trust during the inspection demonstrated that the HSMR was under 100 and in the 'as expected' range.

Our findings

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. The latest SHMI at the trust was 1.00, which was within the expected range.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Community	Good	Good	Good	Outstanding	Good	Good
Overall trust	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Charles Clifford Dental Hospital	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016
Royal Hallamshire Hospital	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022
Jessop Wing	Inadequate Apr 2022	Requires Improvement Apr 2022	Requires Improvement Apr 2022	Inadequate Apr 2022	Inadequate Apr 2022	Inadequate Apr 2022
Northern General Hospital	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022
Weston Park Hospital	Good Nov 2018	Requires improvement Nov 2018	Outstanding Nov 2018	Outstanding Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Sheffield Dialysis Unit	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall trust	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022

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

Rating for The Charles Clifford Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016
Overall	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016

Rating for Royal Hallamshire Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate ↓↓ Apr 2022	Inadequate ↓↓ Apr 2022	Inadequate ↓↓ Apr 2022	Inadequate ↓↓ Apr 2022	Inadequate ↓↓ Apr 2022	Inadequate ↓↓ Apr 2022
Services for children & young people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Critical care	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
End of life care	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Maternity and gynaecology	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Surgery	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022
Urgent and emergency services	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Overall	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022

Rating for Jessop Wing

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Inadequate Apr 2022	Requires Improvement Apr 2022	Requires Improvement Apr 2022	Inadequate Apr 2022	Inadequate Apr 2022	Inadequate Apr 2022
Overall	Inadequate Apr 2022	Requires Improvement Apr 2022	Requires Improvement Apr 2022	Inadequate Apr 2022	Inadequate Apr 2022	Inadequate Apr 2022

Rating for Northern General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Good →← Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022
Critical care	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016
End of life care	Good Nov 2018	Good Nov 2018	Good Nov 2018	Outstanding Nov 2018	Good Nov 2018	Good Nov 2018
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Surgery	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022
Urgent and emergency services	Inadequate ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Inadequate ↓↓ Apr 2022	Inadequate ↓↓ Apr 2022
Overall	Inadequate ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022

Rating for Weston Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Good Nov 2018
End of life care	Good Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall	Good Nov 2018	Requires improvement Nov 2018	Outstanding Nov 2018	Outstanding Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018

Rating for Sheffield Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Community end of life care	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Community health inpatient services	Requires Improvement →← Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓↓ Apr 2022	Good →← Apr 2022	Requires Improvement ↓ Apr 2022	Requires Improvement ↓ Apr 2022
Overall	Good	Good	Good	Outstanding	Good	Good

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

Northern General Hospital

Herries Road
Sheffield
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www.sth.nhs.uk

Description of this hospital

The Northern General Hospital, situated in the north of Sheffield, is home to the city's adult accident and emergency department and major trauma centre.

The Northern General is the largest hospital campus within Sheffield Teaching Hospitals NHS Foundation Trust spanning 100 acres. The hospital has over 1100 beds and employs more than 6,000 staff. It provides a wide range of specialist services including orthopaedics, renal, heart and lung services and has a purpose-built spinal injuries unit. There are a general and cardiac intensive care services onsite.

Sheffield Teaching Hospitals NHS Foundation Trust provides acute and community services to an estimated population of 694,000. The trust provides specialist services for the populations of Yorkshire & Humber, parts of Mid-Yorkshire and North Derbyshire.

Urgent and emergency services

Inadequate ↓↓

Is the service safe?

Inadequate ↓

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

Mandatory training

The service provided mandatory training in key skills, however not all staff had completed the required modules and we did not see evidence of the highest level of life support training provided to staff.

Staff were not all kept up-to-date with their mandatory training.

Between January 2021 and August 2021, mandatory training figures were RAG rated as red on the governance scorecard in two months and amber in six months. This meant the department did not meet the trust target for any of the eight months in the reporting period.

Between January 2021 and August 2021, oxygen training was rated as red on the governance scorecard in five months and amber in one month, and oxygen cylinder training was rated as met in two months and amber in six months. This meant the department did not meet the trust target for six out of eight months in the reporting period.

The trust target for compliance with mandatory training was 90%. Average training compliance showed that no staff group met the target for mandatory training. Additional clinical services staff met the target in six out of 13 modules. There were particularly low levels of compliance in moving and handling training (58% compliance) and safeguarding children and young people level 2 training (33% compliance).

Nurse staff met the target in four out of 12 modules. There were particularly low levels of compliance in moving and handling training (63% compliance) and safeguarding children and young people level 2 training (63% compliance).

Medical staff met the target in seven out of 12 modules. There were particularly low levels of compliance in moving and handling training (31% compliance).

The service also had Job Specific Essential Training (JSET), and the target for compliance was 90%. Average training compliance showed that no staff group met the target for JSET. Additional clinical services staff met the target in four out of 12 modules. There were particularly low levels of compliance in the two mental capacity act training modules (32 and 38% compliance) pressure ulcer prevention training (47% compliance) and falls training (64% compliance).

Nurse staff met the target in three out of 13 modules. There were particularly low levels of compliance in the two mental capacity act training modules (50% and 51% compliance) pressure ulcer prevention training (65% compliance) and falls training (64% compliance).

Medical staff met the target in none out of seven modules. There were particularly low levels of compliance in mental capacity act training (32% and 38% compliance) safer use of insulin training (44% compliance) and falls training (36% compliance).

The trust did not provide training compliance data for intermediate or advanced life support training level three for resuscitation of patients. The service was a major trauma centre and it was a concern that there was no clear system to identify and monitor staff training compliance for intermediate and advanced life support. However, during the factual accuracy process, the trust told us that all the trauma team leaders would have either advanced life support or advanced trauma life support training and was contained in individual staff files, however they did not provide additional evidence to support this statement, nor did they provide evidence of compliance rates for staff who worked within the service.

The department ran weekly simulations and a trauma of the week session where staff from all roles could learn together. Trauma of the week was a remote session, therefore staff who were not on shift could participate.

Specific training on recognising and responding to patients with mental health needs was included in the job specific training information provided by the trust. Additional clinical services and nursing staff training compliance exceed the trust target of 90%, at 95% and 91%. Medical staff did not meet the target for compliance, with an overall training rate of 75%. The service did not include learning disabilities, autism or dementia training in the mandatory or job specific training information. This meant staff may not have the knowledge and skills required to care for and meet the needs of all patient groups. During the factual accuracy process, the trust told us they provided Continuing Professional Development opportunities relevant to learning disabilities, autism and dementia, however they did not provide any evidence of the number of staff who had completed any relevant learning in these areas. The trust also told us they had plans to add national training standards relating to learning disabilities, autism and dementia training later in 2022, but they did not provide any additional information to evidence their roll out plans.

Managers monitored mandatory training and alerted staff when they needed to update their training, however the department had significant capacity challenges, and training was often cancelled to support the needs of the department.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, however they did not always meet the trust target for safeguarding training modules.

Nursing staff received training specific for their role on how to recognise and report abuse, however nursing and support staff did not meet the trust target of 90% for training in safeguarding children and young people level 1, where compliance was 87%, safeguarding children and young people level 3 training, where compliance was 63% or safeguarding adults level 2 training, where compliance was 89%. Additional clinical support staff did not meet the training target of 90% for safeguarding children and young people level 2, where compliance was 33%. This was a concern as staff may not have the knowledge and skills to recognise and react to safeguarding. The trust did not routinely provide emergency care to children, however staff may encounter safeguarding in adults that had the potential to affect children, therefore required training in this area to keep people safe, and the department did see children aged 16 and 17 who may require mental health assessment.

Medical staff received training specific for their role on how to recognise and report abuse and met the trust target of 90% for role specific training.

The trust had a safeguarding adults policy in place. It was in date and version controlled. The policy covered expected content and included signposting to local services.

The trust had a safeguarding children's policy in place. It was version controlled, however it was past its due date for review.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, however, they did not always use the information available to influence future care. We saw examples during the inspection where safeguarding concerns had been documented at previous visits to the department, or there were documented protection plans in place, and staff did not put their understanding of safeguarding into practice and respond to this information appropriately.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment visibly clean. However, the main areas in the department were visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. We saw regular, routine cleaning across all areas of the department and staff worked a rota 24 hours per day to provide domestic services to the department. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, however records did not include all tasks including changing disposable curtains.

Staff did not always label equipment to show when it was last cleaned. We saw multiple examples of disposable curtains that were not dated, or changed, in line with the trust process. This posed an infection risk as it was unclear how long they had been hung, or when they needed to be changed.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw several examples of staff wearing PPE inappropriately across different job roles, including masks worn under the chin and pulled down while talking. We saw examples of equipment not wiped clean between patients, and staff did not always change their gloves or wash their hands between clinical and non-clinical cleaning. Not all staff who were in clinical areas in the department were bare below the elbows.

Staff did not always clean equipment after patient contact. We saw examples of equipment used to transfer patients by ambulance staff which was not cleaned after use. We also saw examples of monitoring equipment used and not wiped clean between patients.

There was no alcohol gel in the entrance to the department throughout the inspection. There was alcohol gel available at the reception desk, however, the holder at the main entrance did not have any gel in situ, where we saw some patients having to wait for long periods to be booked in at the reception area.

The service had oversight of current infection risks and had processes in place to manage this. Patients identified as having an infection risk were isolated in side rooms and appropriate signage was used to indicate the potential for infection to protect staff and patients.

The service had a COVID-19 area which was used to see and treat patients with confirmed or suspected COVID-19 and they completed point of care testing for covid-19, where symptomatic patients attended the department and had not had a confirmed positive test result. When this area was full there was a process in place to manage patients in cubicles where they could barrier nurse, however staff were not all clear on this process, and we saw an example of a symptomatic patient waiting in the main waiting area because the COVID-19 treatment area was full.

Between January and September 2021, infection control had been documented and monitored through the governance scorecard. We saw that indicators were not checked regularly. There were 11 indicators scored across the nine completed months (January to August 2021). Out of 83 potential scores, 36 had been noted as NA, seven had been RAG rated as red, but had no score, and 19 were rated as red and scored between 33% and 93%. Commodes were consistently rated red, improvement peaked in May 2021 at 91%, and had consistently declined in the months to September 2021 where the score was 50%. The governance scorecard was part of the department's clinical governance meeting agenda, and we saw the worst performing area was, discussed, however the actions documented lacked pace when considering the performance had been below target for 9 consecutive months. There was no evidence of previous actions discussed. This was also noted in the service's IPC audit report. This was a concern as it meant that equipment was not always cleaned in line with trust guidelines and could pose an infection risk to patients.

The trust had completed hand hygiene audits in April and May 2021 and compliance was noted as 100%. No further hand hygiene audits had been completed in the reporting period.

We asked the trust to provide their infection prevention and control policy and any specific COVID-19 policies. The trust provided 63 policies. We reviewed the trust's policy for infection control isolation precautions and patient placement guidelines, as the most applicable policy to patients attending the department. The policy was version controlled, however it was past its review date, which was due on 01 March 2016, therefore it did not include COVID-19 isolation requirements. The trust did not provide an overarching COVID-19 policy to reference.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment.

All patient bays had access to call bells, however they were not always in reach of patients, specifically those patients who were unable to mobilise, and staff did not always respond quickly when called. We saw at least 13 examples of patients with no access to call bells who also had bed rails in situ across the inspection period. This posed a risk to patients as they could not always call for assistance when they needed to.

The design of the environment did not always follow national guidance. The service had a mental health room which was minimally furnished with sturdy furniture and was large enough to seat four people. The room was visible from the nursing station if the door remained open and the door had an additional vision panel to support observations. There was a strip alarm around the walls. The room was designed to be ligature free, however during our visit a fitting on the ceiling had become loose and was a ligature risk which had not been observed and mitigated by staff. We made the trust aware of our concerns during the inspection. The trust told us the fitting was reported and repaired on the same day.

Patients with mental health conditions who were considered a risk were allocated to bays in the clinical decisions unit. The trust had a standard operating procedure in place in accident and emergency which guided staff to remove potential ligatures from areas in which patients who were at risk from self-harm were being cared for. Staff also followed a mental health risk assessment which outlined that patients noted as high risk due to their mental health needs would be allocated the support of one to one observation.

However, staff did not always follow these processes and we saw that it was difficult to do so in a busy department where patients moved freely between rooms and settings. In six of the incidents involving a ligature, the risk of self-harm had been identified but items which could be used to ligate had not been removed in order to keep the patient safe.

Staff carried out safety checks of specialist equipment. We reviewed the daily departmental checklists for each area for seven days. We saw gaps in daily checks across all areas of the department, including gaps in checking resuscitation equipment, medication rooms and fridges and PPE availability. This meant that managers in the department were not assured that all checks that should be completed to provide safe care and treatment had been done. However, we saw evidence of documenting when issues were identified, which was good practice.

The service had suitable facilities to meet the needs of patients' families. There were two relatives rooms in the department where families and loved ones could wait. One of the relatives rooms gave direct access to the department's viewing room which meant families of patients who were bereaved could see their loved ones. There was a forget-me-not flower sign when the room was in use to notify staff, and we saw this was used during the inspection.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. However, we saw an example of a sharps bin that was not dated or signed in line with guidelines.

The service had key performance indicators (KPI) in place to monitor medical devices that required maintenance. Devices in the care group had been maintained in line with the KPI. Where there were areas that had not met the KPI, the trust had a recovery plan in place. There were no concerns highlighted for the Urgent and Emergency Care group; 100% of high priority maintenance had been completed and 95% of standard priority maintenance, with a KPI of 90%. This was above the trust target.

The service had recently implemented a weekly nursing assurance checklist for the nurse in charge of the department to complete in response to concerns we escalated to the trust in a letter of intent which required the trust to take immediate action to protect patients from the risk of harm. We undertook a second visit to the department to check whether the trust had taken sufficient action to protect patients. In the second visit we reviewed the most recent checklist. It had been completed, however there were some gaps and we saw the process was embedding in the department; when we asked staff in the department who undertook the nurse in charge role, they were not all aware of the checks.

The trust had a fire risk management strategy which was under review and a fire evacuation strategy for the hospital site. The strategy detailed measures to reduce the risk of fires occurring and the actions to take in the event of a fire.

Visibility of the main waiting area from reception was poor and the layout did not meet the needs of the department due to the capacity of patients being seen. Senior leaders were aware of this and overcrowding of the department was on the risk register, however, we did not see routine checking in the waiting area to make sure patients were safe. We saw that when the waiting room was full there was not enough room for patients to wait in the department and maintain social distancing. Patients were seated, sat on the floor, in the doorway and outside the main department doors during the inspection.

When the number of patients in the department was over capacity, it was incident reported by governance staff. Each incident was managed as part of the overarching risk assessment for overcrowding in the department. However, we did not see from the overarching risk assessment that action was taken as a direct response to each incident of overcrowding; this meant that the service may not respond to factors in their control appropriately, because the focus was on the overarching problem.

Assessing and responding to patient risk

Staff completed risk assessments for each patient, however they were not always completed in a timely way. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. However, staff did not always act upon the outcomes of these tools, and the deteriorating patient policy had been out of date for four years. We reviewed the draft policy which was being reviewed by the trust at the time of the inspection; it reflected current practice and guidelines. The trust had moved to monitoring patients using a nationally recognised tool, and this was not reflected in the policy in place for staff during the inspection.

Both iterations of the policy were to monitor patients through observations, the new policy to follow the NEWS2 (national early warning scores 2) guidance. Where an indicator of sepsis was identified, the trust followed the Sepsis Six model to provide testing and treatment to patients within one hour. Early warning scores were used to monitor patients and detect deteriorating patients, or patients who required escalation or additional care or treatment.

We saw four examples of patients in the department during the inspection period who had not had their observations recorded in line with the local policy or national guidelines. Recording observations is important for clinical staff to monitor patients. In the examples we saw, patients required regular monitoring, and this was not recorded in the patient records. Not all staff could describe the trigger for a medical review of a deteriorating patient, where sepsis might be indicated, and we were told that when patients suffering from sepsis were escalated there was not always a prompt response from medical staff; this was due to departmental pressures and the acuity of other patients in the department.

During our inspection we saw a patient presented with an intentional overdose. The patients Glasgow coma scale (GCS) was scored at eight and later declined to seven, with this score the patient would be classed as in a coma (Patients with scores of three to eight are usually considered to be in a coma). There was two hours 35 minutes between the patient scoring a GCS of eight and it dropping to seven. We also saw the NEWS for this patient was 11 and was repeated 42 minutes later therefore the documentation of observations and the frequency they were formally carried out was not in line with guidelines. The trust reviewed this case and during the factual accuracy process told us that the department was under considerable pressure at the time of this patient's treatment, and that the patient received continual visual monitoring during their time in resus. However, we did not see evidence of this documented in their patient record and this evidence was not provided by the trust.

We saw that decisions to amend parameters based on the clinical history of patients was not always documented in patient records, and staff described a blanket approach to some patient groups, for example, we saw in the record of a patient with chronic breathing problems that observations had been completed within a specific oxygen saturation range, and not on their own baseline. We saw this had been discussed by medical staff in the mortality and morbidity meeting in May 2021, however a blanket approach meant that patients who were deteriorating may be missed or not acted on appropriately or in line with guidelines and was poor clinical practice.

The service had a pathway in place for patients who needed neurological surgery. This was important as the service was a major trauma centre and neurological surgeons were not based on the site seven days a week.

Urgent and emergency services

Staff described the department as often overcrowded with long wait times for triage and to see a doctor. Staff told us this impacted on their ability to complete observations and assessments in a timely way, and within guidelines and policies.

Staff did not always complete risk assessments for each patient on arrival, and risk assessment tools were not always available or fit for purpose. Risk assessments were not always reviewed regularly or completed in a timely way.

The department did not have a specific risk assessment for the use of bed rails. We asked staff while reviewing records and there was no risk assessment in place, where the risk did not relate to falls or patients living with dementia. We saw many examples of patients with bed rails in situ; 13 patients also did not have a call bell in their reach. We escalated this at the time to ensure patients were given the means to gain the attention of staff. This posed a risk to patients, as they were not appropriately assessed for bed rails to be used in the delivery of their care.

The falls risk assessment was not fit for purpose and was not patient centred to meet individual needs. The falls policy was based on inpatients, and there were no specific references to the emergency department, or when reassessment would be required, other than a change in the patient's condition. We saw recent examples of falls reported as incidents in the department, and in two examples falls risk assessments had not been completed or acted upon because the department was overcrowded or had a high number of patients with a falls risk.

There were 78 falls in the department between 01 October 2020 and 30 September 2021. We reviewed the incident reports for falls in the department and saw that in 24% a falls risk assessment had not been completed prior to the patients fall. When there was a timeline available, we saw most patients that had not been assessed had been in the department for over two hours. This was a risk as, because of the challenges in the department's flow, patients were routinely in the department for several hours and assessments were not always completed in a timely way to ensure risks were mitigated.

The service carried out a review of falls for a three-month period between June and September 2021. They found that, of the falls in that time span, 27% of patients had not had a falls risk assessment prior to their fall. Following the review, the department introduced the "yellow socks" initiative, where patients who are identified as a falls risk are given yellow socks as a visual prompt for staff, as soon as the risk is identified. We heard about the yellow socks initiative during the inspection, and saw patients wearing them in the department.

Most staff knew about any specific risk issues, such as pressure areas and sepsis, however they told us they did not always have time to complete patient risk assessments or respond to risk assessments that had been completed. We reviewed 10 sets of patient records and saw risk assessments were inconsistently completed, body maps were not always completed to identify areas of concern or risk. We saw two examples where the patient's history and presentation should have indicated a skin integrity check, but there was no evidence in the patient record this had been completed. We also saw an incident in the department where pressure areas were not checked in the department and were identified following admission to a ward in the hospital. This posed a risk to patients as assessments were not always completed to ensure patients were receiving safe care based on their needs.

We were not assured that staff had sufficient oversight of patients in the waiting room. Patients' told us that staff were not a consistently visible presence in the waiting areas and that no-one came to check on their welfare. We observed the waiting area and did not see regular review of the entire waiting area by clinical staff. There was an over-reliance on reception staff to escalate concerns, however they were not clinically trained, and when the department was busy, they were often too busy dealing with patients booking into the department to also have oversight of the area. We did not see evidence of proactive monitoring of patients whose condition might deteriorate by appropriately trained staff.

Urgent and emergency services

The layout and capacity of the waiting area, while maintaining social distancing meant that patients were often observed sitting on the floor, in doorways, round corners, and even waiting outside of the department main doors, therefore they could not be easily observed by any staff. There were signs at reception prompting patients waiting to tell reception if someone looked like they needed assistance, however this indicated an over-reliance on patients and their relatives escalating concerns.

There was a hospital policy for intentional rounding, however there was no specific procedure for the implementation of this in urgent and emergency care. We saw limited evidence of intentional rounding in the department, for example to review pressure areas, dehydration and the observation of patients' potential deterioration. In the records we reviewed, six out of 10 patients were in the department for over six hours and there was limited or no intentional rounding, including no documented nutrition or hydration. This meant opportunities to manage and mitigate patient risk, and avoid potential harm were missed.

We escalated this concern to the trust in a letter of intent which required the trust to take immediate action to protect patients from the risk of harm. We undertook a second visit to the department to check whether the trust had taken sufficient action to protect patients. In the second visit we saw this had improved and we saw 12 patients in bays in the department who all had access to food and drink, and had their call bells in reach, or were in line of sight from the nurses station. However, there was no intentional rounding to check patients had not deteriorated in the waiting room while waiting times were long.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. There were regular nurse and consultant in charge huddles and nursing and medical handovers in the department. The nurse and consultant in charge monitored patients in the department using the e-whiteboard and patients arriving by ambulance using the electronic ambulance system. The whiteboard had information which gave the staff in charge oversight of the demands on the department and it auto-calculated the escalation score based on the department’s activity. This was good practice.

Patients arriving to the department by ambulance were handed over to the Initial Assessment Unit (IAU). When this area was full, patients would queue in the back of ambulances. The nurse and consultant in charge of the shift kept oversight of patients in the IAU by monitoring the electronic whiteboard for signs of deterioration. The nurse and consultant in charge of the shift told us they kept oversight of patients waiting in the ambulance queue through paramedics escalating concerns, and when the wait was long, they completed a “ward round” of ambulance patients waiting. We were not assured that this was a robust process, and when the department was busy and understaffed, the nurse and consultant in charge were not always able to stay in the department to support the IAU.

During the inspection we observed reception staff streaming patients to other, such as local GP services, we asked the service for the guidance for reception staff. The procedure we reviewed did not delegate responsibility for reception staff to stream patients away from the department, it is specified as the role of a triage nurse. We were not assured that there were appropriate processes or training in place to support reception staff to make these decisions. We saw that reception staff had a copy of the conditions which could be streamed to the GP service, and this was used to decide if a patient could be streamed away from the department. This was not in line with the trust process and posed a risk to patients, who may be inappropriately streamed by staff without the training, skills and competencies to do so.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). However, the response times were long and patients often waited in the department for several hours, overnight, and in some cases several days to be assessed and admitted to an appropriate bed or placement.

Urgent and emergency services

Between 01 December 2020 and 31 November 2021, 34 patients with mental healthcare needs aged 16-18 were cared for in the department for more than 12 hours. In the same time period, 486 patients with mental healthcare needs aged over 18 were cared for in the department for more than 12 hours. This was a risk because patients were not in the most appropriate environment to meet their needs and risk assessments and the department facilities were not designed to meet the care needs of these patients.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, mental health risk assessments were not robust. The risk assessments were completed for patients who presented to the department with a mental health concern and assessed a patient as either a red (high) or green (low) risk. Staff completed the risk assessment form for all patients once a day, including those assessed as high/ red risk. The form used by the trust did not have a category for patients with potential to escalate such as a medium or amber category which would have resulted in more frequent reviews of the patient's risk assessment. We escalated this concern to the trust in a letter of intent which required the trust to take immediate action to protect patients from the risk of harm. We undertook a second visit to the department to check whether the trust had taken sufficient action to protect patients. In the second visit we saw no changes had been made to the mental health risk assessment used in the department. The trust reviewed the risk assessment and concluded it was fit for purpose.

Patients deemed high risk were noted to need the support of constant observation by staff. This had not occurred in most of the records we reviewed. This meant that whilst staff had assessed the risk to patients resulting from their mental health, they did not take the action required to manage these risks safely. During the factual accuracy process, the trust told us that the risk assessment form contained conflicting information about the circumstances that one to one observation was required, and the form had since been amended.

The trust had undertaken an audit of compliance with the risk assessment which had shown an improvement in completion of these assessments. However, managers noted that the trust's audit process had focused on whether staff had completed the required assessment template but had not examined whether the delivery of care was in line with the risk management plan outlined.

During the inspection we saw and were told about examples of patients waiting for more than 12 hours in the department for mental health assessment and treatment. There had been incidents reported in the department where patients had absconded while waiting for an approved mental health practitioner (AMHP) from the local mental health service or waiting for an appropriate bed following assessment. We also saw incidents where patients with mental health concerns accessed items that could cause harm to other patients and staff.

We spoke to the lead clinician and nurse for the department who told us about how they risk assessed patients' needs and the most appropriate place for them to stay whilst waiting. We had concerns that when patients stayed in the department, they were not in an appropriately secure or observable space; although the department had lockable doors, there was a large reception hatch which patients had attempted to climb through, and patients who were assessed as low risk were in an unsecure seated waiting area, sometimes for long periods. There were multiple incident examples of patients who absconded from this area, and we had concerns about other patients in the bays who we observed to be disturbed by these behaviours when privacy curtains were drawn.

The service had a pro forma in place to complete senior rounding on patients in the department with mental health needs. This included checking that risk assessments and capacity assessments had been completed. Patients were allocated to different areas of the department depending on their risk level. There was a process in place to remove

ligature risks from bays in the CDU and yellow area of the department to create a safer environment for patients with mental health needs. However, we saw examples of the pro forma that had been completed incorrectly and did not reflect the assessed level of risk of patients we saw in the department. This meant that staff in charge may not have full oversight of the patients in their care, and their needs.

We asked the trust for the mental health pathway and policies. The service had developed action cards to escalate mental health risks, where one to one care could not be supported by the current staffing. This gave staff a process to follow to request additional staff from across the hospital and agency. However, if additional staffing could not be found, there were no alternative actions present. We saw examples of patients who were assessed as high risk, where one to one care was not requested or provided appropriately. This posed a risk to those patients and other patients in the department.

Service leaders were aware of the challenges that increases in mental health presentations brought to the department and had taken some actions to mitigate the risks through specialised staffing and better oversight and tracking of mental health patients. These measures were new to the department and still required embedding.

Nurse staffing

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed day to day staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers had calculated the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, however this had not been updated since the COVID-19 pandemic when an additional clinical area had been opened. This meant that the number of staff required had not been reviewed, even though the footprint of the department had been changed.

The department had increased its staffing need when the COVID-19 area was opened, but the planned staffing and establishment had not changed. This meant there were more areas to cover, with no uplift in nursing or support staff.

The service did not have enough nursing and support staff to keep patients safe and the number of nurses and healthcare assistants did not match the planned numbers.

The department had a fill rate (the number of available shifts filled by staff) of 99% for registered nurse staffing during the day and 85.6% at night. Care and support staff had a fill rate of 92% during the day and 79% at night. This meant that the number of shifts vacant were predominantly during the night shift. During the inspection we saw that demand in the department had increased in the afternoon and evening.

We looked at two weeks of rotas for the department. The planned staffing was 16 registered nurses and 8 health care. In 45% (19/42) of shifts, there were not enough registered nurse staffing to meet the planned numbers. There were 81 unfilled shifts for registered nurse staff in the period checked. Of the unfilled shifts, 49.3% were night shifts. In 50% (21/42) of shifts there were not enough non-registered nurse staffing to meet the planned numbers. Of the unfilled shifts, 32% were night shifts. A twilight shift had been introduced to uplift registered nurse staffing in peak times, however often, this additional staffing didn't account for the gaps in the standard rota, therefore there was no additional staff on the department.

We asked the service for a summary of the gaps and they stated that some data was incorrect due to late shift changes. This meant that the service was not always able to clarify the actual staffing on every shift in the department.

Nurses and health care support workers were split into groups to identify triage and phlebotomy trained competencies. This meant that when the rota was completed, it was easy to identify different competencies to allocate the right skill mix for the department.

During the inspection the department was regularly busy with long waiting times. We spoke to nursing staff who told us they felt staffing was unsafe at times and they did not always have time to give safe or good care.

Staff were routinely moved to other areas of the hospital to support staffing shortfalls. We spoke with nurses in the department who told us they were frequently moved to other areas to support which left the department short, even when staffing was low already in the department.

The department manager could adjust staffing levels daily according to the needs of patients. However, this often meant reducing time for senior nurses and nurse educators to carry out their roles by including them in the nursing numbers. Senior staff we spoke with told us they did not always get time to carry out their allocated duties as they were needed to provide care and treatment in the department. We observed the nurse in charge move staff around the department to support different areas when there were pressures, for example moving additional staff to resus to ensure there were enough staff to meet the needs of those patients who required urgent responses. We also saw additional staff brought to the department for short periods of time to assist with cannulas and phlebotomy; staff we spoke with told us this did not routinely happen.

Additional staff were moved from other areas of the department to triage patients; during the inspection we saw this happen when the waiting time for triage rose above two hours.

Staff we spoke with told us that there was not always enough staff to provide one to one care for mental health patients when it was needed. To mitigate this risk, patients requiring that level of care were in bays close to the nurse's station, whenever possible.

Sickness rates were 6.3% which was above the trust target and total leave in the department was 27%; the trust target was 24.3%. This meant that more staff were off work than had been allowed for in the establishment.

There were 3.08 whole time equivalent vacancies (WTE) in the nurse staffing establishment for the department. Care staff were over recruited by 0.47 WTE.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

The medical staff matched the planned number.

The service had low vacancy rates for medical staff. The emergency care staffing had two consultant vacancies out of 23 established posts. There were no other medical vacancies in the department.

The service had low and/or reducing turnover rates for medical staff.

Sickness rates for medical staff were low. The sickness rate for medical staff in emergency care was 3.39 which was better than the trust target of 4%.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had plans in place to increase medical staffing to match modelled attendance data, and to improve medical cover at weekends. A business case had been submitted to the executive team, and there were plans to implement the model to improve the safety of care and treatment provided in the department in the next 12 months.

The service always had a consultant on call during evenings and weekends. The service had provision of 24 hour consultant medical cover in place. We looked at three weeks of rotas and there was a consultant on duty on every shift.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, or stored securely and easily available to all staff providing care.

When patients transferred to a new team in the hospital, there were no delays in staff accessing their records, as electronic patient records were used.

Records were not always stored securely. We saw multiple examples across the inspection where computers were left unattended and unlocked, with smart cards in situ. This included patient information which was visible to any person passing by.

Patient notes were not always comprehensive, however all staff could access them. Staff told us that records were not easy to navigate, and they did not always use the tools available to them, for example body maps, because they were not easy to complete. Patients arriving by ambulance had key documents scanned on to their electronic patient record, however, some staff we spoke with told us it was difficult to find the documents as they added to one general scanned document area, and they could not tell easily what each document was.

The trust had not completed a recent general records audit, or any recent audits to assure themselves that staff were using the tools available to them appropriately; the last audit was completed in January 2019 and the trust told us that all actions resulting from that audit had been completed.

We asked the service for their most recent audit of falls and dementia risk assessments, or any assessment on the effectiveness of the risk assessments that were in place, however, they did not provide any further information.

The service had completed an audit on the documentation of consent in the emergency department for patients requiring a reduction of shoulder dislocation. Overall compliance in the first cycle, completed in 2018 was 56.8%. Compliance had declined to 34.1% in June and July 2020.

The report had a risk assessment which identified two actions to design and implement a consent form on the electronic patient record system and link it to the generic patient advice leaflet. However, the audit was carried out in January to June 2020 and these actions had a long completion date of March 2022. The report did not identify actions that linked to

the conclusions of the audit which indicated the need for improvement in several areas, including recording discussion with patients about risks, alternative treatment, and written information provided to patients. This was a concern as the compliance had declined, and the service could not evidence that patients were given enough information to give informed consent for the procedure. A re-audit was planned for April 2022.

The service had a proposal for improvements to shared records and referrals to improve the management of patients requiring the support or assessment of the local mental health trust. However, there were no details provided to determine the status of the proposal, or specific details relating to implementation.

Medicines

The service had systems and processes to safely prescribe, administer, record and store medicines, however they were not always followed by staff.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The Trust had an electronic system for prescribing and administering medicines. Staff told us that there had been some incidents where double doses had been administered by mistake due to an ongoing electronic system issue which would alert staff that a second dose was due, and not that the first dose had recently been given.

We found the medicines room to be organised and clean.

We found medicines in the resus trolley were not being checked each day which was not in line with the trust policy. We found the fridge temperature in resus was outside of range during the inspection and did not see evidence of action, therefore we were not assured medicines were being stored safely.

When patients were self-medicating in the emergency department or in the clinical decision unit, staff did not always record this. This was a risk as it may increase the chance of a medication error.

When patients were transferred from the department to a ward staff had to discharge them from the department to allow the new ward to have access to the medication chart. We found that patients were not always discharged in a timely way which meant they did not receive medications on time on the ward.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. The department had recently appointed two pharmacists who visited the department from Monday to Friday. This was a relatively new role which was embedding and the team had started to review policies and procedures within the department.

We were told that only critical medications were given to patients in the emergency department. Critical medications were not always in stock in the department and there were often delays in receiving. We saw several examples of missed medications across the department, as well as delays in administering prescribed medications.

We saw loose oxygen and entonox cylinders in the corridor department areas which had not been secured in line with guidelines.

Between January 2021 and August 2021, oxygen training was rated as red on the governance scorecard in five months and amber in one month, and oxygen cylinder training was rated as met in only two months and amber in six months. This meant the department did not meet the trust target for six out of eight months in the reporting period.

The trust had completed an audit of the controlled drugs in July 2021 and found two areas of non-compliance. There were several omissions of dose relating to administration of morphine, and not all staff signatures had been verified. We asked the trust for any related action plans for the audit and none were provided. This was a risk because without correct documentation of dose administered, there service could not be assured that doses administered were correct.

The trust had a process in place which contained guidance for staff in the use of rapid tranquilisation medication and for monitoring patients post rapid tranquilisation. However, the process was not in line with national guidance. It did not include a proforma for post rapid tranquilisation monitoring. Therefore, we were not assured that patients were appropriately monitored after rapid tranquilisation was administered. This was a risk to patients as deterioration may not be appropriately acted upon and could result in harm.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately. Staff investigated incidents and shared lessons learned with the whole team and the wider service, however action plans were not always in line with national guidelines. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. However, when we spoke to staff they told us they did not always have time to report incidents, particularly where no harm had occurred. We also heard that staffing concerns were not always reported and there was an accepted level of low staffing in the department.

The service had been no never events in the department in the last 12 months.

Managers shared learning with their staff about never events that happened elsewhere. Staff we spoke with told us they had received bulletins which included learning from incidents.

Staff reported serious incidents clearly and in line with trust policy. However, recommendations made in incident investigation reports did not always adhere to SMART (Specific, Measurable, Achievable, Realistic and anchored within a Time Frame) principals and action plans lacked detail, rigour and measurability. The action plans we saw were a summary of headlines, and were not in line with the SMART principals, as per national guidelines

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw an example of a multi-service incident and staff we spoke with knew about the incident and actions that had been taken to address it.

Managers investigated incidents. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Seniors members of staff told us that they held debriefs with staff after difficult or traumatic incidents in the department.

Incidents and learning from incidents were discussed at care group level governance meetings.

Incidents were investigated by the governance lead for the department. Learning was fed back from the governance team, and by newsletter to all staff in the department. Department staff were included in investigations when it was

required, however senior staff in the department told us that this wasn't a regular occurrence. Although it freed up their time to do other tasks, and support the department clinically, it also meant that senior staff were not always involved in investigation into incidents in the department they led and senior nurses missed out on learning and professional development opportunities.

Staff described a large proportion of incidents were submitted for monitoring purposes, such as violence and aggression from patients, and incidents relating to pressure damage on arrival to the department made up 50% of the incidents reported. These incidents were not always investigated on an individual basis, and we saw an example of an incident categorised as for monitoring, which should have been investigated. We also saw an example of an incident which had been investigated that included incorrect information about the equipment available in the department. We were concerned that because incidents were investigated by staff who did not routinely work in the department, they may not always be reviewed in line with current departmental information, and this may not then mitigate future risks for patients.

The most recent morbidity and mortality meeting for the department was in May 2021. We reviewed the minutes and saw that there was documented evidence of discussions and reflections relating to patient seen in the emergency department, however there was no attendance list included and we did not see any evidence of plans to follow up on the discussion. We did not see evidence that meetings were scheduled frequently to review mortality and morbidity in the department, or that action was taken following discussion to implement changes or review suggestions.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on evidence-based practice, however policies were not all in line with national guidance and best practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver care, however not all guidelines and policies were up to date or reflected best practice.

The service told us that six out of seven guidelines had been updated in line with national guidelines and that one was progressing. However, the emergency care guidance that had not been completed was published in 2016 and there was no detail provided to evidence progress in implementing the guideline, or mitigation that was in place while the guidance was being reviewed, therefore we were not assured updates were always made in a timely way.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, staff were not confident in using the guidance on rapid tranquilisation in the department and risk assessments that considered the mental capacity of patients were not in line with national guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Urgent and emergency services

The trust had not submitted data to the NICE shared learning database in the last 12 months.

The trust told us they had a policy in place to monitor and manage compliance with national guidance. They described the steps that would be taken, however we did not receive the policy to review. The described the process for updates, and how oversight was monitored at provider level, with involvement of the individual care groups.

We asked the trust to provide their most recent prescribing audit, however there had not been any completed in the reporting period for the acute and emergency medicine care group.

Nutrition and hydration

Staff did not always ensure patients had enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff did not always make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

On our first visit to the department, we did not see evidence of intentional rounding for patients in the department or their nutrition and hydration needs being met. We escalated this concern to the trust in a letter of intent which required the trust to take immediate action to protect patients from the risk of harm. We undertook a second visit to the department to check whether the trust had taken sufficient action to protect patients. In the second visit we saw this had improved; patients were offered food and drinks were available to those in the department. However, we did not see any evidence of intentional rounding in the waiting room, to ensure patients waiting for long periods of time had access to nutrition and hydration.

Staff told us they could access specialist foods for patients with individual needs and preferences, including religious and cultural preferences. When patients were waiting in the department for significant times, staff told us they could access hot meals for those patients.

We asked the trust for their most recent audit covering nutrition and hydration in the emergency department, however they did not provide one as none had been completed in the reporting period.

There were vending machines in the main waiting area where patients could buy hot and cold drinks and snacks, however we did not see any healthy snack options.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. However, staff did not always give pain relief in a timely way, and not all patients had a call bell to alert staff they were in pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients did not always receive pain relief soon after it was identified they needed it or they requested it. Staff told us that for those patients in pain there were delays in administering pain relief, depending on the time of day. Nurses used patient group directives (PGDs) to give regular and approved medications to patients, however patients did not always receive pain relief in a timely way. Pain relief complaints were higher overnight than through the day and staff told us that although these incidents were escalated with the nurse in change, delays in pain relief were not always reported through as incidents.

We saw examples during the inspection of patients waiting for pain relief; one patient waited over two hours from the time we escalated to staff they were in pain, to the pain relief being administered. We observed a number of patients who did not have their call bell in reach. This meant that they could not alert staff they were in pain.

Staff prescribed, administered and recorded pain relief accurately in patient records.

Patient outcomes

Staff monitored the effectiveness of care and treatment, however there were delays in completing audits, and the department had limited recent audit data to respond to. They used the findings to make improvements and achieved good outcomes for patients.

Due to the COVID-19 pandemic, national audits had not been published in the most recent years. We asked the trust about their most recent audit data relating to sepsis. The trust had plans in place to collect and submit data for current and future audits.

We saw results from two recent audits in the department, one which looked at recording of vital signs in adults and one which updated on a sepsis audit. Although there had been improvements across 54 metrics in both results since the previous audit, we saw areas of concern where audit results had did not meet national standards. For example, we saw in the 2020 audit result data reviewing sepsis care, 72% of patients were seen by or discussed with a senior consultant; this had declined from 76% in 2019 and was below the RCEM (Royal College of Emergency Medicine) standard of 100%. The trust did not provide any action plans to evidence what they were doing to make improve following the audits; this was a risk to patients as they were not always receiving appropriate care and treatment in a timely way, and actions were not evidence to improve services from audits.

Between January and September 2021, the service had completed one clinical effectiveness audit in the emergency department, 10 were in progress and twelve were not progressing.

The most recent audit of compliance with VTE assessments for emergency care was 100% which was above the trust target of 95%.

The service had a lower than expected risk of re-attendance than the England average. The service's unplanned re-attendance within 7 days rate was 7%, which was better than the England average of 8.5%.

We asked the trust for their most recent pain audit in the emergency department, however they did not provide one as none had been completed in the reporting period. There was an audit in progress at the time we wrote the report.

We looked at two sets of meeting minutes which showed that audit was discussed at relevant departmental meetings. The service also told us that audit and quality improvement project results were discussed in the weekly governance huddles, however service leaders did not describe a mechanism in place to ensure information discussed at the huddle was shared with wider staff groups routinely.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff were experienced, qualified and however managers did not always have oversight they had the right skills and knowledge to meet the needs of patients.

Urgent and emergency services

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, administration time for senior nurses who completed appraisals was not protected, and the demands of the department meant appraisals and one to one conversations or supervisions were not always completed. Managers we spoke with told us they tried to check in with staff informally on shifts, and during regular safety huddles nurses had conversations with the nurse in charge about any concerns or challenges they had on shift.

The trust target for appraisals was 90%. Medical staff appraisal compliance was below the trust target at 86%. Nursing and additional clinical services staff appraisals did not meet the target of 90% with an average compliance of 52% for registered nurses 53% for additional clinical service staff. This had declined from the last inspection where overall compliance for completion of appraisals was 74% and 75%. The service told us that there were plans in place to improve medical appraisal compliance following the formal suspension of appraisals due to the COVID-19 pandemic, however they did not provide any plans in place to address the appraisal rates in nursing and support staff.

The clinical educators supported, the learning and development needs of staff when operational pressures allowed. However, due to staffing challenges, they were often required to work clinically. Staff we spoke with told us that to continue to provide education, when working clinically, the nurse educators were paired with new or newly qualified staff, to provide support.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. However, when the department was busy, planned training was suspended. Staff could choose to complete training in their own time, but they were not routinely provided with time in lieu of this.

Managers made sure staff received any specialist training for their role.

The department ensured staff who triaged patients were competent to do so. There was a training day in place, followed by supernumerary supervised practice time to give staff practical support and experience. Staff competency was reviewed using a triage specific booklet, which included signing off the use of PGDs in triage. However, we saw that reception staff followed triage guidelines to signpost patients to different areas, depending on their presentation, and they had no specific training to do so; this was not in line with the service's policy.

There were 10 security staff for the whole of the hospital site. We spoke with two security guards who said they had little to no face to face training and e-learning was occasional; they remembered completing mental health conflict resolution and dementia training.

The trust told us that staff did not undertake restraint training beyond clinical holding, but that security staff were trained in security industry authority door supervisors' course which included a section on physical intervention skills. This was not appropriate to ensure the safety of patients; improper restraint techniques can result in injuries to staff and patients and in some cases asphyxiation. In the incidents we reviewed we were concerned about the methods of restraint used. References were made to patients being 'carried' 'placed on the bed' and 'detained' and one incident noted security staff moving a patient with 'an arm on each side'.

Urgent and emergency services

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Medical and surgical specialities came to the department to discuss the care and treatment patients required before admission to the hospital.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression and required urgent mental health assessment.

The city's psychiatric liaison team were based in the emergency department and available throughout the day and night, the team included a consultant psychiatrist. Staff referred to the team for assessments for patients as required. More recently the trust had employed a core mental health team working in the emergency department to support the work of the psychiatric liaison team and provide guidance and education to staff. However, staff we spoke with told us that they found difficulties in finding appropriate placements for patients with mental health needs, particularly those who had been detained under the Mental Health Act.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the department. They had developed their departmental patient information leaflets as an online resource and there were posters with QR codes around the department so that patients could look at any leaflets that might support them.

Staff assessed each patient's health when admitted and provided support for any individual needs.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. Or to support patients who lacked capacity or were experiencing mental ill health to make their own decisions.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment, however when patients did not have capacity to consent and staff made decisions in their best interests, this was often not documented. We also saw that risk assessments had a blanket approach to mental capacity, this was not in line with national guidelines, where mental capacity and best interest decisions must be made on a specific decision, and not a blanket approach. Documentation in the department

that we saw stated that patients either did, or did not have capacity, but this did not relate to a decision that was required to be made. We escalated this concern to the trust in a letter of intent which required the trust to take immediate action to protect patients from the risk of harm. We undertook a second visit to the department to check whether the trust had taken sufficient action to protect patients. In the second visit we saw no changes had been made to the assessment of mental capacity in the department.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

The service had trust wide policies in place for consent, mental capacity and deprivation of liberty. Not all policies were in date, but the trust told us those that were not were in review.

Staff did not always make sure patients consented to treatment based on all the information available. The service had completed an audit on the documentation of consent in the emergency department for patients requiring a reduction of shoulder dislocation. Overall compliance in the first cycle, completed in 2018 was 56.8%. Compliance had declined to 34.1% in June and July 2020. No actions were identified on the report, or provided, to improve compliance, and a re-audit was planned for April 2022. Poor compliance areas included recording discussion with patients about risks, alternative treatment, and written information provided to patients. This was a concern as the compliance had declined, and the service could not evidence that patients were given enough information to give informed consent for the procedure.

Staff did not clearly record consent in the patients' records.

Nursing staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, however training compliance was poor and did not meet the trust target of 90% in two modules; compliance was 32% and 38%.

Staff completed the mental health risk assessment template produced by the trust. The trust had an audit programme which examined whether staff had completed the necessary assessment template.

The mental health risk assessment template included a risk management plan for high risk patients which was not routinely implemented by staff. This included the requirement for patients deemed high risk to be placed under constant observation by staff which did not occur in most of the records we reviewed. This meant that whilst staff had assessed the risk to patients resulting from their mental health, they did not take the action required to manage these risks safely. Managers noted that the trust's audit process had focused on whether staff had completed the required assessment template but had not examined whether the delivery of care was in line with the risk management plan contained within the template.

The trust has adapted a specific room within the emergency department to provide a safer environment to care for patients at risk due to their mental health needs. The room met best practice for mental health assessment rooms. This included minimal furnishings, an accessible patient call alarm system and adaptations to significantly reduce ligature risks.

The Clinical Decision Unit also provided care for patients with a mental health need. The ward environment had not been specifically adapted to reduce risks to patients with mental health needs. Staff told us that they could remove items from spaces on the ward to reduce ligature risks. During our inspection, we found that staff had not fully implemented risk management plans by ensuring patients at high risk due to their mental health were placed on constant observations.

Urgent and emergency services

We asked the trust for the mental health pathway and policies. The service had developed action cards to escalate mental health risks, where one to one care could not be supported by the current staffing. This gave staff a process to follow to request additional staff from across the hospital and agency. However, staff told us this was not used routinely in the department.

The service had policies in place to support staff decision making relating to restraint and rapid tranquilisation. The rapid tranquilisation policy outlined which roles could prescribe medication, and actions that were required to make sure patients were safe, however it was past it's due date for review. We also saw policies which included aides to support staff when making decisions about capacity, detention and restraint in the emergency department. Staff we spoke with were not always confident in the observations required after rapid tranquilisation, to ensure patients were safe.

The service had a process in place when mental health patients were delayed in the emergency department, for assessment or admission. The process included an escalation structure with local mental health trust key roles. Limited actions were identified to escalate this within the trust, for example, to senior managers and the process did not identify which role was responsible for completing the escalation actions, therefore it was not clear and robust.

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff treated patients with compassion and kindness, however they did not always maintain their privacy and dignity.

Staff were not always discreet and responsive when caring for patients. We saw examples of patients without privacy screens or curtains drawn when they required privacy to protect their dignity, including to use facilities and be transferred. Privacy screens were not always in place in the initial assessment unit. We also saw examples of patients without call bells in place who tried to attract staff to help and support them.

We saw patients who required observation and did not receive it enter bays of other patients in the area who were visibly shocked.

Patients said staff treated them well and with kindness.

Staff did not always follow policy to keep patient care and treatment confidential. In the initial assessment area we saw patients in trolleys in the chair area. We reviewed the escalation plan for the department which did not include measures to increase the trolley space in this area. We saw inconsistent use of privacy screens when this area was used, and when they were in place, they were not effective in giving patients total privacy if that was required. We saw doors to the triage rooms open when patients were being seen which were linked to the main department and access corridor for members of the public. This meant patient privacy and dignity could not always be maintained.

Urgent and emergency services

Staff understood and respected the individual needs of each patient and showed understanding, however we saw an example of staff displaying a judgmental attitude when caring for and discussing patients with mental health needs. We heard staff say “oh brilliant another one of them” when a patient arrived in the department and were detained under the Mental Health Act.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff we spoke with told us they provided support to patients who were in the department for a long time to meet their care needs, including access to shower facilities, hot meals and preferred drinks.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing support to patients when they were able to. Staff told us about examples of providing meals that met the cultural and religious needs of patients.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. However, the availability of staff due to the pressures and the layout of the department meant that patients were not always responded to in a timely way.

Staff demonstrated empathy when having difficult conversations. We saw the relatives room and viewing room in use during the inspection and staff were respectful and compassionate to families.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Between January 2021 and August 2021, the care groups governance scorecard identified patient experience scores decline. Positive scores declined from 84.9% in January 2021 to 69.7% in September 2021. Negative scores increased from 9% in January 2021 to 20% in August 2021. This showed a decline in the experiences of people who used the service. The declining score was noted in the Emergency Department Clinical Governance Meeting minutes, but no actions were documented to address the decline.

Is the service responsive?

Requires Improvement 

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

Urgent and emergency services

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population.

Senior leaders had completed a self assessment against the patient first toolkit and had actions in place to mitigate and resolve low scores. This included improving the footprint of the estate and expanding the workforce to facilitate safe care for patients. They had identified measures to support staff and their wellbeing.

The service had plans in place to increase medical staffing to match modelled attendance data, and to improve medical cover at weekends. A business case had been submitted to the executive team, and there were plans to implement the model to improve the safety of care and treatment provided in the department in the next 12 months.

Facilities and premises were not always appropriate for the services being delivered. The department's estate did not meet the patient demand. We saw regular overcrowding in the department, which had been compounded by national guidelines relating to the COVID-19 pandemic, however there was not enough capacity in the department to meet the needs of the numbers and acuity of patients accessing the service and there were significant waits for patients to be seen by nursing and medical staff.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The local mental health service provided in-department assessment of patients who needed it, however there were often delays in finding placements when required. This was a system wide issue, and managers escalated long staying patients regularly, however they did not always move patients to a more appropriate inpatient ward of the hospital.

The service had systems to help care for patients in need of additional support or specialist intervention. There were specialist link nurses in the trust that could be called to the department to support the care and treatment of patients.

Facilities and premises were not appropriate for the services being delivered to patients with mental health needs because ligature risks were not always mitigated and managed appropriately. The department had the facilities to provide mental health assessment to patients, but not the care and support required to keep patients with mental health needs safe.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people's individual needs

The service was not always inclusive and did not always account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services, where this was possible. They coordinated care with other services and providers.

The service had recruited three mental health nurses, who were due to start in November 2021, to support the department's increasing demand for mental health care and support, including patients detained under the mental health act. The service had also created an escalation policy and had access to care plans from the local mental health trust for patients who were in their care.

Urgent and emergency services

Staff tried to ensure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The clinical decision unit was quieter than the main department and provided a calmer environment for patients who had mental health needs or learning disabilities. Staff could access hot meals for patients in this area for those patients who had been in the department for a number of hours, or days. However, we did not always see evidence of regular patient rounding for all patients across the emergency department which was due to significant pressures.

However, we were made aware of an incident whereby a patient with a learning disability was being cared for in the clinical decisions unit. The patient was highly distressed and whilst we appreciated the inappropriate nature of their placement, they were not moved to a side room to ensure they were cared for with appropriate dignity. At the time of our inspection we observed three people in the department for longer than 12 hours without a decision to admit. Some patients were being cared for in the department in excess of 24 hours.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports when they were available. The trust was part of the city wide learning disability and autism strategy and had plans to relaunch the use of health passports and they participated in the LeDer (learning from deaths of people with a learning disability) programme. Staff had developed activity boxes in the department to support patients living with dementia.

The service had a learning disabilities link nurse, and good relationships with the psychiatric liaison team.

However, the trust did not have a clear strategy and training plan for learning disabilities and autism. This meant that there was limited oversight of people accessing the trust with a learning disability with no specific pathway tracking in place and support to carers.

The service had information leaflets available in languages spoken by the patients and local community. They had developed patient information leaflets online, which could be accessed using QR codes in the department, and could be printed for patients who could not access them, or required them in a different language.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The department had access to a telephone translation service, however there were often long waits for a translator. There was a translation machine in the department which could also be used to support patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed, however patients did not always receive treatment within agreed timeframes and national targets. The department had seen an increase in attendances, and waiting times for treatment, decisions to admit and admission had increased and did not meet the national standard.

Urgent and emergency services

We saw an increase in the total number of attendances in the departments from August 2020 to August 2021 by 26%. The median time to assessment and median time to treatment had increased between March and July 2021 by at least double and did not meet the national target.

The trust reported the total number of attendances in August 2021 was 26% higher than in August 2020.

The median time to assessment increased from 8 minutes in March 2021 to 23 minutes in July 2021. The median time to treatment also increased over five months from 84 minutes in February 2021 to 147 minutes in July 2021.

The percentage of patients waiting over four hours from decision to admit to admission doubled from 14% in April 2021 to 30% in July 2021. In August there was a slight decrease to 26%. From August 2020 to July 2021, the trust reported 16 patients waited more than 12 hours from the decision to admit until being admitted.

From July 2020 to June 2021 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average and has increased in line with the national trend since February 2021.

We saw long waits for ambulance to handover patients in the department. The percentage of ambulance handovers completed within 15 minutes in June 2021 was 41.95%, which had declined from 47.36% in April 2021. The percentage of ambulance handovers that took more than 30 minutes in June 2021 was 17.65% which had declined from 7.81% in May 2021.

The trust identified that the performance reflected challenges across NHS services, including national data for June 2021 which showed the number of 999 calls answered per day was the highest since recording began in 2017. To mitigate this risk, the service had identified key actions which included close working with the local ambulance service, using ambulance service data to predict demand and encouraging self-handover where appropriate. We reviewed the trust's admission data and saw that at the time of the inspection, the trust was not under significant pressure from COVID-19; covid bed occupancy trust wide was 7.1% in October 2021.

Direct conveyance processes to the same day emergency care (SDEC) and infectious diseases areas in the trust had also been put in place, however, when we spoke to staff in the emergency department, they said direct conveyancing to SDEC was still embedding.

We saw delayed handovers on every day we visited the service and staff told us that this happened routinely. When ambulances were delayed handing over patients, it meant they could not respond to other emergencies in the local area. We saw multiple ambulances waiting for handover. When waits were longer than one hour, the consultant in charge completed rounding to check patients had not deteriorated.

The nurse and consultant in charge would meet hourly when the department was overcrowded to try and manage the flow. This included reviewing patients waiting for a bed in the hospital to determine if they were appropriate for same day emergency care, or alternative services.

When the ambulance queue was very busy, the local ambulance trust sent a 'Hospital Ambulance Liaison Officer' (HALO) to support the department.

We spoke to staff who led the department about the long waits we observed for ambulance handover, triage and waits for treatment. They described that the biggest issue was flow out of the department was poor. We saw an example of 44

patients waiting in the department for a bed in the hospital. This meant patients who had been seen and treated could not be moved from the department to other areas and caused a bottleneck in the department. Ambulances queued and patients were waited a long time to be seen by a doctor in the main waiting area, because bays were not available to assess them.

During the inspection we saw long waits for triage; patients sometimes waited up to 2 hours. An additional triage nurse was added to help reduce the wait time. The nurse in charge was responsible for monitoring the triage time. When waits were long, staff could be allocated from other areas, or specialist nurses, nurse educators or matrons could be called to support triage in the department. When triage waits were up to two hours, we saw one extra nurse added to the department to help manage the number of patients waiting.

We observed the nurse in charge move staff around the department to support different areas when there were pressures, for example moving additional staff to resus to ensure there were enough staff to meet the needs the patient.

We also saw the department had long waits to see medical staff, including up to nine hours waiting time for a doctor on one morning of the inspection. This meant that the service was under sustained pressure across most of the day and night.

Receptionists signposted patients to triage, the minors area, or the GP service which is located in a building close by to the department. However, this was not in line with trust policy which indicated patients should be streamed by a nurse.

The department did not have a standard operating procedure for the management of the waiting room at the time of the inspection, however they told us that one was in development. They told us that triage staff were responsible for observing the waiting area, to identify inappropriate behaviour and patients that appeared unwell, and we saw this documented in training slides. However when we observed triage practice during the inspection, staff did not always do a full visual check on the department, and we were told that when the department was overcrowded, patients waiting outside of immediate eyeline could not be seen. This was a risk because we saw that there were significant pressures in the department which meant patients regularly waited a long time, sometimes over two hours, to see a triage nurse, and patients were often observed to be waiting in the doorways, sat on the floor, and outside of the department when the waiting room was full.

The department had reported several incidents of mental health patients absconding. During the inspection, we heard examples of this occurring. One of the reasons that staff gave for this was significant waits for treatment.

The service had a process in place when mental health patients were delayed in the emergency department, for assessment or admission. The process included an escalation structure with local mental health trust key roles. Limited actions were identified to escalate this within the trust, for example, to senior managers and the process did not identify which role was responsible for completing the escalation actions, therefore it was not clear and robust.

Between 01 December 2020 and 31 November 2021, 25 patients with mental healthcare needs aged 16-18 were cared for in the department for more than 12 hours. A further nine patients were cared for in the department for more than 12 hours, and then admitted to the acute medical unit for more than 12 hours. In the same time period, 413 patients with mental healthcare needs aged over 18 were cared for in the department for more than 12 hours. A further 73 patients were cared for in the department for more than 12 hours, and then admitted to the acute medical unit for more than 12

hours. These patients were not identified in the trust's performance data as breaching the 12-hour standard, because they were not given a decision to admit until a placement, or alternative care and treatment was arranged. Whilst these patients hadn't had a decision to admit, there had been a conscious decision not to discharge them home, or admit them to a hospital ward.

There was a trust wide escalation plan in place with an escalation matrix and action cards which identified actions that should be taken by specific roles to reduce pressure within department when required, depending on the level of risk identified and pressures on the service. We saw trust senior leaders in the department supporting flow into the hospital during the inspection, however staff told us that this level of support was not always in place. The service also received enhanced staffing support during the inspection. Staff told us the enhanced support offered was not routinely experienced in the department

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. There were posters in the department to direct patients to the complaints process.

Staff understood the policy on complaints and knew how to handle them. Staff told us they could manage some feedback in the department before it escalated to a formal complaint.

Managers investigated complaints and identified themes. We spoke to managers and they told us about incident themes and actions they had taken to make improvements; however, the biggest challenge to the department were long waiting times which were difficult to mitigate due to the pressure in the department.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. There were regular staff bulletins which included information about complaints themes.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Inadequate 🔴 ↓↓

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

Urgent and emergency services

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the daily priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, local leaders were not well supported by the wider organisation.

Leaders in the department understood the daily priorities and issues that the service faced and managed those immediate risks in a dynamic way. They knew about and acted on plans to appropriately escalate the department when it was in surge.

Senior staff were available to support staff and safety rounds had been introduced to provide regular visibility of staff in charge of the department and ensure teams could escalate concerns in a timely way.

Leaders and senior leaders within the service were passionate about the department and we saw that although they had significant challenges at the time of the inspection, they acted to support the department and staff.

The department was in a challenged position due to capacity and flow and local senior leaders acted upon the daily challenges to address immediate patient safety concerns in an appropriate manner. We saw examples of senior leaders escalating patients who had been in the department for a long time and contacting other services where required to escalate their care requirements.

Despite the best efforts of the local leaders within the department to improve safety, this was not always supported by the wider organisation or senior and executive leaders.

Senior leaders and executive leaders were not routinely visible in the department.

Vision and Strategy

The service did not have an up to date vision for what it wanted to achieve or a strategy to turn it into action. The vision and strategy were focused on sustainability of services and did not reflect the current challenges the service faced.

The service did not have a vision and strategy which ensured responsibility for delivery was shared and co-owned by the department and the wider trust.

The service provided a three-year strategy for the acute and emergency care group which was dated from 2017-2020. The strategy was now out of date therefore it did not reflect the challenges the service faced, and had been facing in recent years, or actions the service planned to take to make improvements to the service.

The service provided a business plan on a page for 2021/2022 which documented the priority areas for the department and the results of those areas, with dates for delivery. However, the trust did not comment on the delivery of the business plan, or if it was achieved. During the factual accuracy process, the service provided information relating to their business plan for 2022/2023, but we did not see evidence of a strategy for the current financial year.

There was a trust wide mental health strategy for 2020-2022 in place, which included a vision for the future. Actions were split into directorate and organisational actions, however there were no specific actions identified for the department or care group. Patients presenting to the emergency department with a mental health presentation was increasing, and this was identified in the background information, however the strategy did not reflect this nor did it address the identified risk of 16-18-year olds who presented at the department.

Culture

Staff felt respected and valued by their direct line managers and peers within the department. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear, however staff did not always have time to do so. Department staff were not always supported by the wider trust and not all staff felt they were provided opportunities for career development.

Staff we spoke with told us that there was a good culture in the department. They worked well as a team and supported each other in their daily work, managing pressures across the department and flexing to the needs of their patients where they could.

Staff in the department gave mixed feedback about opportunities for career development, and some staff we spoke with told us that requests for additional training had not been provided in a fair way.

Staff told us they felt supported to raise concerns if they needed to, however we saw examples where staff were under pressure and felt the service was not safe, and they did not have time to escalate these concerns.

However, local leaders and staff did not always feel that they were supported outside of the department and care group, and we saw examples of staff working hard to escalate the department, as per the policy, and not receiving the appropriate support, despite delivering all actions required as part of the process in place.

This had resulted in an acceptance that support would not always be provided and meant staff did not always report and escalate concerns at the earliest opportunity. Staff told us that the trust level support we saw in the department during our second inspection was not regularly provided.

We saw in the department there was an accepted level of staffing below the establishment that would not be escalated routinely. When one to one care or support was required for high risk patients, if there were no staff in the department to provide this, staff did not always escalate this because staffing was an issue across the trust. Leaders and staff told us when staffing rotas changed because of short notice staff moves or shift changes, updates were not always made to the staffing tools in place. This meant that senior leaders did not always have assurance that appropriate staffing was in the department to meet the needs of patients.

Staff we spoke with told us that there was not enough senior support in the department on a shift by shift basis in the clinical decisions unit which was a challenging area to work in because of the acuity of patients and the distance from the main department. Managers told us they tried to allocate senior staff members to this area of the department, however they did not always have the skills and competencies or job role required to escalate concerns and issues in this area of the department.

Urgent and emergency services

Governance

Local leaders operated governance processes, but they were not always effective in supporting leaders to identify and manage concerns and issues in the service. However, staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

Senior local leaders and senior staff had clear roles and responsibilities for managing risk and incidents outlined in the care group governance framework.

Senior local leaders we spoke with told us that they dynamically assessed risks on a daily basis in the department, which we saw during the inspection, however the governance processes that wrapped around the department did not always support leaders to make strategic decisions and changes.

The emergency department had a risk register which included control measures that were in place. The department monitored and managed risks through departmental governance processes and had overarching risk assessments in place. When we spoke to senior local leaders, they told us about the top risks on the register and strategy they were taking to address the concerns. However, the strategy was overarching, addressing the departmental model and did not actively address all of the key risks we identified during the inspection, therefore we were not assured the governance processes in place supported local leaders to identify and manage risks and issues in the department.

There were regular meetings in place to review risks and they were monitored by appropriate staff roles.

The service used a governance scorecard. We saw the worst performing area was discussed in meetings, however the actions documented lacked pace when we saw the performance in some indicators had been below target for multiple consecutive months, for example in infection control. We did not see evidence of previous actions that had been taken had been discussed.

The service had a risk management approach to incidents. When an incident related to an overarching risk, the incident was often closed, and the service described actions were taken using the overarching risk assessment action plans. This meant that individual incidents did not always receive an individual response or action plan.

We were told about examples of incident investigations in the department; however, we were not assured that incidents were appropriately investigated by persons who had current knowledge and understanding of the department, facilities available to staff, and national reporting requirements. We saw examples of incidents that were inappropriately graded as low or no harm, when it was evident from the description that harm had occurred, or patient care had been affected. We also saw incorrect information in outcomes of incident investigations.

We reviewed information the trust provided relating to falls incidents in the emergency department. We looked at 78 incident records and found that four were inappropriately categorised as no or insignificant harm, when staff had noted bruising, swelling and skin tears. Although a small number, it was a concern that some incidents were incorrectly categorised; this is because the level of harm to a patient indicates the level of investigation that may be required.

Recommendations made in incident investigation reports did not always adhere to SMART (Specific, Measurable, Achievable, Realistic and anchored within a Time Frame) principals and action plans lacked detail, rigour and measurability. The action plans we saw were a summary of headlines and were not in line with all the SMART principals, as per national guidelines.

We reviewed minutes and the action log from the department's governance meeting in September 2021. The action log did not include target dates for actions to be completed, and where actions had documented outcomes, it was not always clear if the action was closed, or further action was required. Actions were not always measurable. It was not clear how the action log could be used to track timeliness of outcomes, or measure effectiveness.

We reviewed two incident investigation reports relating to serious incidents that had occurred in the last 12 months in the department. We saw action plans linked to the recommendations made in the report, however, we did not see evidence that additional actions were considered to address contributing factors that may have been in the trust's control.

We saw policies throughout the inspection that were past their review date, and at least two policies that were due for review in 2016 and 2018, therefore they were significantly past due.

The service had a process in place when mental health patients were delayed in the emergency department, for assessment or admission. The process included an escalation structure with local mental health trust key roles. Limited actions were identified to escalate this within the trust, for example, to senior managers and the process did not identify which role was responsible for completing the escalation actions, therefore it was not clear and robust.

Departmental audits were not always carried out, or were not always effective, which meant that senior leaders had limited mechanisms to support them in identifying issues and themes in the department through a formal process.

We saw evidence that audit programmes were discussed at care group meetings, however, discussions, actions and monitoring were not at an appropriate pace, particularly for items that had been identified in several consecutive months as being below the trust or national target. Several audits had not been completed in a number of months and we were not assured that the service had the capacity to identify and respond to areas that required action.

Staff had developed their own governance systems in the absence of wider trust support, however the standardisation of the approach resulted in standardised outcomes and missed opportunities to learn and make improvements.

Management of risk, issues and performance

Systems to identify, monitor and manage risks and issues were not always effective and did not support local leaders to take appropriate and timely actions. However, local leaders and teams used systems to manage performance. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service did not have an accessible and coherent risk register. Instead, senior leaders and their team had developed overarching risk assessments. We were not assured that there were appropriate mechanisms to support the senior leaders to identify and act upon risks and issues in the department in a timely way, and when issues were identified, we did not always see timely actions.

Senior local leaders and their teams had developed overarching risk assessments in the department to address the service's main risks. We looked at three risk assessments which covered the department's top three risks. The top three risk controls were last updated in July 2021. The documents had been developed to provide overarching information on the controls in place and actions being taken to mitigate risk and reduce the risk level, however, the documents were long, narrative based, repetitive and did not include measurable actions, or evidence of risk reduction.

The risk assessments had control measures which, according to the document, should state what was in place to mitigate the risk identified, however there were not always specific information of the control measure in place at the time of last review to reduce the risk score. It was unclear from the document where control measures had reduced the risk score, because the only score documented was the risk score at the time, and there was no evidence that the controls had been effective in reducing the risks documented in the assessment.

There were action plans linked to the risk assessment, however they did not have the information required to monitor pace of delivery, not all actions had target dates for completion, and there was no evidence that once an action was completed, that it was effective. This was a risk because it was unclear when progress was made, or if that progress was effective in mitigating the service risks. We did not see evidence that all the actions listed as controls had been implemented in the department.

The risk assessments were developed with an MDT approach, however, not all staff groups were involved. For example, when the service developed the overarching risk assessment for arrival to department and triage area, receptionists were not included. We were told this was because the focus was on clinical risks, however, from our inspection we saw there was an over-reliance on reception staff to escalate concerns in the waiting area, therefore their input may have strengthened the risk assessment and actions that were developed to address the risk at departmental level.

There was a system in place to review risks in the department. Extreme risks were reviewed every six months and then shared with teams to complete actions identified. This was monitored and escalation points were agreed. Staff we spoke with told us this was managed by the governance team who were responsible for implementing systematic changes in the team. There was a central team in the trust who monitored progress.

The department had back-up generators in place in case of a failure to essential services occurred. There was a regular testing programme in place.

The department held a weekly meeting with medical, nursing and management representation where an electronic operational performance dashboard was reviewed which highlighted trends in performance. Staff used this information to inform ideas and interventions to make improvements to patient care.

Performance was monitored by the senior local leaders in the department. There had been significant pressures in the system and the department was not meeting performance standards at the time of the inspection. Leaders we spoke with described the medium and long term plans in place to improve performance in the department, including environmental changes, winter management plans and staffing establishment reviews.

In the immediate term, the department staff and local leaders moved resources and staff to try and support flow in the department, however there were challenges in admitting patients into the hospital and physical capacity of the department which were not always in the gift of the staff to act upon. We saw trust senior leaders in the department supporting flow into the hospital during the inspection, however staff told us that this level of support was not always in place and when they followed the escalation plan in place, support was not always available. This meant that senior staff in the department had to balance managing a department in escalation and managing staff and patient issues as they arose; this was a challenge.

Information Management

The service collected data and analysed it within the department. Staff could find the data they needed, in easily accessible formats, to understand performance and make daily decisions. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff used e-whiteboards and electronic ambulance systems to monitor real time performance. The e-whiteboard gave senior staff in the department real time information about waiting times, numbers of patients in the department, waiting for admission, waiting for triage and waiting to see a doctor. It also automatically calculated the escalation score in the department, based on the indicators set, which made it easy for senior staff to identify which escalation action card they needed to follow.

Reception staff scanned patient letters and documentation directly into the patient record system. This included patients admitted by ambulance where clinical test results, DNACPR records and handover sheets were scanned into the system so that staff had access to important information to make clinical decisions. However, staff we spoke with told us that scanned documented were added to the same section of the record and it was difficult to identify each document.

There was an electronic operational performance dashboard which highlighted trends in performance. Staff used this information to inform ideas and interventions to make improvements to patient care.

The service had a proposal for improvements to shared records and referrals to improve the management of patients requiring the support or assessment of the local mental health trust. However, there were no details provided to determine the status of the proposal, or specific details relating to implementation timelines and approvals.

The service used information gathered through electronic recording and performance monitoring to determine specific audits and workstreams to make improvements in the department. The service told us about overarching quality improvements that were ongoing, for example, a nurse staffing review, a review of streaming in the department and the development of electronic assessments for specific patient conditions.

Patient information leaflets were available online to patients and there were posters in the department with a QR code which gave access directly to common leaflets and also to the whole database to patients, so they could look at the leaflets outside of the department without needing paper.

Engagement

Local leaders and staff used feedback from patients, staff, the public and local organisations to plan and manage services. They worked with some partner organisations make improvements. However, the service did not have formal methods of engaging either staff or patients.

The service had formal and informal methods of gaining feedback from patients. They promoted feedback including feedback cards, online queries and telephone contact. This information was collated and reviewed quarterly to ensure appropriate action was taken.

The service participated in the national patient surveys and developed a number of actions as a result of feedback given by patients who participated. Leaders told us feedback was used to make improvements in the service.

Senior leaders told us they were involved in system and place meetings which focused on the local area plans and development of services as a whole system approach. This was an opportunity to share and learn from other local services.

The service had collaborated with a local service who provided support to patients affected by violence in the department four days a week, including the weekend.

We did not see intervention from the wider trust to support meaningful engagement with patients or staff members. The service relied on feedback from patients to identify issues, and we did not see any mechanisms in place to proactively engage with patients or staff to make service wide improvements that was not linked to complaint or incident responses.

Learning, continuous improvement and innovation

Staff had an understanding of quality improvement, however there was limited proactive or innovative approaches to problem solving. Staff participated in research.

Staff in the department tried to implement new ways of working to improve the service offered to patients. We asked staff for examples of innovations and ideas that had been implemented. They told us about the initiatives that were in place.

Navigators identified patients in the department who had been affected by violence, engaged with them and offered emotional support during their time in the department. They could signpost to specialist services in the local area and also worked with patients in the community where appropriate. There were Navigators in the department on Thursdays and Fridays from 3pm to midnight and on Saturdays and Sundays from 10am to midnight.

The department had eight ongoing research projects, one on hold and one that had been completed in the reporting period. There were seven planned research projects awaiting approvals and implementation. This showed us that staff were actively engaged in quality improvement and research to improve outcomes for patients.

The service had developed and implemented QR codes that patients could use to access patient information leaflets on their phones. We saw posters in the department which gave direct links to 12 information leaflets, including wound and plaster care, and common illness or injuries. There was also a QR code to access all patient information leaflets for the emergency department in the trust.

Nurses and health care support workers were split into groups to identify triage and phlebotomy trained competencies. This meant that when the rota was completed, it was easy to identify different competencies to allocate the best skill mix for the department.

There was a translation machine in the department which could be used to support patients when they were unable to access translation services by telephone due to long waits.

The trust had developed aide memoirs for staff relating to the Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards. These one-page summaries were provided to staff as part of mandatory training to be used as quick reference tools.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

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

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Staff we spoke with confirmed they were up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, as a result of COVID, face to face training had been suspended. For example, this meant staff missed out on scenarios to address patients displaying aggression.

Managers monitored mandatory training and alerted staff when they needed to update their training. Specialities had practice educators that supported staff in maintaining their training compliance.

We saw from data supplied by the trust that most of the staff in the medicine specialities we visited had exceeded the 90% compliance target for mandatory training or were on track to do so. We asked the trust to provide mandatory training data split by location however this was not received.

Safeguarding

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

The trust had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was regarded as being everyone's responsibility.

The trust had a lead for safeguarding who was the chief nurse and they (or their delegate) represented the trust at the local safeguarding boards for adults and children.

Trust wide level monitoring took place through the safeguarding team who reported at least annually to the board of directors.

We saw the trust had up to date safeguarding policies for adults and children.

Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

Staff had access to safeguarding advice and support from link nurses on the ward, from the trust's intranet, and the trust's central safeguarding team.

Any patient considered at risk of female genital mutilation or child sexual exploitation was referred to the safeguarding team and other appropriate agencies for follow-up working with local system partners and established reporting mechanisms.

For medical staff and nursing staff respectively, training compliance data for trust wide was as follows. We asked the trust to safeguarding training data split by location, however this was not received: safeguarding children and young people - level 1 (86%) (94%); safeguarding children and young people - level 2 (92%) (92%); safeguarding children and young people - level 3 (82%) (91%); safeguarding vulnerable adults - level 1 (no data) (100%); and safeguarding vulnerable adults - level 2 (79%) (89%).

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

The trust told us that patient led assessment of the environment audits (PLACE) were suspended because of COVID and had not yet been re-started. However, the infection prevention and control (IPC) ward accreditation scheme was still operational. We saw a sample of audit history reports for the wards we visited which showed scores of 100% compliance for areas such as hand hygiene, commodes, and cannula care. The audits were done monthly.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE), including hand washing and bare below the elbow. Staff also had access to isolation rooms on the wards to further control the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Mostly staff managed clinical waste well.

We found the ward environments used keypad door locks to secure access to the ward, and wards were clutter free, wheelchair accessible, and with enough equipment for staff to carry out their role. We saw clear signage.

Most wards we visited did not display any quality of care boards, which display public information to help the public see that patients are safe. For example, about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance and IPC performance. Leaders told us new boards were being rolled out across the wards.

The service had examples of suitable facilities to meet the needs of patients' families. For instance, rooms set aside to break challenging news.

The service had enough suitable equipment to help them to safely care for patients. For example, staff could order in specialist mattresses when required to address pressure ulcer care.

Resuscitation trollies were being checked in accordance with trust policies.

The trust told us for medical equipment, assurance was derived by use of a maintenance database at the site. This allocated a maintenance schedule plus use of stickers showing when the equipment was due its maintenance check. Performance was tracked using key performance indicators. All equipment we saw was in date for maintenance checks.

On the ward staff disposed of clinical waste safely. However, we found two main storage areas in the corridor outside the wards, used for storing biological waste, were regularly un-locked. For instance, in one area, whilst we reported this to staff, and staff immediately locked the storage area, when we passed the area again, it was un-locked. We also noted another storage area for biological waste where staff were using a lock that had been taped over to prevent the door from locking. Staff told us the lock was broken and it had been reported to be fixed. Staff had not taken action to mitigate risks until the lock was fixed.

Assessing and responding to patient risk

Whilst staff completed and updated risk assessments for each patient they did not always take action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Whilst we found that staff completed risk assessments, whether for venous thrombo-embolism (VTE), falls risks or pressure ulcer risks or mental health risks, the output from the risk assessment was not always documented.

In relation to falls, for example, we saw that staff were supported to assess falls risks using an electronic assessment. However, we could not find documented plans of care, such as how often a patient should be observed or what equipment the patient required. When we queried this with staff, we were told patients at risk of falls were all placed in one area. This area was in a high observation location. It was overseen by a single member of staff. However, when we observed such an area, we noted the single staff member was often behind the curtain attending to other falls risk patients. This meant they could not see the other patients at risk of falls.

Turning to pressure ulcers. Whilst staff completed electronic risk assessments, we found examples where either a mattress required following the assessment had not been actioned, or the review of the pressure ulcer had not been documented. After the inspection, the trust sent us a draft pressure ulcer policy. This stated a check should be done at least weekly. On the patient record we saw this had not been done.

Staff had access to an electronic early warning score (NEWS) to assess the health and wellbeing of patients. Staff were using this. This tool supported staff to identify if the clinical condition of a patient was changing for the worse. This helped staff to keep the patient safe by planning early intervention or escalation.

The trust tracked whether scores were done on time within the first 12 hours post admission and then at 36 hours. Data supplied by the trust showed 100% compliance.

On all wards we visited staff had access to electronic whiteboards situated at or near the nurses' station. This provided staff with headline clinical information about a patient to help them keep the patient safe.

We observed a handover which followed a situation, background, action and result structure for each patient. This was an additional tool staff used to try and assess and respond to risk. However, we did not observe staff conducting intentional rounding even though some records suggested this had occurred. Nor did we see any safety huddles.

Staff had access to guidance on managing sepsis and access to a critical care outreach team.

We did not consider the trust arrangements to support staff with violence and aggression from patients was safe.

If a patient was assessed as being at risk of suicide or self-harm, or was displaying aggression to staff, acute staff sought guidance from the crisis team.

Staff reported, with minor exceptions, that the support from the crisis team to ward based staff was mainly phone based. Staff reported this was because the team prioritised the emergency department.

We found one example where the crisis team had attended the ward, but the records of the patient were not clear around whether the patient, following the crisis review, was at a higher risk.

Ward staff told us they had escalated delays about accessing a mental health assessment with system partners. Without a timely mental health assessment, staff tried to manage challenging behaviour from patients using de-escalation, security staff, police, and medicines, such as rapid tranquilisation (rapid tranquilisation medicine is used, as a last resort, as a way of controlling violent or aggressive behaviour in patients).

Staff that provided security services reported that they had no objective criteria to help them assess and respond to requests from staff for assistance. Security staff, we were told, responded based on what seemed to staff to be the most pressing situation. Ward staff informed us that security staff provided one to one observation of challenging patients and had had the training to so. However, security staff had not had the training required to manage restraint safely in a healthcare setting. The training provided to security staff did not meet the standards of the Restraint Reduction Network.

For medical outliers, staff could track medical outliers using the trust's electronic patient record system. Staff told us outliers were seen daily by a doctor for the speciality concerned.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, whilst managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction, we were not assured this was safe.

The leadership team for medicine at the site were clear that nursing staffing was under significant challenge. This was echoed by staff we spoke with. We found planned and actual staffing levels were not displayed on the entrance to all medical wards we visited. We asked the trust to provide staffing rotas for the medical wards we visited, however, did not receive them.

Staff described, even if their ward was fully staffed, often staff would be moved to another ward to make up short staffing numbers on that other ward. For example, staff told us the same day emergency care unit would have to close early because of lack of substantive staff for that unit. Patients were moved upstairs to the acute medical unit.

To support staff in planning staffing levels based on patient needs, three bed meetings took place daily. To try and ensure staffing remained safe, both during the day and night, staff used professional judgment, together with an electronic rostering system. A matron of the day was available for any escalation and followed a clear policy of escalation.

However, we were not assured the system to support staff in making decisions about staffing was being used in a safe way. For example, staff were unable to produce to us, within a reasonable timeframe, actual versus planned staffing for a ward, after considering last minute ward moves. Although data was subsequently received by CQC showing systems to plan staffing as safely as possible were in place, this did not consider contextual information such as competency and skills of staff, and staff on wards could not provide CQC with access to this system when this was requested onsite.

We were not assured the way in which staff were being moved was safe. For example, staff we spoke with gave us examples of being moved to other wards, or cross-site, in circumstances where it did not appear to be safe to do so. Staff told us escalation did not always work. Staff reported being moved with inadequate training and support.

Information supplied by the trust showed that existing bi-annual workforce reviews usually carried out in January and June each year had been paused as a result of the COVID-19 pandemic. A programme of quarterly rapid workforce reviews was implemented in its place, however this did not include any temporary wards.

The medicine leadership team were trying to address staffing shortages by recruiting to international nurses, nursing associate roles, and by regular bed management and staff review meetings. The actual vacancy position as at September 2021 showed 13.47 % vacant registered nurse/midwife posts. However, care support staff, were over-recruited - 9.72 %.

Staff reported good support with induction. However, other staff reported that this impacted on skills mix because new staff required lots of support so taking more experienced staff away from their duties.

Most student nurses we spoke with reported a positive experience although some reported that they were, sometimes, used to support care support workers.

Staff reported that agency staff were not interested in filling gaps in the rota because there was a lack of incentive for doing the shifts that were difficult to fill, such as night shifts, more so if this was on a challenging ward.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We found a traditional model of medical care. Consultants carried out board rounds every day, which included a discussion of each patient with junior doctors. Patients' own specialty doctor would review them twice a week. At weekends, there was an on-call rota, and access to consultants present onsite, though not present on every ward.

Data sent to us by the trust showed no or very minor vacancies in the doctor staffing. This accorded with discussions we had with medical staff.

All the services we visited had a daily consultant attended board round and multi-disciplinary team meetings (MDTs).

Medical care (including older people's care)

All specialities we visited had medicine consultant cover at least two days a week with on call 24hour for weekends and out of hours.

To support the medicine wards there were a range of junior doctors who reported good supervision, good learning, and good support from nursing staff. The trust also made use of physician associate roles.

Records

Staff kept detailed records of patients' care and treatment but this was not always accurate and contemporaneous. Whilst records were clear, mostly up-to-date, and stored securely, staff did not report the electronic part of the records were easily available to all staff providing care.

We reviewed nine sets of records being a mixture of electronic and paper records. We found evidence that records were not easily accessible for staff and not being completed contemporaneously or accurately.

The trust used mainly paper records to record patient care, but some risk assessments were in electronic form. Staff told us that everyone was trained on the use of electronic risk assessments. Staff were aware which risk assessments were electronic and which were paper. Staff told us the electronic part of the records was very slow to use. Staff told us this had been escalated but they had not seen any improvement.

Staff also had to record their evidence of care in multiple platforms. This made it a challenge to ascertain, within a reasonable timeframe, what care had been provided. For example, to establish what staff had recorded around use of rapid tranquilisation, we had to consult whiteboard data, data on the electronic record, and paper notes.

All the above meant that we did not consider it could be said with confidence that staff had easy access to records. As nursing staff mainly had to use the electronic part of the record, this impacted on them more than medical staff, who mainly used the paper records. However, even the medical staff had to use the electronic record for prescribing.

We also found examples where records were not being completed contemporaneously or accurately. For example, we found intentional rounding documentation where the rounding had not taken place at the specified time, but someone had completed the record to suggest that it had. In a record of a patient identified as living with dementia using the butterfly symbol, we could not find any evidence that the patient's electronic record had been sufficiently individualised and correct assessments completed to ensure their needs were fully assessed and being met. The trust had identified the limitations of the current electronic patient record as a risk requiring further development. On another, intentional rounding documentation about pressure ulcer care was internally inconsistent, with a rash recorded one day, and then nothing the next. This suggested this aspect of rounding was not being done safely.

When we asked senior leaders about records audits, we were told they were done when part of an investigation. A trust record keeping audit was also underway at the time of the inspection covering inpatient, outpatient and community services. While this had commenced in September 2021, the trust had not provided any evidence of outcomes by the time of publication of this report.

Medicines

Except for medicines used for rapid tranquilisation, the service used systems and processes to safely prescribe, administer, record and store medicines.

Rapid tranquilisation medicine is used, as a last resort, as a way of controlling violent or aggressive behaviour in patients.

We reviewed the use of rapid tranquilisation medicines and found this was not subject to any overarching medicine audit. On records we reviewed, where rapid tranquilisation medication was used, we found staff were not recording use in accord with trust policy. The policy itself was overdue for its review. For example, with one exception, staff were not recording steps taken to avoid using rapid tranquilisation medicine. After administration, staff were not recording patient observations hourly.

The overall absence of any medicine audit in this area, combined with staff not following the policy, meant that we could not be assured that this area of medicine was being used safely. Whilst staff told us rapid tranquilisation medicine was used as a last resort, we could not assess this.

Apart from the above, we checked the storage of medicines, fluids and gases on the wards we visited. We found that medicines, fluids and gases were stored securely in appropriately locked rooms or fridges. Checks were in place and stocks seen were in date.

Wards we visited did benefit from a visit by a pharmacist technician each day and during core hours take home medications were being clinically checked and dispensed and patient medication reconciled.

We found that staff benefited from 24-hour pharmacy availability. However, we were not confident that pharmacy had oversight of the issues affecting medicines.

In addition to rapid tranquilisation, (see above) staff told us that pharmacy permitted wards to audit their own use of storage of medicines. For instance, staff on the acute medical unit conducted storage of medicine audits not pharmacy staff. This meant there was a lack of independent oversight which could result in issues not being highlighted or acted upon.

Further, on the acute medical unit, the clinic room temperature was not monitored daily. We saw the temperature was showing as 30 degrees Celsius. Most out of fridge medicine needed to be stored at temperatures well below this. Whilst staff told us this had been reported nothing further had happened. Yet pharmacy staff visited the ward regularly.

However, we did see evidence that pharmacy carried out quarterly ward-based checks of controlled drugs. For the reports we saw there were no major issues noted, although a few of the audits were noted to be late owing to staffing pressures.

On all the wards we visited, we found controlled drugs were locked away in a metal cupboard in a locked room. We carried out a random check of controlled drugs and found all records of controlled drugs that staff kept were complete with no gaps. Stock seen was in date.

Fridges used to store drugs requiring refrigeration were locked and logs for checking whether the fridge temperature had gone out of range were complete. However, a fridge used on the acute medical unit was showing as above 11 degrees Celsius, but this had not been reported to pharmacy.

Incidents

Mostly staff recognised and reported incidents and near misses. Managers investigated incidents but evidence of shared lessons learned with the whole team and the wider service was absent. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Medical care (including older people's care)

We were not assured that all incidents were being managed well. For instance, a review of incidents showed staff regularly reported violence or aggression by patients against staff as low or no harm. This meant such incidents were not being subjected to a full review such as would be done if harm was categorised as moderate or above. For instance, in the period 1 October 2020 to 20 September 2021, the trust reported 515 incidents of disruptive, aggressive behaviour. Of these, 513 were reported as low or no harm.

Further not all staff knew what incidents to report and how to report them. For example, staff felt that because a patient had a deprivation of liberty safeguard in place, it was not necessary to report incidences of violence and aggression by that patient.

However, the trust had an incident reporting policy that was in date.

Whilst we did find evidence that some areas were trying to analyse and learn lessons from violence and aggression from patients, this was not evident across all of medicine.

We were not assured that lessons learned were being shared safely with frontline staff.

When asked how lessons were shared leaders often referred to the safety huddle. However, on wards we visited, we did not see any safety huddle. Neither did staff on the ward mention taking part in such a huddle. The handover and board round we observed were about whether patients were medically fit for discharge or was focussed on handing a patient over. Neither of these focussed on safety issues or learning.

Further, there appeared to be a dis-connect between trust policies in this area, and what we saw happening on the wards we visited.

For example, policy dictated that there should be a food huddle on a ward before handing out food to patients. However, on one ward we visited, where we saw food being handed out to patients, staff we spoke with never mentioned the food huddle. We did not observe this happening.

After the inspection the trust sent us example of electronic ‘safety of the month’ messages that were being sent out by the medicine leadership. No staff we spoke with on the wards mentioned these.

Further, the messages often invited staff to print out posters or order them, to display them. However, we did not see any such posters displayed. When we queried with staff the absence of posters, some staff told us displaying posters could upset patients with dementia. If this were accurate, it did appear to clash with the messaging above.

The trust sent us a draft snapshot audit done in September 2021 which looked, in part, at use of falls signage in wards. The report, although in draft, showed not all wards were using the signs. This accorded with what we found around falls management.

Following inspection, the trust sent us examples of investigations that had been done into serious incidents and mortality and morbidity meetings. All of these appeared to be detailed and identified lessons to learn and compliance with the duty of candour, where relevant. However, on some of the action plans, the dates for the action to be completed were blank.

Systems were in place trust wide to act on any national safety alerts.

Medical care (including older people's care)

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers mostly checked to make sure staff followed guidance.

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies and procedures relevant to their role.

However, some audits had been suspended. For example, PLACE audits had not re-started since their suspension because of the COVID 19 pandemic and the trust wide resuscitation trolley audit was not due to re-start until November 2021. A records audit had commenced in September 2021, however, the trust were not able to provide any evidence of outcomes by the time of publication.

The trust had a procedure for implementing best practice guidance, including all types of NICE guidance using a NICE database. For each piece of new guidance, the hospital's clinical effectiveness unit completed an assessment of the trust's compliance, and actions were put in place to achieve compliance with any recommendations not met.

The trust shared data with us that showed they were able to track current compliance with new guidance on a rolling basis. This was supported by an audit information management system.

The trust provided us with various audits which showed that care and treatment was evidence based and improvements made. For example, an audit of falls and compliance with NICE guidance around preventing falls. Also, an audit on compliance with meals standards. Both audits recommended further auditing to embed best practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

We found that the services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

On admission each patient had a nutritional assessment and staff described how dietitian services could be accessed for complex cases. Where necessary, food charts were used to monitor intake of food. For example, we spoke with staff handing out food and saw how they used a chart to note which patient needed a special diet. The trust policy indicated there was meant to be a 'food huddle' before food was handed out but we did not see this take place and staff did not refer to this.

Data supplied by the trust showed that ward-based nutrition audits had been suspended during 2021 and replaced by a trust wide audit. An audit for 2021 showed that whilst there had been some positive progress there was still embedding to do around the food huddles.

The medicine service at the site offered patients a full range of meals to meet any needs arising from religion, culture, allergies or personal choice. Staff told us they could go out of menu where necessary and provided snacks outside of mealtimes. Pictures could be used to assist patients in choosing food. Visitors could access snack machines.

Staff described how they tried to encourage patients to be independent when eating but would help where needed, with patients requiring help being noted on handover sheets. We did not see any red tray initiatives to help staff spot which patients needed help. Leaders told us this would be information on a board above a patient's bed. With some minor exceptions, where the board was on the door, but not filled in, we did not see these boards in place.

Water jugs were in reach and staff told us they were replenished regularly.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients.

Following inspection, the trust shared with us examples of audits undertaken to improve pain management in a range of different patient groups. This ranged from epidurals, to acute pain management.

Pain relief was discussed at handover and any issues noted in addition to analgesics being reviewed on ward rounds.

Staff had access to the trust's acute pain team who could supply expert advice on pain and its management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service had systems and processes in place to monitor patient outcomes including, various trust wide initiatives around reducing high-grade pressure ulcers or falls with harm, and audits, all with a view to providing effective patient outcomes.

On a trust wide level, the trust told us about the initiatives in relation to reducing high grade pressure ulcers or falls with harm to help improve patient outcomes. For example, when on the wards staff told us about the react to red campaign to focus on reducing the number of high-grade pressure ulcers. Staff showed us the electronic risk assessment they could complete to support them in obtaining better outcomes for pressure ulcer care. A similar approach was also adopted with falls with harm. The trust told us it had recently completed a thematic review of falls with harm since April 2021 and was about to re-start the falls group that would feedback thematic learning.

However, despite these trust wide initiatives, at ward level, we found evidence suggesting that management of falls risks and pressure ulcer risks were not effective. We revisited the service four weeks after this inspection and found the management if falls risks and pressure ulcers had not improved despite this being raised following our inspection.

When speaking to leaders, we were told the trust was still taking part in relevant national audits. For example, the chronic obstructive pulmonary disease audit (October 2018 to April 2019). This showed performance was better than the national aggregate for all six measures. Another example was the dementia audit. In 2019, performance was like other hospitals for all four measures. Staff explained some of the steps they had taken to improve patient outcomes following that audit. For example, supply of activity boxes to the relevant wards for patients with dementia. However, with minor exceptions, we were unable to locate such boxes when on the wards we visited.

At a local level, staff told us about several initiatives to improve patient outcomes.

For instance, on the acute medical unit, work had been done to create a checklist for caring for patients that may display violence or aggression.

On the cardiology wards the staff had audited door to balloon times to see how to improve the timeliness of that procedure. Staff described how they had used the results of the audit to create a dedicated staff member, when staffing allowed, to prioritise this area of work.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through specific competency training relevant to the staff member's role.

The trust shared global appraisal data with us following the inspection and this showed most of the medicine care groups were at or around 80% for compliance with staff appraisals. Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal.

Staff explained that they received additional training relevant to their role. For example, on the coronary care unit staff received additional training on how to use balloon pumps. Some wards had access to practice educators. In the respiratory wards staff had been trained on non-invasive ventilation.

Whilst the international nurses were experienced nurses in their home country, they did require support to successfully transition to working at the trust. Staff told us how they ensured these nurses had an assigned educator to support the staff. As a result, two of the international nurses had been promoted.

For students, staff told us there was a clear training pathway and students we spoke with who had trained on the wards reported a generally positive experience.

All wards visited had link nurses for various areas including infection control, safeguarding, learning disability and dementia to support staff in maintaining competence in these areas.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision with regular meetings.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

When we visited the wards and observed a handover, we saw a variety of staff working together, such as nurses and support workers, to benefit patients.

We could see from the handover sheets and records we examined that there was detailed communication between staff of different grades and roles.

We observed an MDT board round. This was attended by a physiotherapist, a ward clerk, consultants and junior doctors. All patients were discussed, and actions agreed to benefit the patients. For example, we saw how the physiotherapist input supported a timely discharge of the patient.

Seven-day services

Key services were not available seven days a week to support timely patient care.

The trust advised us that, until further notice, owing to the pandemic, system partners had suspended data collection of compliance with seven-day standards.

At weekends, there was an on-call rota, and access to consultants present onsite, though not present in every ward.

In all the wards we visited we found there was no access to therapy staff including SALT and dieticians on a weekend.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, staff were not documenting any mental capacity assessment before imposing a deprivation of liberty

Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards.

We saw that the trust had an up to date policy dealing with consent and mental capacity. At the last inspection, the trust was told that it must record best interest and capacity assessments in patient records. However, whilst we found staff were completing deprivation of liberty safeguards forms, we did not see evidence that this had been preceded by a recorded assessment of capacity. Improvement in this area was a ‘must’ from the previous inspection.

The trust shared data with us about the audit it had done on mental capacity and deprivation of liberty which revealed continued staff non-compliance in this area. It was noted that resources to re-audit this area were challenged.

For patients with mental health act rights, staff could access support from the commissioned psychiatric liaison team or out of hours from the on-call psychiatrist commissioned from a local mental health trust.

Medical care (including older people's care)

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. For example, we saw staff enhance a patient's dignity, whilst assisting the patient back to their bed, by pulling up a patient's clothing.

Patients said staff treated them well and with kindness. We spoke with one patient who described how staff were excellent.

Friends and family feedback from patients, for the period June to August 2021, according to the banding used by the trust, showed a mixed picture. While the majority of wards reported a positive score, response rates were low when compared to discharges, leading to substantial differences in positive and negative percentage scores between wards and areas.

Staff followed policy to keep patient care and treatment confidential. For example, laptops used to access the electronic patient record were only accessible with an employee card. With one exception, laptops were seen to be locked or always attended. We saw that patient paper records were kept in high visibility areas such as near the nurses' station, although unlocked.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For instance, we reviewed notes of a patient who required rapid tranquilisation. We saw from the notes in the records that staff had recorded how they had tried to use distraction methods to calm the patient down which were not successful.

Emotional support

With minor exceptions, we saw staff were too busy to provide emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Overall, we found a staff workforce that was too busy trying to keep patients safe to provide emotional support to patients, families and carers to minimise their distress. However, in the cardiology service, for instance, we did come across an example where emotional support from staff had taken place.

The wards we visited did allow relatives to visit loved ones by arrangement, but with minor exceptions, we did not see any relatives or carers on the wards when we visited them.

Staff had access to chaplaincy services for those patients with a faith or none.

Staff undertook training on breaking bad news, and, on some wards, there were suitably decorated rooms set aside for this purpose.

Whilst staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them, we did not consider staff always had the time, owing to staffing pressures, to display this.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. For example, a patient we spoke with confirmed they knew what they were in for, had their questions answered, and knew what they were waiting for before they could go home.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. For instance, we observed how staff compassionately carried out a reconciliation of medicines for a patient.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust operated a friends and family survey as well as a carers survey.

Is the service responsive?

Requires Improvement 

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

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

The leadership team we spoke with described several ways in which the service had been designed to meet the needs of local people following discussions with local commissioners.

For example, the cardiology speciality was undergoing a planned refurbishment to enable the service to take more cardiology patients from the regions it served and provide a better patient experience in a purpose-built modern environment.

In the frailty unit, there were plans to increase the ambulatory capacity to support commissioner led initiatives such as home first. This was an initiative to avoid unnecessarily admitting elderly patients.

We saw that each speciality had its own dashboard which looked at various patient markers such as, referral to treatment, cancelled operations and do not attend. For instance, the dashboard for integrated and geriatric stroke medicine, for the months April to June 2021, showed: 18 week referral to treatment target of 95% was achieved 100%; cancelled operations for a non-clinical reason were zero; with do not attend rates targets only being met in one month (for follow-up and new). The dashboards were discussed at governance meetings to monitor and improve the patient journey.

In the respiratory speciality, we saw evidence of how the team had re-designed the pathway for patients with cystic fibrosis, to support use of technology, thus avoiding unnecessary face to face clinics.

We found no mixed sex accommodation breaches.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Whilst we saw that staff cared for patients as individuals and strived to meet their individual needs, this was not supported on the wards we visited by any ward initiatives or bespoke equipment that clearly impacted on people's daily wellbeing.

On admission to the ward each patient received an individual assessment to support staff in identifying their individual needs.

On the wards we visited we found one activity box for patients with dementia. Apart from this, some wards had areas for patients to watch television and some of these rooms had books and games in them. However, none were in use when we were on the ward. Staff told us there were no activity staff to keep patients with dementia occupied and no planned activities.

We saw staff did not have any planned activities for patients or enough time to do put a planned activity in place if a patient requested it. Staff confirmed that there were no planned activities and no activity nurse.

The wards we visited did not have activities to stimulate the minds of patients who were living with dementia, such as dementia boxes. Staff told us patients had access to bedside television and other media services on a subscription basis. Owing to the cost of this service staff told us many patients did not use it. With minor exceptions, we did not see any patients using this service.

Where wards had dedicated space for socialising, such as a television room, with games and chairs and seats, we found the rooms were empty and not in use. When we spoke with the leadership team about these issues, we were told there were plans to re-introduce activities into the appropriate wards. Staff told us such plans had been put on hold due to COVID-19

Staff told us that they could access language interpretation services and leaflets could be produced in different languages. The trust's website had a dedicated page around translation services and obtaining information in different formats.

The trust told us it had a dedicated lead nurse for dementia and the trust told us they were overseeing a roll out of activity boxes for such patients. Also, there was ongoing recruitment of dementia ward champions. The trust did use a symbol to help staff identify patients living with dementia. However, on one record, where we found this was in place, a capacity assessment was absent.

For patients who had special needs, staff could use a 'this is me' passport to support staff in meeting their individual needs.

Access and flow

People could access the service when they needed it and received the right care promptly. Whilst staff used various methods to try and ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards, these were not always responsive.

The services had systems and processes in place to monitor access and flow and to ensure that they were responsive to the needs of patients, but they were not always responsive.

At the start of the patient pathway in medicine, we saw that the trust had what it called a same day emergency care area (SDEC). SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided. Patients are referred to SDEC through a number of different routes including streaming or triage from the emergency department and direct referral from GP services. We saw SDEC was staffed by the acute medical unit (AMU) which meant the staffing was diluted across both units. We saw evidence which showed SDEC had been used to accommodate inpatients from other specialties (outliers) for example surgical patients. This meant SDEC could not operate effectively for the purpose it was intended until the outlying patients were transferred back to their speciality or discharged.

The trust told us the SDEC model was subject to improvement work and we saw minutes to support this. The whole flow in acute services was being reviewed as a 'Big room' exercise involving discussions with many specialities. But it did appear from speaking with staff that, because of the pandemic, progress was slow.

For the period March 2020 to February 2021, at the Northern General location, patients in Cardiology had a higher than expected risk of readmission for elective admissions. Patients in Geriatric medicine and Respiratory medicine had a higher than expected risk of readmission for non-elective admissions.

From April 2020 to March 2021 the average length of stay for medical elective patients at Northern General Hospital was 13.8 days, which is higher than England average of 6.5 days. For medical non-elective patients, the average length of stay was 6.9 days, which is higher than England average of 5.7 days. Average length of stay for elective specialties, such as, Cardiology were like the England averages. Average length of stay for non-elective specialties, such as, older people's medicine and respiratory medicine, were like the England averages.

Referral to treatment (percentage within 18 weeks) was better than the England average for general medicine (100% against 88%); older people's medicine (100% against 94%). In cardiology the position ranged from 76.2% to 82.7% over the previous 12 months with a low of 67.4% in June 2020

The percentage of patients with suspected cancer seen by a specialist within two weeks of an urgent referral from a GP was 81% against a target of 93%. Treatment within 62 days was 65% against a target of 85%.

We saw on the wards during a board round that we observed how staff identified patients that were medically fit to be discharged. This information was immediately captured on the electronic whiteboard in each ward area. The data would then be used in bed meetings which were held three times a day to help staff plan patient movement through the site. Staff we spoke with reported that this system worked well.

The trust did have a discharge team that supported frontline staff with complex discharges. We learnt that this team had done a lot of work with system partners to try and improve the flow out of the acute site into the community. However, we did find some patients who had been on the base wards in excess of 21 days after they were fit for discharge.

Staff told us the system was not able to place such patients because of the pressures it was under. In one case, staff told us about a young patient who was on the AMU for 20 days because there was no appropriate bed in the community to cater for that patient's mental health needs.

The hospital had a discharge lounge which we visited. Staff reported that whenever management decided to move its staff to other ward areas, the lounge was simply closed. Further, the lounge did not benefit from a dedicated ambulance. This meant elderly and frail patients could sometimes be waiting for transport for five hours. Lastly, staff reported that when take home medicines were not on time this could also cause delays.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The services had a system in place to encourage complaints and compliments with a view to improving services for patients.

We saw the trust had a complaints policy that was in date.

In the last 12 months the medicine service had 189 complaints. The highest number of complaints were in gastroenterology (42); respiratory medicine (33); cardiothoracic services (29) and integrated geriatric and stroke medicine (23). Most complaints had been responded to within 31-40 days. The top area for complaints was communication and information.

Staff told us they would seek to resolve a concern informally first, but complaints were dealt with formally if necessary. Whilst there were governance arrangements in place to ensure that lessons from complaints were shared amongst staff, we did not observe any safety huddles. Staff we spoke with reported there were no complaints or themes in relation to their ward areas.

For most of the wards, we did not see notices displayed within the services, showing how to complain or signposting patients or their carers or relatives to the trust's patient advisory and liaison service, (PALS), for support in making a complaint.

We saw that complaints and compliments and sharing learning from them was a standard agenda item on speciality meeting minutes.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

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

Leadership

Frontline staff reported local leaders were not always visible in the service for patients and staff. Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

Leaders we spoke with felt that they were visible. However, staff on the wards provided us with mixed reports about leadership visibility. In some specialities, staff reported visibility was good whilst in others they reported leaders were not visible. However, there was no evidence to suggest that leaders were not approachable.

We spoke with staff in leadership roles and they all described having been trained in leadership or having access to the trust's leadership programme.

We saw from minutes of governance meetings we reviewed and from speaking with leaders that leaders understood the priorities and most of the issues the medicine service faced. For example, all governance minutes were aligned to the trust board's integrated performance report. This meant all leaders were looking at the same headline issues as the trust board.

All staff on wards reported their ward managers were supportive and visible.

Vision and Strategy

Whilst leaders and staff understood and knew how to apply the vision and strategy, monitoring progress was not always robust. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Progress of the strategy and vision was monitored through the various governance meetings at operational level through committees (such as, the patient experience committee, clinical effectiveness committee, or the safety risk management board) and from there up to the board.

However, at speciality level we noted that 'milestones' on business plans, to track performance against the plan, were either blank or not specific, timed, realistic or measurable. For example, one milestone read: "ongoing throughout 20/21".

We saw that the trust executive group (TEG) conducted an annual review of each directorate. The trust shared the review for the medicine directorate dated August 2020. However, this did not apparently pick up the issue around the business plan milestones.

The trust's vision was to be recognised as the best provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

The values to support the vision were: patient first; respectful; ownership; unity; and deliver, (PROUD).

The strategy to turn the vision into a reality consisted of five strategic aims, covered in the integrated performance report.

We saw that the trust had various strategies to support it on delivering the strategic aims, including a quality strategy, a people strategy, and at department levels, operational strategies and business plans.

It was clear from papers we read that all the above had been created following extensive and widespread consultation with all relevant stakeholders.

Governance minutes we saw looked at spending money wisely to ensure services remained sustainable. Financial sustainability was also overseen by a making it better board. Finances were one of the strategic aims and considered by the board as part of the integrated performance report.

Culture

Except for issues around violence and aggression, use of technology and staffing pressures, staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

It was clear from speaking with and observing, staff on the wards, that they were focussed on the needs of their patients receiving care. However, a significant source of irritation to staff were the staffing pressures, ward moves to make up numbers on other wards, use of technology, and violence and aggression towards staff. Whilst local leaders told us they were working to address these concerns, we did not find that all frontline staff were feeling respected, supported, and valued around these issues.

Staff in leadership positions spoke highly and with pride about their teams working on the wards. Leaders described, owing to restrictions on movement around ward areas because of COVID, that it had been challenging to support staff in the normal ways. For example, there was no scope to engage in any social activities. However, leaders were proud of the fact that they had continued to appraise their staff.

The trust made use of annual thank you awards. The chief executive officer sent round briefings and weekly email bulletins.

The trust also had a partnership forum for management and trade unions to meet.

Staff could access information and resources on the trust's intranet, including accessing the NHS wellbeing offer the trust participated in.

The trust also offered employee development programmes and several staff told us about the nursing associate role they had studied for.

The results of the most recent staff survey was being analysed by the trust at the time our inspection. However, we saw the trust had done action plans flowing out of the previous staff survey and most actions from that, for the services we looked at, were shown as completed.

Staff also could seek support from the freedom to speak up guardians. The guardians were supported by ward-based champions.

Governance

Local leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medicine services had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed. However, as noted above, some of the documentation supplied to us, demonstrated a lack of specific, realistic, measurable, and timed outcomes. This had not been identified by the care group and executive leadership.

In terms of local governance, the leadership team consisted of a nurse director, an operations director, and a clinical director. This ensured that all staff groups were represented at this senior level. This team met monthly and, more often, informally. We spoke with the leadership team and they described many meetings and forums they took part in to operate effective governance processes. It appeared the local and ward leadership worked well together within the tools, systems and procedures set down by leaders above them.

We saw minutes for a variety of speciality clinical governance meetings. At a local level we reviewed minutes of meetings for July to September 2021 of a selection of the specialities we visited. We saw that the meeting topics were aligned to the integrated performance report so that local leaders and the board were looking at the same issues. We noted issues considered such as, mandatory training, IPC, appraisals, complaints, incidents, and performance.

Performance was considered with the benefit of a dashboard that looked at items such as referral to treatment, length of stay, and do not attend rates. This was a snapshot of a more detailed performance dashboard that was considered in other forums. For example, improvement meetings. Spending money wisely was also considered.

All leaders we spoke with described having a written job description and were clear about the role they played in the governance of their area.

Whilst we only reviewed a sample of business and governance meeting minutes it was clear from speaking with leaders that they took part in many other meetings to learn about performance in their service. For example, the ‘Big room’ work to look at re-designing how the acute take could operate differently.

We also spoke with leads for dementia, falls, pressure ulcers, and discharge. It was clear from these meetings that staff were working internally and externally to try and improve performance in these key areas.

Management of risk, issues and performance

Leaders did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Leaders and teams mostly used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We saw that the trust operated a framework approach to support leaders in managing risk, issues and performance, which fed up from directorate meetings, through committees, and then onto the board.

We identified risks that did not appear to be on the risk registers we were sent. For instance, the use of rapid tranquilisation medicine, was not on any risk register. The trust supplied a risk register relating to this core service. While there were some risks relating to records, none directly related to accuracy or contemporaneousness of record keeping.

Leaders we spoke with explained that these matters were being looked at with a view to placing them on the risk register at the appropriate time.

We also found the risk register was not being used in an effective way, with potentially duplicated and overlapping risks, with different scores, albeit broadly involving the same issues and affecting all specialities. This had not been identified by the care group and executive leadership.

For example, there was a risk for slips trips and falls with a risk rating of six. However, there was a risk for the inpatient falls audit of 2017 that had a risk rating of 12. Each had different review dates. Yet both involved falls.

Different specialities had broadly the same issues in terms of risks of falls, but had differing controls in place, with different review dates. For example, respiratory medicine had a risk for slips trips and falls. However, the review date was September 2022. Whereas integrated geriatric and stroke medicine had a review date of April 2022, for the same risk, with different controls in place. Neither risk mentioned the falls work which was noted in a separate risk about falls relating to the falls audit.

We were not satisfied that risks were being scored, reviewed and escalated in a timely, dynamic and consistent way. For instance, for integrated geriatric and stroke medicine there was a risk on the register concerning violence and aggression in the workplace affecting staff, patients, relatives and family. This risk had been on the register since 2014 and had been reviewed annually. The next review date was planned for May 2022 with a current rating of six. When we questioned leaders about this, because we had many reports from staff about violence and aggression, we were told there had been a recent spike in incidents of violence and aggression, and this was being reviewed. However, the risk register had not yet been amended to reflect this." A similar risk for AMU was rated at nine with a review date that was in the past.

The trust shared with us a data quality improvement plan which presented, in September 2021, the latest findings about management of risk in the trust. The report did not pick up these issues. The plan was started because, in 2020, an external audit had criticised the way in which risks were managed.

At a trust wide level, in accord with trust policy, lower graded risks were managed locally, and medium grade risks featured on the trust risk register. Higher graded risks received a focussed review by a validation group. Higher risks made their way onto an integrated risk and assessment report which was reviewed at board level.

Likewise, at trust wide level, performance and issues were considered by established committees, which reported into the board, who looked monthly at an integrated performance report.

When we spoke with leaders the top three risks were staffing, falls and flow. Staff outlined the mitigations in place. For example, regarding staffing, the recruitment of international nurses, and creation of nurse associate roles. In relation to falls, staff confirmed there was a thematic review since April 2021 and the re-launch of a falls oversight group. In relation to flow, with what was an increasingly elderly and frail adult patient population, staff referred to initiatives at ward level to try and improve flow. For example, the 'Big room' discussions around access and flow.

Medical care (including older people's care)

Information Management

Whilst the service collected reliable data and analysed it, staff could not always necessarily find the data they needed, in easily accessible formats, to understand performance, and make decisions and improvements. The information systems were not integrated although secure. Data or notifications were consistently submitted to external organisations as required.

Whilst staff reported that data, once obtained, was reliable and useable, all staff, including leaders, reported significant dissatisfaction with the electronic patient record, not just in terms of its usability, but also in terms of poor signal coverage, and slow operation.

The trust operated a number of electronic and paper systems, with varying degrees of integration. To gain a full picture of patient care, staff may need to look in several different places, some of which were easier to access than others.

All the above meant that we did not consider the trust was making it easy for staff to access the information they needed.

We saw these issues had been escalated. Whilst leaders told us there was a programme to replace the electronic systems, staff working in wards did not appear to be aware of steps taken to address their concerns.

The trust had systems and processes in place to ensure notifications were made as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw that the trust had agreed with system partners a set of principles to engage about its work with the public, staff and patients. This included running friends and family surveys. Leaders we spoke with described how they made a point of reading comments made by patients on friends and family feedback. The trust's quality board, that oversaw the delivery of the strategy for quality, included in its membership representatives from patients and the public.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We spoke with staff about learning, continuous improvement and innovation. It was clear that, despite the pressures produced by the pandemic, that the trust was still engaging in research.

For example, in stroke, funding was secured for two research nurses full time to help them develop their clinical academic careers. The hope was to utilise this resource in geriatric medicine.

The trust's website also detailed the research work the trust was engaged in.

Surgery

Requires Improvement ↓

Is the service safe?

Inadequate ↓↓

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training, although mandatory training was not always comprehensive to meet the needs of patients and staff.

Staff usually received training face to face or via eLearning and topics included health and safety, moving and handling, and infection prevention control. Due to Covid–19, face to face training had been suspended and staff were not clear as to when this method of training would re-commence. Managers monitored mandatory training and staff compliance was monitored through an electronic platform. Staff told us they were sent a reminder by email when training was due for renewal. Some staff told us that they did not always have time to complete all of the training, however ward managers told us they made every effort for staff to complete, where possible and the figures we reviewed onsite corroborated this.

We reviewed mandatory training compliance on Chesterman 3 and saw it was 91% and Chesterman 4 which was 94%. This met the trusts internal target of 90%. However, the overall mandatory training compliance across the health group was 89% for nursing staff and 79% for medical staff and therefore we were not assured that all staff received their mandatory training.

Medical staff compliance was described by managers as ‘not as high as we would like’ and told us they ‘reviewed the position against targets and aimed to fill gaps’.

There was no requirement for clinical staff to complete mandatory training in learning disabilities, autism or dementia and training for dementia link staff had ceased since the onset of COVID-19. We saw patients with dementia were cared for on every ward we visited, and staff told us that training to support these patients was only available if specifically requested.

There were plans to make more training ‘live’ with simulations and scenarios and medical staff told us they received support from nurse educators.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. We reviewed the surgical divisions overall training compliance rate for Safeguarding adults Level 2 and saw 94%. Safeguarding Children and Young People Level 2 training compliance was 92%. This met the trusts internal training target. However, we asked staff about their understanding of PREVENT and none of the newly recruited staff we spoke with, knew what this was.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us that most patients arrived to the ward with safeguard alerts already in place. For example, concerns raised by ambulance crew when patients were admitted.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw contact numbers displayed on and around the ward and staff were able to describe who the hospital safeguard team were.

Ward staff knew where safeguarding policies were for support. They used online forms to refer any safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern. Staff could add any safeguarding issues to patient care plans on the trust's patient records system. Staff told us the safeguarding team were helpful and gave in-depth and engaging training.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment to protect patients, themselves and others from infection. However, control measures were not always in place.

The service acted appropriately to reduce the risk of COVID-19 transmission and managed flow and admissions to wards according to whether patients had isolated or not prior to surgery. Patients testing positive for COVID–19 were managed on 'red' wards and isolated accordingly.

Streaming of the wards was clarified through colour coding and we saw the function of each ward flexed regularly depending on the demand of patients and their COVID-19 status. Visitors to the wards were reminded to comply with social distancing requirements and to wear a face covering at all times. Patients testing positive for COVID–19 were managed on 'red' wards and isolated accordingly.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We saw portable equipment was visibly clean, but they did not have 'I am clean' stickers in place in accordance with trust policy.

Staff on Firth 3 told us the ward had failed IPC accreditation and had only passed the day before our inspection. Staff said this had been due to staff not following IPC processes.

The provider told us they carried out monthly infection prevention and control (IPC) assurance visits across all wards. We reviewed the data submitted by the service; however, this did not cover all surgical wards, and therefore did not provide clear overall compliance data for the service. The provider did not clarify why the data submitted was incomplete.

We saw audits were completed inconsistently. Not all audits included or showed overall compliance scores to show the outcome of the audit. For example, we saw IPC compliance on Firth 3 in April 2021 scored 100%, however the same audit tool was used on Firth 7 and Huntsman 5 in January 2021 and no score was shown. Therefore, we were not assured that robust IPC monitoring was in place.

Surgery

There was no PLACE audit data as this was suspended nationally in response to the COVID-19 pandemic and has yet to be recommenced.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we observed followed the Standard Infection Prevention and Control Precautions policy, they were bare below the elbow and always wore surgical masks during the inspection. Hand sanitiser was available at the entrance of all wards we visited, and we saw these were regularly replenished.

We requested hand hygiene audits for the surgical health group, but this was not provided for all wards. We reviewed a sample of audits which showed 100% compliance.

In the period between July 2020 and June 2021 the trust reported no surgical site infections for The Northern General Hospital.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste safely

The service did not always have suitable facilities to meet the needs of patients' families. We found room environments were not always used for their intended purpose. For example, we saw on the surgical assessment unit, patients were waiting in the corridor to be assessed. The nurse in charge told us a business case had been submitted to improve the environment as it was recognised that this was not ideal for patients.

Staff did not carry out daily safety checks of specialist equipment. We saw on Firth 4 the resus crash trolley had not been checked every day and the entry for the day of inspection (10/11/2021) had been signed for the next day in error (11/12/2021). This was escalated to the sister who noted the error as human error and amended the form to reflect the correct date. Sisters were reminding staff regularly that the checks needed completing and stated that equipment checks were missed as pressures on the ward increased.

The service did not have sufficient suitable equipment to help them to safely care for patients. Several wards we visited had cluttered or unlabelled rooms full of equipment. On Firth 4 we saw a specialist tilt bath was in situ, however this was suitable only for patients with a specific mobility need.

A physiotherapist told us their ward had specialist seating shortages incorporating sitting balances, which are used to aid a patient's recovery. They had raised this with their senior sister.

Ward staff told us they could access rarer equipment from the equipment library located in the corridor of one ward.

Staff told us clinical engineers were responsive in repairing any broken equipment.

We found no medical gas signs on the storeroom doors of all wards we visited. These rooms stored Entonox and oxygen inappropriately on the floor behind the door. Storeroom doors were all unlocked which meant medical gases were accessible to anyone on the ward. This is not in line with (HTM 02-01) NHS estates guidance for medical gas pipeline systems.

Staff did not dispose of clinical waste safely. Sluice room doors were also unlocked on wards with confused patients. We saw on Huntsman 7; the cleaning cupboard door had no lock facility and chemicals were left out on the shelves in easy reach. This meant anyone could enter and access harmful COSHH chemicals stored inside.

At the last inspection we saw that stock rotation was not in place with newer items at the front of storage cupboards. We also found that some clinical stock items were out of date. At this inspection we sampled 15 clinical stock items and saw that they were all in date and we also saw evidence of stock rotation.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimised risks. Staff did not always identify or act quickly upon patients at risk of deterioration. The trust did not have a systematic approach to assessing risk relating to patient's mental health.

Staff used a nationally recognised tool to identify deteriorating patients however they did not always escalate them appropriately. The service used the national early warning score (NEWS). However, staff told us that the trust's patient records electronic system (main screen) did not show patient's NEWS scores or flag deteriorating patients, but their patient flow e-whiteboard did. This meant staff were not prompted to complete observations to assess patients who may be at risk of deterioration. We asked senior ward staff when risk assessments would therefore be completed and told us senior sisters on each ward had oversight of patient care plans and risk assessments, and they should know when these were required.

On Firth 4 we saw one patient who had a NEWS score of 3, had not been observed for over six hours. However, we also reviewed five other patients records across the speciality at the hospital and found that all had a completed NEWS score recorded within the electronic database system.

We requested the most recent NEWS audit information from the provider and reviewed information dated October 2021. However, this was not provided in a clear format in which to interpret accurate figures.

We saw the provider had developed guidance for the management of sepsis however this was due to be reviewed in on the 6th of November 2021. We did not receive updated guidance following our inspection.

Staff did not always complete or review risk assessments for each patient in a timely way using a recognised tool. Staff told us the aim was to complete a risk assessment for each patient on admission. These included pressure ulcer risk assessments venous thromboembolism and tissue viability risk assessments where appropriate. However, staff also told us that they did not have capacity to fulfil this aim due to a lack of staff and ward managers had implemented a plan to ensure all assessments were completed for all patients on a specified day of the week. For example, weight Wednesdays. Nursing staff told us that if day staff didn't have enough time to do this then this task would be passed to night staff to complete.

We reviewed the records of three patients on the surgical assessment ward, all of whom had a diagnosis of dementia. We requested risk assessments in relation to patient's mental health and risk management plans to support patients with challenging behaviour. Staff told us that there were no risk assessments for dementia and there were no systems to review, record or support patients with a mental health concern, including behavioural issues.

We asked a member of staff to demonstrate how these individualised bespoke care plans could be created within the system and observed that the database crashed on several occasions.

Within the same three patients we reviewed Patient Handling Risk Assessments. All three patients had these assessments completed at the point of admission but were not reassessed again. These risk assessments were not scored to show which patients were deemed to be high risk, leaving vulnerable patients at high risk of harm.

Staff told us that one patient was at high risk of absconding. We observed that this patient appeared unsteady on their feet. We requested the falls risk assessment for this patient, but we were told that it had not been completed as the patient had not yet fallen.

Staff told us that the risk of absconding had been raised by family members who had notified staff upon the patient's admission.

We requested the risk assessment for this but again this was not complete. No documentation had been completed for this risk or any documentation within the nursing records to highlight these concerns. Inspectors brought this to the attention of ward sister who advised they would complete the necessary assessments as a priority.

Inspectors returned to visit this patient who had subsequently moved wards and were told that the patient had absconded the previous evening. We requested the risk assessments for this patient and found that no assessments had been completed.

We also found falls risk assessments were not always reviewed within set timeframes for patients deemed to be at very high or high risk of falls. For example, one falls risk assessment had not been updated or reviewed on the trust's patient records system since 2 June 2020. On Huntsman 7 we found two patients falls risk assessments which were more than 6 days overdue. One of these patients had also scored 31 on their latest Waterlow risk assessment, the same day as our records review, indicating high levels of care and intervention were required.

Staff did not complete and reassess weight monitoring charts for patients within required timeframes. For example, we saw on Firth 4 ward 12 charts were overdue for re-assessment and two charts were overdue on the F2 ward. Two records showed staff had not reviewed the charts for over six days or as the patient's condition indicated and three patients had also been waiting over five days.

Therefore, we were not assured that patients were appropriately risk assessed to protect them from potential or actual harm.

Shift changes and handovers did not always include all necessary key information to keep patients safe. We saw that key information was taken from the trusts e-whiteboard system and shared with staff as part of the daily handover. This would include specific patient concerns, for example falls. However, as there were no risk assessments completed for the above patients and there was no documentation for the risks, we are not assured that these concerns would have been captured as part of the handover

Staff told us that 'Nightingale' or safety huddles were completed on some of the wards we visited but we saw this was not consistent. These huddles were supplementary to handovers and provided staff with key safety concerns for patients residing on the wards.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Surgery

The service did not have enough nursing and support staff to keep patients safe. On all wards we visited actual nurse staffing was consistently below planned establishment. For example, during our inspection on Thursday 7 October 2021 the Huntsman 6 ward actual staffing registered nurse (RN) and clinical support worker (CSW) numbers were all one below those planned for the morning and afternoon shifts.

On Firth 4 we saw across the month of September 2021 there had been a total of only five days across the entire month that the ward met their full staffing establishment. In August we saw there were no days in which the ward met their full staffing establishment.

Not all wards displayed planned and actual staffing numbers which were visible to everyone visiting the ward. Staff told us this was because staff were moved around constantly to meet the needs of the busiest wards and departments. All staff we spoke with were concerned about nurse staffing numbers and told us substantive and regular staff were always being moved to other wards from their own, which caused further destabilisation to the ward. Night practitioners were available to support patients, although staff expressed concerns about the capacity of night practitioners to see all patients.

Managers reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the service's process to escalate staffing shortages was unclear. Matrons told us they would inform the deputy nursing director (DND) then the nursing director (ND). Staff we asked did not always feel they could raise staffing issues; however, we saw the provider had demonstrated they acknowledged staffing difficulties through changes in regard to 'you said we did' examples and staffing discussions.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites. They discussed expected admissions and discharges, wards with closed bays and newly cleaned bays that had previously held patients undergoing screening or isolation following COVID-19 infection. Several bays and specific beds were identified as clean or requiring deep cleaning and patients were moved between bays. The ward manager could request additional staffing levels daily according to the needs of patients. However, staff were not always provided.

A ward manager told us they worried about staffing at times. They told us of examples when they had had to reduce staffing resources to divert staff to other areas. We were told at times nurse staffing was difficult. An example was staff told us on Firth 9 that there were a lot of patients who were at high risk of post-surgical bleeding. However, managers had provided additional support and a bleep holder to mitigate this higher risk. We asked staff if they would they be able to close beds if the risk was too high and they said to say that they were not able to reduce the ward bed base from its usual establishment but were able to refuse to open additional capacity beds. On Firth 3, 4 and 9 the trust told us establishment on the wards was not reduced when the patient numbers were reduced from 28 to 26 in the last 18 months.

Senior managers told us all off-duty records were signed off by the senior sister and matron before they were given to nurses. Matrons on both sites told us they liaised with the nursing director regarding staffing issues. However, we observed bed meetings where senior nurses across the care groups provided an overview of need when wards were understaffed. Senior nurses recorded evidence of discussion, but staffing risks assessments and acuity were not formally recorded. We regularly saw and heard about staff being moved from one ward or area to another. Ward sisters told us they knew if any shift was fully staffed on their ward, they would lose a nurse or HCA to cover another area where the need was greater.

Surgery

Bed meeting discussions included expected admissions and discharges, wards with closed bays and newly cleaned bays that had previously held patients undergoing screening or isolation following COVID-19 infection. Several bays and specific beds were identified as clean or requiring deep cleaning and patients were moved between bays.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Senior staff told us unfilled shifts were offered to bank staff and if these remained unfilled after two days they would go out to agency. Some staff we spoke with said they felt this was too long to wait and said they regularly found shifts could not be filled. Staff told us they knew agency staff often took shifts at other local trusts rather than Sheffield Teaching Hospitals because they knew conditions were better elsewhere and other trusts offered an uplift in pay.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. In March 2021, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England averages.

We saw the percentage of consultants at this trust were 61% when compared to 50% as the England average.

We saw the percentage of junior doctors at this trust were 13% when compare d to 11% as the England average.

In the same reporting period, we saw the following grades reported to be working at the trust were lower than the England averages.

We saw the percentage of middle career doctors at this trust were 5% when compared to 11% as the England average.

We saw the percentage of Registrar doctors at this trust were 21% when compare d to 28% as the England average

The medical staff matched the planned number.

We spoke with five doctors across the hospital who told us they felt well supported by their senior team members and were able to access advice and peer support as they required it. Doctors were supported by the 'hospital at night' system with three advanced nurse practitioners and two support workers who could help with tasks such as cannulation and taking bloods.

Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw on the wards we visited sufficient numbers of medical staff to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear but not always kept up to date. Paper records were not always stored securely but were easily available to all staff providing care.

Surgery

The service used an electronic database in which to record nursing care plans and risk assessments for patients. Nursing records were also held to supplement the electronic records. These included fluid balance charts, intentional rounding records and general nursing intervention records. Medical notes were paper based and were stored securely in document trolleys around the wards.

We saw allied health professionals documented comprehensive care and treatment plans within the paper nursing records that we reviewed.

The trust did not utilise dynamic electronic systems which interlinked together. This meant that staff could not access records for all patients using the trusts current electronic system. For example, we saw some patients had been transferred to the neurosurgery ward from critical care, and that ward used an entirely different record system so care records from that care episode were printed out and placed in the patient's file. These were not secured in the records we checked.

Patient notes were not always comprehensive or up to date. We reviewed five patient records, all of whom had a diagnosis of dementia. In four of the five records a cognitive assessment had not been completed by medical staff. This section of the clerking document had been left uncompleted. In the fifth record we saw the ward clerk had added a reminder sticker to the patients records to show that the assessment had not been completed. We returned to the ward to review the records and saw the assessment was in place.

Records were found to be mostly legible, however they were not always dated and signed. We saw clerking assessment documents were unsigned in three of the five records we reviewed.

We saw the trust used a 'whiteboard' electronic overview screen (e-whiteboard) on all wards we visited. This provided ward staff with a digital overview of all patients on that ward at that time and any key indicators such as patients who were waiting for assessments or were ready for discharge were indicted. Staff were also able to see the flow of admissions into the hospital through accident and emergency. Most staff we spoke with told us the e-whiteboard system provided an accurate overview, however electronic systems that supported this, were a barrier to care planning. We saw the system operated slowly and often crashed when staff tried to access specific screens. Staff told us that these problems had been escalated to senior ward managers several times, but nothing appeared to be done to improve this.

We saw two of notes which included a do not attempt cardiopulmonary resuscitation (DNACPR) record. The DNACPR was located at the front of the notes ensuring easy access to this information.

The service told us that a trust wide audit had not been completed since November 2018, however a record keeping audit had been recently commenced and was in progress at time of inspection.

Records were not stored securely. On all wards we inspected, records were not stored securely. On several wards, notes were stored in suitable trolleys, but none were locked. On some wards, records were stored on open shelves and on ward F2 we found nursing record sheets were kept attached to large clipboards which were hung from handrails outside patient rooms and bays. These records clearly showed patient identifiable information and observations including details of their personal care.

On ward F2 we also found end of life care information and do not attempt cardiopulmonary resuscitation (DNACPR) forms on display.

Surgery

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

The hospital used an electronic system to prescribe medicines for patients. Staff did not always follow current national practice to check patients had the correct medicines. We saw the alcohol withdrawal regime within the Trust's policy had not been followed and the assessment for the risk of alcohol withdrawal had not been fully completed. We also found that when a person was given an injection to relieve anxiety, staff had failed to monitor their physical health observations in accordance with national guidance.

Some medicines to be used in an emergency were not stored in a tamper proof container. Medicines in the medicines room were not locked away and access to the room was not restricted, allowing any member of staff with a badge to enter.

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. Wards we visited only had current temperatures recorded on medicines fridge checklists, with no minimum or maximum. The times of daily checks varied. Some dates were also missing between 24 August to 2 September, and 7 to 15 September. These were usually but not always weekend days. The same signature was signed most days of the last few months, and this was not double checked.

On ward F2 we found out of date vaccines stored in the medicine's fridge. The ward sister told us they would be removed but took no immediate action.

We saw the controlled drugs record book signatures for prescribing Botox were not witnessed since 10 August, and 8 September for prescribing controlled cancer treatment drugs.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw a pharmacist was available all 24 hours a day with one pharmacist working through the night. Staff on Chesterman 3 told us that pharmacy would often come onto the ward to assist in preparing discharge medication.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, we talked to several members of staff, but their responses were varied in how safety alerts and incidents were discussed. Staff said that alerts would be relayed via email, however they did not have time to read their emails all of the time.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report but did not always report them. Most ward staff we asked could not give us recent examples of any shared learning from incidents. They could not list the top three incident-related risks on their ward or department beyond broad categories such as falls.

Surgery

Staff did not always raise concerns and report incidents and near misses in line with trust/provider policy. Staff were able to articulate the incident reporting process and explain how incidents were investigated, however staff told us that they did not have time to report all incidents. For example, staffing shortages on the ward unless it was particularly challenging and felt to be unsafe.

We reviewed 76 incidents which occurred across a seven-day period in the specialities that provide surgical services at The Northern General Hospital. We saw the highest number of incidents related to clinical care issues followed by slips trips and falls with drug incidents issues as the third highest. Other themes included discharge issues, medical equipment and staffing.

The service had never events in theatres and on wards. The service had never events in theatres and on wards. The service reported eleven never events since 1 September 2020 to the 31st August 2021. Of the eleven, six were reported through NRLS and 5 through STEIS.

Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers.

The most common theme was retained foreign objects. The second most common were treatment delays. CQC had written to the Trust in June 2020 and again in July 2020 following concerns about the number of Never events reported by the Trust. They had responded to CQC with a letter in July 2020 detailing how they would disseminate learning throughout the trust of previous never events. It was apparent during this inspection that lessons had not been learned and Never Events continued to occur.

Managers shared learning across the care group about never events that happened elsewhere. However, no ward staff we asked could detail any shared learning from never events. The nurse director told us they were responsible for "signing off" never events in their area. They mentioned two recent never events involving insertion of a wrong lens and two wrong site injections. They said they had carried out some action planning and took plans back to governance meetings every six months.

Managers described how a team had learnt from a never event. A wrong site incision had been reported within the care group and the team had carried out a simulation of all the elements that contributed to the outcome. They found there had been several human factors involved. They carried out a debrief to understand all five steps for safer surgery. This involved the multidisciplinary team and included senior managers and resulted in themed work being carried out within the care group.

Staff reported serious incidents clearly and in line with trust policy. Staff we asked knew where and how to access the trust incidents reporting system. However, they were not always encouraged to report incidents relating to staffing shortages or pressures by ward managers and matrons. Several staff we asked had either stopped raising incidents around staffing as they felt no action was taken, the response was inadequate or there was no solution.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. No ward staff we asked mentioned duty of candour. However, when prompted staff said they were aware of the importance of being open and honest with patients and their families.

Surgery

We reviewed the service's musculoskeletal care group minutes from September 2021. This confirmed duty of candour training was available, and all senior nurses were encouraged to attend. Staff could book this through an online learning delivery platform and were referred to our website for duty of candour updates.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. However, we saw some shared incident information on surgical wards from incident investigations.

A ward matron told us action plans from incidents around falls and pressure sores were available on the trust's electronic network system. However, venous thromboembolism (VTE) specific incidents would have alerts in the trust's patient records system which fed into the ward e-whiteboards. The matron's dashboard for key performance indicators (KPIs) was where matrons reviewed monthly data metrics. During the factual accuracy process the trust informed us the dashboard could also be accessed all staff with a trust log-in, however, we were told staff below band 7 could not access it. This meant incident review information was not all in one system or accessible to all staff.

Managers did not always debrief and supported staff after any serious incident. A matron we asked about incident learning said their division used 'five points in five minutes' communication at their ward huddles. This was a way of sharing quick feedback focusing on the main learning from RCAs and investigations. However, no other staff mentioned the 'five in five' approach when describing incident shared learning.

We reviewed the service's plastic and breast governance meeting minutes from 19 August 2021. We saw shared learning from incidents which stated documents were shared for information and learning such as missed cancer diagnosis.

The trust's safety message of the month in June 2021 related to incident reporting. This was sent trust wide to staff about reporting incidents, raising awareness of what constitutes an incident, the metrics and reporting information promptly.

There was some evidence that changes had been made as a result of feedback. The trust supplied one action plan produced following a difficult situation where a deaf patient was unable to understand information a doctor was providing, and staff had to ask a family member to interpret. The action plan showed what actions were required, who was responsible, and timelines for achievement. Some completion dates had passed, and some actions showed evidence of change, but it was not clear if later changes had been completed.

Staff met to discuss the feedback and look at improvements to patient care.Managers told us that a rise in incidents such as falls and pressure ulcers were escalated to the governance team. The service informed us there were pressure ulcer review meetings held trust wide and attendance from all staff groups was actively encouraged. Wider learning was then shared across the organisation.

We asked managers how they were assured that learning would be embedded in practice and they gave an example of how a trust wide falls group worked to embed learning. They had seen a reduction of falls by half as a new system ensured 'certain things' were given on admission. Triumvirates checked incident data monthly to spot any trends arising and would challenge directorate teams if there were any rising numbers.

Safety information

The service did not always use or monitor results well to improve safety. Staff did not always collect safety information and shared it with staff, patients and visitors.

Surgery

Safety information data was not always displayed on wards for staff and patients to see. No safety information was displayed on any wards we visited. After our inspection, the trust sent us data confirming they had stopped compiling 'safety thermometer' data in June 2019. Matrons and ward managers we asked said data for these metrics were available on the trust's patient records system where they could pull monthly reports. Weekly nurse in charge bulletins included latest themes or issues. Allied health professionals (AHPs) said they were updated daily about safety thermometer figures, but these were raised informally and by exception. For example, pressure sore updates were covered at handover.

We also did not see any safety information displayed in ward areas on our last inspection in October 2018.

We asked nursing staff what safety information was available to patients and those we spoke to could not say.

Staff we asked did not see their ward's latest monthly figures for falls or pressure ulcers for example. This meant we could not be assured leads had governance oversight or review with all ward or lower band staff to monitor and improve safety performance.

We reviewed the general surgery governance meeting minutes from August 2021. This confirmed the service had an ongoing falls audit. The service had seen several pressure ulcers reported, and recent changes to how pharmacy delivered urgent repeat medications (URM) were reported by pharmacy for very sick patients were being resolved.

Staff did not use the safety data to further improve services. Staff we asked did not see their latest monthly figures for safety information metrics such as falls and pressure ulcers although some matrons told us this could be accessed through the electronic reports. This meant we could not be assured leads had governance oversight or review with all ward or lower band staff to monitor and improve safety performance.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff monitored the effectiveness of care and treatment.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

We saw the trust had a policy on implementing The National Institute for Health and Care Excellence (NICE) guidance.

The trust employed a NICE Information Co-ordinator who assessed the relevance of guidance for the Trust.

Surgery

Managers told us they ensured staff followed the latest NICE and other national clinical guidance usually via the clinical effectiveness department, and through clinical directors (CD) to appoint consultants to oversee incorporation of guidance, then into management directorate meetings. One clinical group had incorporated guidance into a clearly documented pathway and reported they found this easier to manage when any deviation from guidance occurred. They carried out close monitoring to provide assurance that clinical practice was delivered in line with this guidance.

Staff told us national guidance was incorporated into practice through multi-disciplinary team (MDT) checks and compliance was made clear to staff through supervision and peer support avenues.

An Annual Report of NICE Implementation was produced each year by the Clinical Effectiveness Unit (CEU) and approved by the Trust Executive Group.

We saw NICE guidance implemented into several health group audits and documents including the surgical site infection surveillance programme, open fracture – time to debridement, antibiotic prophylaxis, and the national vascular registry 2018.

Staff knew where to access policies and guidance on the intranet. We requested information from the provider to demonstrate how NICE guidance has been implemented within the surgical health care group. We saw NICE guidance implemented into several health group audits and documents including the surgical site infection surveillance programme, open fracture – time to debridement, antibiotic prophylaxis and the national vascular registry 2018.

We saw a notice in patient records showing the patient was included in the national surveillance of surgical site infection programme, which was in line with best practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. However, the service did not always make adjustments for patients' individual needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients requiring additional hydration and nutritional intervention were monitored through fluid balance charts and nutritional intake records. However, staff did not always accurately complete patients' fluid and nutrition charts where needed. Staff did not total the daily intake and output on fluid balance charts we reviewed. For the three fluid balance charts we reviewed, we noted they were not fully completed, and the daily intake and output was not recorded.

We saw food and fluid charts were not always completed accurately on our last inspection in October 2018.

We saw patients were not provided with different colour lids, trays or plates to help to identify them as needing support at mealtimes. We also saw no equipment was available to help patients living with dementia to eat, for example- coloured plates or cutlery. Staff were able to describe the equipment that was available, but it was not in use at the time of the inspection.

Following learning from a serious incident, the nurse educator had delivered training for staff to ensure patients received food and drink of the correct texture for their needs. Staff told us they held nutrition safety huddles before meals and kitchen assistants had access to a standard operating procedure (SOP) showing how to prepare meals and thickened fluids. We spoke with two kitchen assistants who confirmed this and showed us the information they were given with pictures on how to present meals.

Staff in the head and neck care group used a knife and fork symbol on e-whiteboards to identify patients with additional needs around eating and drinking. Staff told us they had a lot of patients with swallowing difficulties. The trust had employed nutritional assistants to help patients at mealtimes.

Staff told us volunteers on a different ward had completed dysphagia (swallowing problems) training. However, there had been no volunteers on wards since the Covid pandemic began.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition (MUST). We reviewed three patient files and saw that they were completed and up to date.

Specialist support from staff such as dietitians and speech and language therapists were available. Support was offered through specialist meal plans, nutritional advice and dietary specific risk assessments.

Patients waiting to have surgery were not left nil by mouth for long periods. We requested the most recent fasting audits from the provider, but they told us they had been unable to find any audits related to fasting carried out in the past 12 months at either NGH or RHH.

All patients we spoke with told us they enjoyed the food and drinks that were provided with a good choice offered every day.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The provider used a standard pain scoring tool which used a numerical indicator to assess and measure patients pain levels.

We reviewed eight patient records and saw that pain relief was delivered in accordance with prescribed times.

We saw pain nurses actively reviewing patients with complex or ongoing pain issues. Ward staff told us that they were available on the wards most days and were invaluable members of the team.

We asked staff how they gathered information about pain from patients with difficulty in understanding. The nurse director told us they had learning disability (LD) links who were mainly matrons and physiotherapists, and that information would be sent to all these staff. They described some adaptations and reasonable adjustments that could be made for those living with learning disabilities. However, ward staff we spoke with could not say how they ensured accurate pain scores were obtained from patients with dementia, delirium, or a learning disability.

We spoke with one matron who showed us a booklet which could be used as a visual aid to communication. This booklet could assist patients who had specific needs, but this was kept in the nurse's station and not used by staff to support patients at the time of inspection.

Surgery

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make some improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. We reviewed data from the National Hip Fracture Database presented in CQC Insights benchmarking publication September 2021 (data for January 2019 to December 2019) and saw that although the provider did not meet three of the four national standards set based on NICE guidance, results for the KPI's were significantly above the national average and this was commended in the National Hip Fracture Database national report. We also reviewed the six performance measures in relation to the National Bowel Cancer audit 2019 and saw that the trust performed higher in two of the performance measures when compared to other similar trusts.

The provider met three of the five performance measures in the National Emergency Laparotomy Audit 2020 but did not meet three (100%) of the performance standards in the National Vascular Registry 2020.

Outcomes for patients were mixed when compared to England average. From March 2020 to February 2021, colorectal surgery patients and general surgery patients had a higher than expected risk of readmission for elective admissions when compared to the England average

The relative risk for readmission for all non-elective admissions at Northern General Hospital, including general surgery and colorectal surgery patients was similar to expected compared to the England average.

Trauma and orthopaedics patients had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Managers and staff carried out some audits to check improvement over time. We spoke with staff on the hip fracture ward who explained they submitted data to the national hip fracture database and had achieved good measures and outcomes. They had identified risk of falls for several patients due to the need for early mobilisation following hip replacement surgery.

Staff said they would cohort these patients where possible and provide special 1:1 care where possible and said they could provide staff accordingly.

The mortality rate was 30%. Staff said several of their patients were receiving palliative care. A specialist orthogeriatrician was responsible for medical care along with orthopaedic consultant input and a specialist hip fracture nurse. Staff told us they were very proud of their rolling, 12-month infection rate of 0.4%. The hip fracture nurse attributed this to the use of negative pressure dressings that stayed in place for two weeks following surgery.

The return to theatre rate was 1%. The surgical site infection rate was 0.4% at this hospital.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. The provider reported one outlier for mortality.

Provisional PROMS data provided for the trust for the period 1st April 2020 – 31st March showed a marked reduction in arthroplasty operations due to the COVID-19 pandemic. However, the department looked at various digital ways to support communication with patients.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Crude mortality in patients with fractured neck of femur (NOF) started to rise in September 2019 and in March 2021. We were informed that the National Hip Fracture Audit data (NHFD) showed the trust was an outlier and the case-mix adjusted 30-day mortality for patients admitted between Jan 2020 and Dec 2020.

There was significant nosocomial COVID infections in the trust's fractured NOF patients in waves 1 and 2 of the pandemic.

A number of actions were put in place including commencement of point of care testing (POCT) of all emergency admissions (in Feb 2021) and a protected and dedicated pathway for NOF patients.

We also requested the providers recent audit 'Five Steps to Safer Surgery. The provider told us the at the policy regarding this is still under revision. We were told the Safer Procedure Committee had agreed changes to the audit methodology and the programme of re-auditing would re-start as more 'blue' operating slots become available.

The service was accredited by The Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) demonstrating their commitment to patient safety and excellence of care.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. However due to COVID-19 the use of volunteers had been suspended. It was unclear when they would be reintroduced again.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
Staff were not always experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers told us that matrons could view a spreadsheet showing red, amber, green (RAG) rated sections for staff competencies in all areas they managed.

The nursing director told us newly recruited international nurses had one to one meeting with the nurse educator. When nurses struggled with competency the educator worked with them. Sometimes the setting was not suitable for them and the educator held an honest conversation before the nurse lost confidence.

Managers did not always make sure staff receive any specialist training for their role. The provider told us that link nurses were in place across wall wards and departments and had specialist training in areas such as tissue viability, dementia, and falls. We requested the names and the training dates for the link staff on all wards we visited but this information could not be found. Staff told us that no training for link nurses had been provided since the start of the COVID-19 pandemic.

Surgery

We requested data to show what training was offered to staff in addition to the mandatory training programme. We saw the trust provided fourteen courses deemed as essential in areas such as falls, mental capacity, NEWS and mental health awareness. The trust's internal compliance target for completion of this training was 90%. However, we saw that staff met the compliance target for only three of the fourteen courses offered. In some areas the compliance rate was significantly lower. For example, 62% of nursing staff had completed pressure ulcer REACT training and 65% of medical staff had completed in falls training. These figures were concerning considering the concerns we found in relation to pressure ulcers and falls during our inspection.

Managers gave all new staff a full induction tailored to their role before they started work. However, this was informal, as there was no document to confirm an induction had been undertaken. This meant that induction content and quality varied across the trust and was inconsistent.

Managers supported staff to develop through yearly, constructive appraisals of their work. Accountability was with managers and staff appraisals could not be completed without mandatory training completion although managers told us they ensured compliance. A matron told us staff impact assessments were covered as part of their appraisals with line managers. Trust wide staff appraisal data was submitted by the provider for nursing and medical staff. We saw that the overall trust wide appraisal compliance figures for nursing staff in surgery care groups ranged between 79% and 98% in surgery care groups. The trust compliance target for medical staff was 90%. The medical staff compliance rate ranged between 68% for general surgery to 94% in urology. The trust did not collate this information by site.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. A ward support facilitator told us they had specific supernumerary training on the Firth 9 ward. A staff nurse had agreed to complete a mentorship course in order to mentor work with students. We heard about a preceptorship on the Firth 4 ward. Staff told us registered nurses completed two extra surgical study days on top of mandatory training and support workers attended one of those days.

However, many ward staff told us they did not always have enough time as almost always the wards were short staffed. They told us this affected their opportunities to improve competencies.

One ward manager told us they used the 'how healthy is your ward?' checklists when carrying out supervision with senior ward staff. This summarised health and safety, fire, legionella, caring, responsive, effective, safe. This provided consistently in discussion and areas for improvement.

The clinical educators supported the learning and development needs of staff. Ward staff told us feedback about clinical educators was positive. We heard they were supportive and booked staff onto relevant courses to help develop their skills such as cannula and electrocardiogram competence. Lead educators provided clinical supervision and would provide support and follow up on actions on wards.

We spoke with a clinical educator who told us there were education leads in all care groups. They had rolled out training to staff following actions raised from incident trends. There had been a number of falls reported on the electronic reporting system and following investigation into causes of falls, the governance team had produced an action plan. It had been identified that Glasgow Coma Scale (GCS) scores were not documented frequently enough, falls risk records were not being updated, and more falls occurred at night.

Training had been delivered to ensure night staff were not burdened with paperwork and training on completion of falls assessments was provided for staff caring for patients after a fall with the overall aim to ensure patients were safe. Following the training to staff on two wards, an audit showed staff were 100% compliant in carrying out falls assessments within 24 hours of patient admission. This was still underway on some wards during our inspection.

Some medication errors regarding insulin administration had occurred and the clinical educators were rolling out training to ensure all staff administering insulin were competent to do so. Where staff were found to be non-compliant, they had worked with another clinician until compliance was improved.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. All managers we spoke with told us that trying to bring staff together due to staffing shortages was challenging but they sent key information by email and through WhatsApp channels.

Staff had the opportunity to discuss training needs with their line manager however they were not always supported to develop their skills and knowledge. Many ward staff we spoke to were time poor due to almost always being short staffed. They told us this affected their opportunities to improve competencies.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We observed a multi- disciplinary patient review meeting and saw proactive contributions made by all members of the patient care team which included consultants, junior medical staff and nurse specialists, radiologists and nurse specialists.

Allied health professionals (AHPs) worked closely with ward staff, junior doctors and pharmacists on most wards we visited. For example, a rotational physiotherapist on an integrated ward had working hours to match the nursing staff. They attended and could arrange MDT meetings as well as falls huddles. They heard about incident updates and actions on their ward.

Staff on the colorectal ward could access a surgical physiotherapist overnight and at weekends for patients who needed urgent chest physiotherapy or were at risk of deterioration. We heard about weekend physiotherapist referrals for laparotomy patients at the surgical assessment centre (SAC) alongside cover arrangements for occupational therapists and FDRTs.

Allied health professionals including occupational therapists, physiotherapists and speech and language therapists all provided care as part of each ward team and contributed to patient records. They attend ended ward handover, nutritional huddles.

Seven-day services

Key services were available seven days a week to support timely patient care.

Surgery

In general surgery and urology there is a 7 day a week consultant led - post take ward round. All South Yorkshire regional services (SYRS) services have seven-day consultant ward rounds and on-site cover. Staff told us patients were reviewed by consultants depending on the care pathway. The service offered seven-day 24-hour discharge and the pharmacy was open seven days a week.

Staff could not always call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week.

The service offered seven day 24-hour discharge and the pharmacy was open seven days a week.

AHP and ward staff we asked said diagnostic imaging scans were usually reviewed and reported quickly. For example, a physiotherapist told us urgent chest X-rays could be done overnight if necessary.

However, ward staff told us medicines could delay their patients on weekends, as they could not always access doctors or locate their bleep numbers. This was because doctors did not always update the e-whiteboard with their numbers. Staff said medical outlier patients could also be held up as doctors could not contact their teams.

We requested information regarding the review of seven-day services. The trust told us in March 2020 we were advised by NHS England & NHS Improvement that due to current and anticipated increasing pressures upon systems in responding to the coronavirus (COVID19) pandemic, the spring Board Assurance Framework (BAF) submission requirement for the region had been deferred to Wednesday 30 September 2020 and in June 2020 a further communication stated that a September BAF would be unreasonable and would not necessarily reflect business as usual in regards to the 4 priority 7DS standards and advised that the September return was cancelled with no plans to collect a Regional BAF return that year. The trust told us they were awaiting the audit to restart.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff we asked gave patients information on managing their diabetes, pressure area care and smoking cessation to raise awareness and patients could be referred for smoking cessation support upon discharge.

Patients could be referred for substance misuse detox programmes where appropriate.

Wards we visited had lots of information available for patients on leaflet racks. However, we did not see any staff giving patients leaflets post-procedure or before discharge.

We requested information from the provider regarding any health promotion pilots that were currently being trialled, but we did not receive any information.

The trust was working to implement a system-wide smoking cessation programme

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. The did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Managers did not monitor the use of Deprivation of Liberty Safeguards and did not make sure staff knew how to complete them. We saw Dols applications that were completed incorrectly prior to capacity assessments.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. The provider had undertaken an audit of mental capacity assessment and best interest decision making documentation in response to Regulation 28 served by HM Coroner in relation to poor understanding and application of the Mental Capacity Act 2005, including the promotion and use of the hospital passport for people with learning disabilities. we reviewed the audit which was dated August 2021 and saw that four patients receiving care within the surgical care group were selected. The results of the audit showed poor compliance with the mental capacity act and staff lacked knowledge and understanding of their responsibilities within the act. The audit also showed that there was an inconsistent knowledge of the health passport which is a document used to support the care needs of individuals with a learning disability.

During inspection we reviewed five patient files and saw none of the five patients had undergone a mental capacity assessment, all of whom had a diagnosis of dementia and were assessed as experiencing confusion.

We spoke with one of the medical staff responsible for the completion of this document and they told us they were unsure how to complete it.

Service staff told us they had good access to the trust's specialist palliative care team who gave them a realistic idea of how soon the team could arrive on wards. Staff could add end of life (EOL) additional needs to the care core plan on the electronic system. However, EOLC information boards we saw had no information on how staff should gain consent or complete mental capacity assessments (MCAs).

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. We reviewed five patient records all of whom had a diagnosis of dementia and were assessed as experiencing confusion. None of the patient's files we reviewed demonstrated a clear process to determine how consent for treatment was obtained. In two of the files we reviewed we saw conversations between patients' families had taken place for specific interventions such as diagnostic tests without first determining capacity and consent ability. This is not in line with the mental health act code of practice.

However, for patients not experiencing delirium or confusion staff told us that general consent for all personal care and treatment was assumed at the point of admission.

However, we did observe good compliance by staff in theatres when completing second stage of the consent process.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us that they received training in mental capacity and consent. We requested training compliance figures from the provider and saw that staff did not meet the trusts 90% compliance target rate. We saw nursing saw had a 56% completed compliance rate and medical staff had a 42% compliance rate.

Surgery

When patients could not give consent, staff did not always make decisions in their best interest, taking into account patients' wishes, culture and traditions. We did not see evidence of best interest decision making document, in any of the files we reviewed.

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. In two of the patient files, we saw a deprivation of liberty application (Dols) had been made despite not undertaking a mental capacity assessment. The Dols completion was therefore inappropriate and not completed in line with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff treated patients with compassion and kindness. Staff did not always respect patient's privacy and dignity but worked hard to meet patient's needs. Staff told us due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.

Staff followed policy to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

We saw several patients on the surgical assessment unit sat in chairs along the corridors due to the lack of private assessment space. Nursing staff told us that this was not ideal for the patients, however individuals were offered a cubicle when discussing sensitive or personal information.

In addition, patients could also be transferred to side rooms to provide privacy and to respect their dignity. However, staff told this was not always possible due to COVID-19 pressures and patients requiring isolation. We saw on Chesterman 3 that only three of the four side rooms were available.

Call buzzers were not always placed within reaching distance of patients meaning they could not always buzz for help. We saw patients waiting in the corridors on the surgical assessment which meant they had no access to a call buzzer. However, staff were visible and were able to monitor if patients required assistance.

Feedback from people who used the service and those who were close to them was mixed. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The trust provided Friends and Family Test data gathered from the musculoskeletal surgery wards that showed a range of scores the lowest being 58.8% for Huntsman 7 and the highest 100% for Huntsman 2 and P2. The number of responses were very low with 1 response out of 36 discharges on Huntsman 2 to 18 responses out of 75 discharges from Huntsman 6. The information provided did not included details of the feedback given or any qualitive data.

Emotional support

Staff did not always provide emotional support to patients to minimise their distress. They did not always understand patients' personal, cultural, or religious needs.

Surgery

We reviewed five patients who required additional support due to a diagnosis of dementia. In all five patient records that we reviewed we did not see any care plans to support the emotional needs of these patients.

Staff told us that additional care was always provided, for example, additional observations but none of the records we reviewed demonstrated personalised care planning for specific needs or emotional support.

Staff recognised that time providing emotional care including enhanced interaction was limited. All staff we spoke with found the lack of staff to be a significant barrier to delivering quality emotional support. However, all staff were motivated to provide this care whenever they could and feedback from patients during the inspection was positive.

Patients told us the staff were calm and reassuring. Two of the patients we spoke with told us they expressed anxiety when they were admitted to the surgical wards and the nurses and consultants had been reassuring and helped to calm them.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs.

However, We did not see any care plans which supported patients cultural or spiritual needs, however, we understood that cultural and religious needs are part of the activities of daily living within the electronic Core Care plan.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients to understand their condition and make decisions about their care and treatment.

Staff did not always make sure patients understood their care and treatment. We reviewed the records of five patients and saw clear communication recording between medical staff, allied health care professionals such as speech and language services and patients' families. However, we saw one patient within theatre whose first language was not English. No translator was present to ensure understanding of the pre-surgical checklist process and any general communication was understood.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff interaction with families and patients' carers and saw information was provided in a way that was easily understood.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. However, information as to how to do this was not readily available on the wards we visited.

Patients gave positive feedback about the service. All patients we spoke with spoke highly of all staff and recognised how busy staff were. Patients told us they knew they would need to wait longer to access staff when they needed them.

Is the service responsive?

Requires Improvement 

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

Surgery

Service delivery to meet the needs of local people

The service undertook some planning and provided care in a way that met some of the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.

Managers spoke of an unmet need that was hard to quantify, the trust was treating many patients who were less fit but still required complex surgical care. Bed capacity was a big problem, so staff were trying to 'create community capacity regarding virtual beds'. They were also concerned about their ability to sustain the non-elective pathway. Capacity planning was a constant piece of work, with consideration of the use of side rooms and planning throughput to ensure patients had their surgery. The trust had introduced 'demand-based scheduling' which had been a great ambition but in practice staff said this was hard to execute. They were 'still redesigning the methods used for allocation' as they said they 'don't have all the information'.

Medical staff told us they were required to escalate all surgical cancellations before contacting patients to ensure organisation wide management were aware.

At a wider level, bed managers met daily and senior surgeons worked on a rota as surgical commander to ensure balance between specialties for demand versus capacity.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last six months and none told us they had.

We requested data regarding missed appointments and how they were managed from the provider, but it was not submitted.

The service relieved pressure on other departments when they could treat patients in a day. We saw the health care group continued to provide day surgery for a number of procedures.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

A nurse in charge said they discussed patients with any dementia needs at handover, so all their staff were aware. They would try to nurse in a highly visible environment and could call the onsite dementia team for further help.

Staff told us they thought they cared for approximately 50% of patients who had delirium, dementia or required DoLS. However, the provider did not collate any further data in relation to improving outcomes for this group of patients.

On our last inspection in October 2018 we told the trust it should improve the experience for patients who need extra support, such as those living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Ward staff we asked described how they would give patients with dementia or LD extra support. A staff nurse

would arrange video calls with the family of one patient with dementia. The nurse reintroduced herself each time she gave patient care or re-orientated patients in the later stages of dementia with their surroundings. AHPs mentioned they had access to resources to comfort patients with dementia. However, this was very ad-hoc as no patients had personalised dementia care plans in place.

Staff answers varied greatly, and their understanding of dementia was poor. We saw the butterfly symbol being used for one patient with dementia. However, when we asked the matron about this, they said the patient was 'just confused'. We saw the Alzheimer's Society 'All About Me' forms on ward noticeboards for patients with dementia, but staff did not use them. Staff told us some wards no longer had a dementia champion due to COVID-19.

One nurse in charge told us their ward had higher numbers of medical outlier patients with dementia. This meant these patients could potentially be more disorientated and overlooked at times of high acuity or when the ward was understaffed. They would try to nurse patients with dementia in the same area to concentrate staff.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Service staff told us they had good access to the trust's specialist palliative care team who gave them a realistic idea of how soon they could arrive on wards. Staff could add end of life care (EOLC) additional needs to the care core plan on the trust's patient records system. However, EOLC information boards we saw had no information on how staff should gain consent or complete mental capacity assessments (MCAs).

The service had information leaflets available in languages spoken by the patients and local community.

Managers told us that they made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. However, no staff we asked had used this but two had seen it in use on their ward.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with some national targets.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and some national targets.

Managers reported growing waiting lists which they said was worrying but they said this was in line with national direction. Theatre cases per list were lower due to COVID-19 safety measures they followed, and staff said they needed to find ways to complete the same number of cases as pre-Covid. Staff said it could take years to reduce most challenges due to the scale of the problem, complexities of ward types (grey, blue and red). They said there were tight recovery plans in place and staff had attended a performance summit led by the CEO. We asked to view these plans, but they were not made available to inspectors during or following the inspection. Directorate staff met to discuss key deliverable target measures. Managers said staff understood and contributed to good recovery action plans.

Staff told us they mainly kept up with time critical patients; specialties held fortnightly meetings to review patients with long waits to see if they needed reprioritisation.

A service manager we spoke with could not remember the exact numbers of P3 and P4 patients waiting for procedures but would be able to provide a list if inspectors required it. We requested this data from the provider, but we did not receive it.

Surgery

Medical staff we spoke with said their elective procedure waiting lists were growing, but 'the senior leadership team does not seem to have a plan' or contingency to tackle the waiting lists. They said there was no weekend or waiting list initiative work planned to help clear the backlog. One consultant told us 'all consultants are more or less doing clinical harm reviews'. However, clinicians did recognise cancer patient procedures and Priority 2 procedures were ongoing and uninterrupted.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers told us they had run a caseload management exercise to understand their current situation. Managers told us waiting lists were reviewed regularly with caseload management discussions for those waiting 52 weeks and above to ensure patients were safe.

Senior clinicians had noticed that more orthopaedic patients than before had chronic health issues, so staff had to carry out extra work to triage and manage patients before surgery was imminent. They noted there been increases in post-surgical complications.

Managers told us there was recognition that patients waiting for surgery were coming to harm, so they monitored risk and, where possible, they utilised social support and better pain management, but some patients were simply deteriorating.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers monitored the number of delayed discharges, and knew which wards had the highest number. Staff identified 10% to 15% of current patients who no longer needed acute surgical care. All patients were reviewed for their suitability for transfer to the discharge lounge. Managers and staff told us they started as early as possible to plan discharge.

Staff supported patients when they were referred or transferred between services. Many wards we visited had high numbers of medical patient outliers. For example, the surgical assessment unit had ten medical outlier patients on 7 October 2021. The nurse in charge told us they normally only had one or two.

Managers did not monitor patient transfers to follow national standards. We requested data in relation to the number of patients who were moved between wards and at night, from the provider bit did not receive it.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service did not clearly display information about how to raise a concern in patient areas. No PALS information was displayed on any wards we visited. Support staff told us nine times out of ten ward staff would offer PALS contact details to patients who asked to raise a complaint or concern.

Wards we visited did have friends and family test feedback boxes visible near the entrance and exit. However, patient and visitor information around this was out of date. However, patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with said they would feel confident asking ward staff how to raise a complaint or concern.

Surgery

Staff understood the policy on complaints and knew how to handle them. The trust supplied a log of complaints for the general surgery care group that showed 21 complaints had been received from patients and relatives, with eight ongoing. There was process which ensured managers of wards not subject to a complaint, undertook independent investigation of patient complaints.

The complaints that we reviewed varied in theme and included delays in medical decision making and investigations, poor medicines management and storage, faulty equipment, poor infection prevention and inappropriate conduct of night staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. One ward sister we spoke with described the process they followed with examples of how they had responded to a complaint and the lessons they had learnt and shared with the ward staff.

Staff could give examples of how they used patient feedback to improve daily practice. This included access forward staff to interpreter equipment to help patients whose first language was not English and for patients who used sign language.

Managers shared feedback from complaints with staff and learning was used to improve the service. However, the complaints spreadsheet provided to us did not show what actions had been taken or any changes made as a result of complaints.

Is the service well-led?

Requires Improvement 

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

The trust provided limited evidence when requested by inspectors during and following the inspection. This was a concern highlighting a lack of oversight of the surgery services.

Leadership

Local leaders had the skills and abilities to run the service. They took steps to try to understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgical services were separated into directorates so there were multiple leaders throughout the Trust. The theatre services managers had an overview of all surgery activity and the trust told us the medical director, Chief Operations Officer (COO) and deputy COO had overall leadership responsibility and were well sighted on all issues escalated to them.

Surgery Directorates provided both elective (cancer and benign) and non-elective surgery services. The Directorates were subdivided into specialties.

Surgery

The trust told us specialities worked closely together to provide patient focused care and were consultant led. Surgical services were separated into care groups so there were multiple leaders throughout the Trust. Theatre service managers had an overview of all surgery activity and the Trust medical director, COO and deputy COO had overall leadership responsibility and were reported to be well sighted on all issues escalated to them.

Nursing leadership at ward level consisted of nurse directors who managed a team of matrons who managed two wards. These matrons managed nurses in charge of wards. Each care group had a Director of Nursing who reported to the Chief Nurse.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The Chief Operating Officer and deputies had the overall vision for the organisation with networks between directorates all the time.

The operations director for care group operating service, critical care and anaesthetics (OSCCA) had a clear insight of the vision and strategy regarding operating pathways for surgical directorates. However, managers told us each surgical directorate had its own vision.

There were different strategies and vision for each directorate. We requested the current vision and strategy documents and provider submitted three separate strategies for general surgery, urology and plastic and breast. However, these were all dated 2017 to 2020. There were no newer strategies provided.

Theatre managers reported good theatre provision and recovery plans were being met for priority 1 and 2 patients. However, clinicians reported frustration around theatre availability and being unable to provide a service for their priority 3 and 4 patients.

Managers told us staff had completed an interactive session prior to the pandemic to look at the five values of the trust strategy and medical staff had contributed to the production of a document. The urology department had held a structured day describing the strategy. No work had been carried out since then, but managers reported there had been little change and had been looking into new ways of sharing staff ideas and updates.

Culture

Not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families could raise concerns without fear. However, some staff we spoke with did not want to be identified and were wary of repercussions when raising concerns.

Staff morale and wellbeing varied, and a few staff told us their morale was quite poor. Medical staff, in particular foundation doctors we spoke with told us they felt valued and supported by senior clinicians and the ward teams and that, apart from the constant struggle with IT and records systems, they were able to provide care for patients.

Senior clinicians we spoke with expressed frustration about the lack of theatre access and availability to tackle their waiting lists for P3 and P4 elective operations, although they said the senior leadership team, including executives were receptive and listened to any concerns.

Surgery

Nursing staff felt well supported by their managers and other staff nurses who checked in with them often. One staff nurse appreciated the shout outs to new RNs in the nurse in charge's weekly bulletin. Ward staff on Firth 4 told us they had lots of away days planned leading up to Christmas, to make up for none during the last year of the COVID-19 pandemic.

However, one staff nurse felt the duty matrons were not approachable and did not listen when they tried to raise overnight staffing issues which they felt were unsafe.

One ward staff member told us they were seeking another job to leave the trust due to stress and high anxiety from being one staff nurse under establishment every shift. They reported about six other ward staff members felt similar. They felt service leads lacked compassion for staff who were off sick. They had been off work twice with stress, which got worse when they returned.

One staff nurse we asked described being emotionally supported by medical staff after a traumatic incident involving the cardiac arrest of a patient.

Staff told us the trust were creating a garden for staff to access some "calm time".

Managers explained that staff voices regarding health and wellbeing were recorded in staff surveys and managers heard and understood staff needs. A wellbeing support survey had been sent to all staff and psychology and debriefing sessions had been implemented for staff. Following a tragic event, the trust had brought in specialists to work with the team.

Staff and managers described morale as being 'really tough'. The trust held a silver command meeting weekly with staff feedback at the beginning and end of every session. The main issues raised were about staff capacity, leaders being visible to staff and able to support teams with limited finances. Staff told us they felt relieved about the nursing recruitment programme, but this brought additional work for ward teams to train and support the new staff. Managers told us the new nurses had given good feedback because they felt settled and part of a team.

Managers told us the trust had a 'Give it a Go week' where humour played a part in managing change and adversity. However, many people were exhausted, and due to ward moves, continuity of teams could not be maintained throughout the pandemic. Managers said leaders were positive and helped staff 'see the horizon'.

Medical staff reported the lowest point in morale earlier in 2021. In response to staff concerns, leaders had formed a restructure and a follow up meeting was held to check measures regarding concerns were in place.

Staff spoke highly of the Chief Nurse and CEO and said they provided information regularly.

Some staff reported extreme difficulties in managing increasingly complex patients undergoing elective surgery, in particular those with alcohol dependency.

Staff reported that the difficulties with the IT system affected morale as it makes the job more difficult and had 'tipped a few over the edge to take retirement'. Some staff said the OSCAR system worked very well but was only available for a small number of specialties. They said electronic patient record systems caused multiple problems especially in the time it took to use the system. However, staff said record keeping had not been good prior to using the electronic patient recording system.

Staff said inpatients from other specialties were cared for on surgical wards, and e-whiteboard functionality had had to be amended. Staff said this had been achieved quickly to keep better track of patients being cared for elsewhere.

Governance

Leaders did not always operate effective governance processes. Staff were not always clear about their roles and accountabilities and there were inconsistencies whether staff had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework provided by the trust showed a range of trust wide groups and meetings that fed into governance processes. However, there were no clear lines of accountability shown. The trust provided minutes of governance meetings from several specialities which included information about performance, risks identified and engagement. Actions had been agreed and staff identified to address them. We saw some actions had been completed but very few timeframes for expected completion were recorded.

We observed the matron's daily 'bed' staffing meeting with representatives from all care groups and the two duty matrons from each site. No clear acuity of patients was reviewed and no safe staffing models were used. An operational matron had told us any overnight risks were fed back into this meeting, but only skill mix was discussed. The matron said they had responsibility to update the other matrons about surge areas by capacity and feel. This meant the service used no formalised recorded process for managing staff numbers and skill mix to meet patient acuity.

An operational matron told us mental capacity and risk assessments for patients can often be pre-empted by their staff. It was not clear what was meant by this. They felt nurses were good at getting to know which patients were at high or increased risk.

Senior staff told us there was a standing agenda item on the monthly management board meetings to review all serious incidents and never events. All clinical directors attended these meetings and would present cases from their directorate to the group. An example of this was a case with a retained guidewire in urology. This was taken to the monthly management board meeting, then it was discussed at the safety and risk forum which was open to all staff. The trust then distributed links to training to all staff.

Managers told us senior leads met with matrons to discuss patient safety information. However, they also said different governance teams had different approaches. Most staff we asked did not hear about falls, PUs etc outside huddles or ad-hoc informal updates.

Management of risk, issues and performance

Leaders and teams used some systems to observe performance. They identified and escalated some relevant risks and issues and did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Managers told us they were aware of risks across the surgical directorates. They told us the 'parent' risk was the inability to provide sufficient theatre time to support surgical pathways. 'Child' risks included insufficient staff, the inability to recruit or retrain theatre nurses, staff wellbeing post-Covid, and insufficient post-operative beds. They had created an 'extra type of bed' to help manage this but felt they had not yet reached a final solution.

Managers spoke of an 'unmet need' that was hard to quantify, the trust was treating many patients who were less fit but still required complex surgical care. Bed capacity was a big problem, so staff were trying to 'create community capacity regarding virtual beds'. They were also concerned about their ability to sustain the non-elective pathway. Capacity

planning was a constant piece of work, with consideration of the use of side rooms and planning throughput to ensure patients had their surgery. The trust had introduced demand-based scheduling with had been a great ambition but in practice staff said this was hard to execute. They were still redesigning the methods used for allocation as they said they 'don't have all the information'.

Managers talked about having undertaken lots of work in recent months to mitigate the risks around staffing levels with a national lack of nurses. However, some ward staff told us the trust could not attract agency staff because they chose to work at other local trusts with better working conditions and an uplift in pay.

Staff reported theatre nurses were difficult to recruit so they had created an extra role for a Band 4 assistant theatre practitioner.

Managers explained they identified risks within care groups which went to governance for greater oversight. This had been reinforced over the years to ensure action plans were dealt with promptly or reviewed. Staff said there was not always capacity to reduce risk immediately.

Some staff told us they obtained the right support to identify risks, provide a strategy to address them, regular reviews, and engagement with the COO.

At a care group and trust wide level, bed managers met daily and senior surgeons worked on a rota as surgical commander to ensure balance between specialties for demand versus capacity.

Managers told us they mitigated risks regarding the shortage of registered nurses. The trust was investing in Band 4 nursing assistants, supporting new nursing recruits, and holding performance management meetings to ask staff about their worries. The trust was recruiting overseas nurses with plans to recruit 330 qualified nurses by the end of March 2022. There was a central team to provide these staff with pastoral support and to complete their OSCEs quickly.

Managers described support to nurses as 'imaginative' and used ward support facilitators, additional band 6 nurses, and matron provision over 7 days a week. However, they felt the workforce was incomplete and there were scant finances to support full establishment.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated and records were not secure.

Staff told us and we observed that electronic systems were not cohesive. During our inspection we observed three separate patient database platforms which did not share patient digital information. Staff were therefore required to access each system separately to review the information they needed.

We saw the on the e-whiteboard system that alerts were not accurate and basic observations which showed as being overdue on the main screen, were found to be inaccurate.

We saw e-whiteboards were used on all wards we visited. These displayed the access and flow into the hospital, admissions onto the ward and current patient status indicators. These indicators included potential risks. Staff told us that training to use the e-whiteboard was inconsistent across the trust and some staff reported a lack of training despite the system being in operation for several years.

We visited several wards with out of date or blank general information boards and panels. On other wards we saw that information that was displayed did not always match what staff told us. For example, staff on the colorectal ward said their last fall was four days before our visit, but the date of the last fall displayed was 7 May 2021. Their longest run without a fall sign was not completed.

We observed the main electronic system crash on several occasions, when we asked staff to access patient records on our behalf. Staff told us this was a reoccurring issue that they had escalated to senior staff.

Ward managers told us they could access performance reports, however not all managers we spoke with knew what reports they had access too. Staff told us training in these systems was inconsistent across the trust.

We also saw patient data was not always managed appropriately. We saw care rounding and 24-hour fluid monitoring charts were left hanging from rails outside patient bays which could be potentially read by anyone coming onto the ward. This meant patient confidential information was identifiable and not managed securely.

Engagement

Leaders and staff actively undertook some engagement with patients, staff, the public and local organisations to plan and manage services. They collaborated with some partner organisations to help improve services for patients.

Managers told us the last staff survey had been completed in November 2020 and the trust was in the process of another one at the time of our inspection. The results centred around topical questions relating to the pandemic and staff from different care groups did not always feedback the same concerns. Some staff groups had gone on to develop their own staff surveys following up on results. For example, urology staff had done extra work on areas where the scores had been below the trust average.

Senior medical staff told us the staff survey had highlighted areas that managers had addressed through 'You said, we did' examples including provision of quality food and drink for out of hours staff, coffee room refurbishments and wellbeing champions who liaised with directorate leads.

Managers told us staff feedback really mattered and they were driving this forward. Managers said they listened and took any feedback as a positive step, encouraging an ongoing feedback loop rather than an annual exercise. They said staff liked to see a connection between their suggestions and measures put in place.

Managers said friends and family test questionnaires had continued, albeit irregularly. These identified themes such as delayed prescribing for discharge so a sister had completed a nurse prescribing course. A patient had made a claim after being unable to access an interpreter. As a result of this managers reported the equipment libraries now held signing equipment.

Managers told us a patient representative sat on the Executive MDT meeting. They had attended face to face monthly meetings prior to the pandemic and continued to attend virtual meetings. Patient representatives sat on the Patient experience committee. Managers told us patient representatives used to be associated with care groups. One group had recently been involved in a review of the Huntsman theatre ward to try to reduce cancellations on the day of surgery. They had also contributed to a piece of work on dignity and privacy.

Surgery

We reviewed an action plan developed in response to feedback from patients, where communication had been an issue. We saw seven separate points to be addressed as a result of information provided from patients. However, we saw only three of the seven areas had been actioned by the directorate.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Managers reported major changes in some surgical pathways with 'day of surgery' admissions for more patients than previously and more day case surgery work in all specialties.

The trust had implemented a new role for a cross trust extra duty matron which managers reported helped with hospital out of hours work. There had also been surgical night practitioners appointed.

The trust had introduced computerised surgery pre-assessments so that patients would only have to attend for clinical observations. There was provision of some enhanced care beds for patients with additional needs but did not require critical care.

A multiprofessional abdominal aortic aneurysm (AAA) clinic had been set up., allowing for robust quick decision making.

Expansion and investment in vascular nurse specialists to provide a better link between hub and spoke sites at other local NHS trusts. They had introduced nurse-led intermittent claudication clinics for better compliance with NICE guidance.

A Royal College of Anaesthetists anaesthesia clinical services accreditation assessment had highlighted several areas of good practice. The trust had provided trained quality improvement coaches from the academy and a new improvement lead, so staff felt theses were becoming embedded in directorate work.

Staff told us the trust had reduced its carbon footprint by changing the anaesthetic gases used.

Staff were reducing variation in care, building on getting it right first time (GIRFT) group work. Clinical leads were aligned to patient pathways.

The trust had implemented an Enhanced Care Unit at both hospital sites. Senior staff said this provided quick, decisive care, driven by patient need.

The trust used a colour coded system to identify ward types; a Blue elective ward was a dedicated ward for elective patients only and had helped the trust to sustain elective activity.

There were identified places of safety for patients with chest drains and tracheostomies on dedicated wards where staff had enhanced training.

The trust had instigated the use of photography prior to discharge to support patients with sternal wound management and to help reduce infections.

The trust had introduced night practitioners and a seven-day matron for the Huntsman theatre ward.

Jessop Wing

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Sheffield
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www.sth.nhs.uk

Description of this hospital

The Jessop Wing is a purpose-built maternity unit where approximately 7,000 babies are born every year.

In addition to a 16-bed labour ward, there are 2 postnatal wards and one antenatal ward, a labour ward triage area and an acute obstetric care unit. One of the postnatal wards specialises in caring for women who have had a caesarean section. In addition, the Jessop Wing community midwifery service supports an average of 97 homebirths per year.

The Jessop Wing also provides neonatal intensive care and special care for sick and premature babies and also an assisted conception unit.

Maternity

Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

Staff did not keep up-to-date with their mandatory training.

Data provided by the service showed that 87% of midwifery staff had completed mandatory training against a service target of 90%. We asked the service what impact COVID-19 had on training schedules and were told that all training had been changed to virtual training. During this inspection we were advised that most areas of training were returning to face to face sessions.

Multi-disciplinary training stopped during the pandemic. Evidence showed the service had been providing virtual practical obstetric multi-professional training (PROMPT) since January 2021. At the time of this inspection, there was evidence, face to face multidisciplinary team (MDT) training had re-commenced which was line with best practice guidance.

The documenting, recording and observation of CTG was also identified as a breach in regulation at our previous inspection in 2015. We found this continued to be a concern during this inspection. Compliance rates with CTG training were 81% for midwives and 78% for medical staff as of October 2021 against a target of 90%.

Safeguarding

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

Midwifery and medical staff received training specific to their role around how to recognise and report abuse. Obstetrics, gynaecology and neonatology safeguarding training 2020-21 safeguarding adults training compliance rates were 100% and for children, were 100% against a target of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service followed the Family Common Assessment Framework (FCAF) (incorporating threshold of need guidance) and referral to the local safeguarding hub. The service aimed to commence the FCAF at approximately 16 weeks gestation and set targets of assessment completion within 35 working days. However, recognised further assessment may be identified.

Safeguarding adult and children policies were in place in line with intercollegiate guidelines. However, although the safeguarding adults' policy was in date, the children's policy had recently been updated and awaited ratification at the time of inspection.

Staff had access to practice guidelines such as, but not limited to, female genital mutilation, domestic abuse, referral to the local safeguarding hub, management of substance misuse in pregnancy: identification and provision of care and substance misuse in maternity: care of the baby.

Our previous inspection highlighted that there had not been a recent baby abduction drill. During this inspection we were informed that the baby abduction drill had taken place. We were not informed of any learning or improvements from the drill. However, were informed that baby tagging procedures had been effective.

Cleanliness, infection control and hygiene

Staff did not consistently use control measures to protect women, themselves and others from infection. The equipment and the premises were visibly clean.

Infection, prevention and control audits were undertaken across the maternity department on a monthly and quarterly basis. However, the approach to the audit process was inconsistent and unreliable due to the extensive variability of audit sample size across the maternity department.

Hand hygiene audits between April and September were 100% for the consultant led labour ward, neonatal unit, and Rivelin ward. However, there was no consistency in the number of observations undertaken for the percentages to be quantitative, for example the audits did not state how many observations were undertaken to reach 100% outcome. One ward noted 10 observations for June and July, another noted seven observations for April; 15 for May, and ten for June and July. We were not assured of the exactness of the hand hygiene audits as there were 19 audits provided which did not state the number of observations undertaken to reach 100% compliance. The Norfolk ward met the hand hygiene target of 90% with scores varying between 91.6% July and 95% in June 2021. There had been no audit undertaken in September and there was no evidence supporting how many observations had taken place in June or July 2021.

Whirlow ward had undertaken two hand hygiene audits between April and September 2021 and these were in July and August. Scores of 100% were achieved on both audits. However, there was no evidence supporting how many observations had taken place.

Audits highlighted that the midwifery-led labour ward had not undertaken any IPC audit since May 2021. Whirlow ward had not undertaken audits in May, June or September. This included audits of aseptic technique, cleanliness, dress code, handling and disposal of linen, central venous catheter care, peripheral intravenous catheter care, urinary catheter insertion, clostridium difficile risk reduction, and standard precautions. This suspension had been approved by the service; however, it is noted that most wards of the Jessop Wing continued to monitor IPC to varying degrees.

We saw that staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. ‘I am clean’ stickers were visible on all freestanding equipment, doors etc.

Staff had good access to PPE, and we observed staff wearing appropriate PPE at the time of the inspection. We observed adequate supplies of hand gel and sinks available.

We observed that not all were bare below the elbows and witnessed staff (nine) of all levels wearing watches and rings containing gems, whilst attending the ward areas.

Furnishings appeared clean and well-maintained. Cleaning and decontamination of equipment audits showed that checks were continued throughout the pandemic (2020) for most wards and all wards undertaking the audit had achieved 100% compliance. However, there was no evidence of the completion of cleaning and decontamination of equipment audits on Whirlow ward between April and September 2021. The audit was completed on Norfolk ward in June and July 2021 only.

Environment and equipment

Staff were trained to use equipment, but it was not always readily available or checked as often as required. Staff managed clinical waste well.

There had not been a baby abduction drill carried out prior to the inspection in March 2021, however, we were told a drill had taken place since.

During our previous inspection we observed women waiting for lengthy periods of time on chairs in the corridor outside the labour ward assessment unit (triage) awaiting clinical assessment relating fetal concerns, which posed a risk to patients due to lack of space, poor environment, lack of equipment in an emergency and indicated lengthy delays. There was no process in place for appropriate trisge and women told us there were occasions when there were not enough chairs and they were left standing for long periods. The service had explained that the use of the corridor was necessary to appropriately socially distance women during the COVID-19 pandemic. During this inspection, although there was now a system in place to triage women, however we found that the process did not work due to staff shortages and our concerns remained. We found that there were occasions when there was no staff available to complete the triage tool in a timely manner.

During inspection we noted that resuscitation trolleys were inconsistently checked on all wards and there were no check sheets available to view in theatres.

A re-audit (date unknown) of the labour ward and theatre resuscitaires had been undertaken by the service to assess if standards had been met since changes had been implemented following the previous inspection. The findings highlighted in the re-audit of documented checks of neonatal resuscitaires on the labour ward report dated 21 September 2021, highlighted 50% of resuscitaires had the green stickers present, 25% of resuscitaire items were present as per the check list, 88% of resuscitaires had items within expiry date, 95% of resuscitaires had a checklist attached and 30% of resuscitaires checklist had been signed in the previous 24 hours.

The service stated that the responsibility for the resuscitaires was handed to the labour ward from the ‘resuscitation officer’ who was involved in overseeing compliance with the standards prior to this (2017). The service also stated that it “appears [that] for a time there was no single person who took overall responsibility for this aspect”. During this inspection we found that a ‘resuscitaire champion’ midwife role was allocated to a band 7 labour ward midwife and more recently a clinical safety lead on the labour ward who oversaw the resuscitaires as part of the new role.

There was an adult resus trolley on the postnatal wards, boxes for post-partum haemorrhage (PPH), cord prolapse, and anaphylaxis were available. Adult resus trolleys were checked and observed to have everything present, equipment was working, and nothing had exceeded its expiry date. Monthly checklists were all present and fully completed. There were no issues with tag ID checks.

We observed that the theatres resuscitation room cardiac arrest trolley had no checks and no attached check list.

The neonatal resuscitation trolleys held in theatres were checked by the neonatal team, however, there was no assurance for the labour ward staff if or when they were checked as the paperwork was held elsewhere.

Staff disposed of clinical waste appropriately.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks.

Whilst on inspection we saw some women waiting in excess of one hour to be seen. We observed that there remained a lack of 'wait time' monitoring in the assessment unit. The service clarified that they do not currently record the waiting times for a medical review within day care areas.

During the previous inspection, CQC identified that the service had no process to prioritise women. During this inspection we found that the tool had since been developed but was not used consistently due to staff shortages. The service had audited the labour ward prioritisation tool and found that over the 4 week period (August 2021 to September 2021) 1206 women attended LWAU and 861(72%) had a rapid review and prioritisation RAG rating applied. The range from week to week dropped from 82% in the first week to 65% in the fourth week.

We were informed that There had been considerable staffing challenges since the previous audit results were published and it was felt this had contributed to the reduction in compliance. The LWAU required at least two midwives at all times, one to prioritise on arrival and one to continue care and maintain flow. We were advised that further work was planned to relook at LWAU architecture, staffing and process of working.

Data supplied by the service showed the rate of post-partum haemorrhage at Jessop Wing for September 2021 was 4%, which was an improved figure on previous months of 5.6% (August) and 6.3% (July).

Our review, in March 2021, of incident reports and Health Safety Investigation Branch (HSIB) recommendations showed that staff were not interpreting, classifying or escalating CTG appropriately. Documentation on CTG was poor and not in line with NICE guidelines [CG190]: Intrapartum care for healthy women and babies (2017). Our findings during this inspection continued to support these concerns. We reviewed 15 full sets of records and found variations in the quality of documentation of CTG.

An internal CTG audit undertaken by the service highlighted the following findings:

- Three standards improved since the last audit (date unknown), two remained the same at 100% and one new standard was 100%. These related to recording the name, securing the CTG paperwork in the file, and labelling correctly.
- 31% (4/13) standards decreased since the previous audit, with one dropping below 25%, these included: obtaining a second opinion, and hourly assessments being documented in records
- Five standards were 25% or less, including four repeated standards and one new standard: These included dating the CTG, recording start and end times completion of the hourly CTG sticker
- The audit showed that the Intrapartum Review tool sticker was fully completed in 53.9% of cases, the top row of the sticker was often left blank and/or the 'fresh eyes' section (not signed). Sticker not used at all - in 23% (9/40) of cases.

We requested the previous three months CTG meeting minutes, however the service was unable to provide these as they intended to reinstate these regular learning meetings during November 2021 and CTG would be included as a topic in these meetings, led by the obstetric fetal safety lead. Despite CQC identifying risks to managing deteriorating patients during the previous inspection in March 2021, the CTG meetings had not been in place, so the service could not be assured that they were managing patients in line with best practice.

Despite fetal monitoring being identified previously in our 2015 and March 2021 inspection, recommendations from national guidance and the findings from the HSIB investigation, this inspection highlighted that the service continued to lack urgency and pace in implementing actions and recommendations to mitigate these risks, therefore exposing patients to risk of harm.

Managers worked to keep the number of delays to a minimum by using the red flag system. If a midwifery red flag event occurred the midwife in charge of the service or shift would be notified. We observed that red flags were recorded. A red flag event would be one of the following, for example, if there was a delayed or cancelled time critical activity, missed or delayed care, missed medication during an admission, delay of more than 30 minutes in providing pain relief, delay of 30 minutes or more between presentation and triage, full clinical examination not carried out when presenting in labour, delay of 2 hours or more between admission for induction and beginning of process, delayed recognition of and action on abnormal vital signs, or any occasion when one midwife was not able to provide continuous one-to-one care and support to a woman during established labour.

The service recognised that data provided did not reflect the full list of red flags described in Safe midwifery staffing for maternity settings NICE guideline (NG4) 2015 introduced nationally six years previous.

The red flag reportable areas and plans to extend the current process were identified by the trust as:

- Delayed or cancelled time critical activity incidents are reviewed through the rapid review process of emergency procedures.
- Full clinical examination not carried out when presenting in labour will be monitored through the audit of records. A new tool has been recently introduced that captures this information at the point of admission.
- Missed medication and delayed recognition of vital signs are measures that the service are introducing with the installation of the BR+ tool on the inpatient areas.
- Delay of providing pain relief is a work stream that the service is just commencing in response to a thematic review of recent complaints.

This was to be included in the reassessment of the red flag data collection.

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in detecting the seriously ill and deteriorating. The MEOWS chart was used to enable early recognition of deterioration; advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016).

Audit results showed that 90% of women had a paper MEOWS chart completed, 100% of women had observations completed on the eWhiteboard and 50% of women had the information recorded on both paper and eWhiteboard. The service concluded that the overall compliance for the electronic recording of MEOWS was 80%. The service stated that

the results showed that electronic recording of MEOWS in the inpatient areas exceeded the recording of paper MEOWS documentation. Both the medical records and eWhiteboard records of each patient within the cohort were reviewed to determine whether MEOWS recordings were recorded correctly electronically. A total of 30 sets of records were audited by the service.

However, the service advised they undertaken a retrospective audit which was and reported on it during February 2019. The audit looked at a random sample of maternity patients who were inpatients on Norfolk, Whirlow and Rivelin wards during June and July 2018. This demonstrates that there had not been an up to date audit undertaken prior to COVID-19 in January 2020, and there had been no assurances in place to monitor or assess compliance with the MEOWS guidelines.

We were informed by staff that there were often difficulties requesting additional assistance when women's health was deteriorating. Staff told us that there were occasions when they would 'bleep' for medical assistance on more than one occasion before assistance arriving. We were also told on multiple occasions that there were instances where an emergency call buzzer would be pulled after receiving no response to multiple bleep calls. The service advised that the urgency of the bleep response was dependent on the presenting clinical scenario. We were told that if a response was not 'reasonable' this is escalated to the most senior person on call and/or the duty matron. In the case of a deteriorating picture then a 2222 (emergency call) is initiated. We were told that delayed responses were monitored via the Datix incident reporting process. However, we were unable to evidence this on NRLS.

We found that staff did not always complete risk assessments for each woman on admission / arrival, using an assessment of risk tool, review it regularly or after any incident. We reviewed 15 sets of records and did not identify a risk assessment or SBAR (Situation, Background, Assessment, Recommendation) tool or similar, in any paper or electronic record. As a result, we found that shift changes and handovers did not always include all necessary key information to keep women and their babies safe.

The liaison mental health team provided mental health assessment and care to inpatients and people attending the emergency department. The team was made up of mental health nurses, support workers, psychiatrists, social workers and administrative staff and is run by the local mental health service. Out of hours urgent ward issues could be discussed with the on-call SHO, Registrar and Consultant within the local mental health team, as required.

Midwifery staffing

The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

We were told that the midwife to birth ratio was displayed on the maternity dashboard, which was discussed at a forum within the service, including the board of directors, and also shared with the Local Maternity and Neonatal System (LMNS).

The most accurate measure of midwifery staffing is highlighted when considering one to one care in labour. We saw red flag data which showed between April and September 2021 there were 20 occasions where midwives were unable to provide one to one to one care in labour. However, one to one care in labour figures were not included as a measure of quality in the maternity dashboard.

The midwife to birth ratio for July 2021 was 1:30, August 2021 was 1:31 and September 2021 was 1:32. This does not meet with national guidelines of 1:29. This ratio is calculated by dividing the total annual births by the total staff in post establishment for clinical midwives (excluding midwives in education, governance, management, specialist posts).

Maternity

We were advised that the service was aiming to meet the mean national ratio of a midwife: birth ratio of 1:29 for hospital births and 1:35 for home births (working with Birth Rate Plus©) and was actively recruiting to achieve that. Staffing for October 2021 was due to increase by 11.4 whole time equivalent (WTE) with the recruitment of both newly qualified midwives and experienced staff.

The service had a nursing and midwifery staffing escalation policy in place. The policy detailed how to address any shortfalls in staffing, for example, unexpected absence. An escalation approach via the senior nurses and midwives on duty or relevant on-call teams was clearly defined. Ultimately, if a significant midwifery problem remained unresolved; the chief nurse would be contacted. There was a series of systems and processes in place that operated 24 hours per day, 365 days per year to manage staffing levels. A daily nurse staffing meeting was said to be embedded; the meeting was chaired by a nurse director, deputy nurse director, matron and considered the plans for staffing over the following 24-hour period.

During our previous inspection, we found that the service was not following the Birth Rate Plus report staffing recommendations of an average of 90% registered midwives to 10% maternity support worker (MSW) for maternity. This inspection highlighted that the service is continuing to work towards, but have not yet achieved, an average of 85% registered midwives to 15% maternity support worker (MSW) for maternity. We were told that Birth Rate Plus data was reviewed weekly and triangulated with staffing and incident reports via the service's incident reporting system and that the responses to red flags were monitored to ensure safety was maintained.

The Jessop Wing had been using Birth Rate Plus and intrapartum acuity to capture real time data of labour ward acuity since 2016. Within the live acuity tool was the use of a red flag system, which was reported on a four hourly basis as recommended by Birth Rate Plus and National Institute for Health and Care Excellence (NICE) guidelines. Once a red flag incident had been triggered, the responsive action taken was recorded in real time. A midwifery red flag event was a warning sign that there may be concerns with midwifery staffing levels. If a midwifery red flag event occurred, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing was the cause, and the action required. We discussed the red flag system with ward staff and found that most struggled to verbalise the processes. We lacked assurance that the process was robust and embedded. We found this at both the March and October 2021 inspections.

We were told that Birth Rate Plus data was reviewed weekly and triangulated with staffing and incident reports via the service's incident reporting system and that the responses to red flags were monitored to ensure safety was maintained. However, the number of actual midwives and care staff did not match the planned numbers. We saw evidence provided by the service the unit as a whole was consistently short on care hours per patient.

Following the inspection we requested the most recent formal birth rate plus assessment carried out by BR+ but the service were unable to supply this, and provided the report complied by the midwifery director using the principles of the Birth Rate Plus.

Data reviewed following our inspection showed that between 01 April and 01 October 2021 a total of 35 patient safety incidents had been raised due to lack of suitably trained / skilled staff, examples in relation to midwifery staffing was*:*

- "unable to do traffic light prioritisation as only one midwife in triage after 15.00pm"
- "staff have been moved to various areas leaving ward understaffed on most occasions for last couple of weeks. All wards on level 3 reduced midwifery staffing to 2 midwives in afternoon.
- "Very unsafe staffing levels on labour ward".

- “Staff member needed to be taken to CLC unable to prioritise workload due to unsafe staffing - i.e. fetal monitoring not completed on time / drugs and observations late”.

During this inspection, we found that ward coordinators were not supernumerary. They were counted in the numbers for the floor, which gave an inaccurate picture of the staffing on duty and not deemed to be adequate against the number of patients or level of acuity.

Managers preferred to use their in-house bank and recruited agency staff as a last resort. When agency staff were used, familiar staff were requested for each service. We were not assured that agency staff had a full induction and understood the service.

Patient feedback also highlighted concerns about staffing levels and the lack of time for staff to give information and support. There was acknowledgement that staff were doing their best but stretched too thinly. We received one description of “dangerously low staffing levels”.

The service was one of the first maternity units in the country to successfully implement an apprenticeship scheme for maternity support workers (MSWs). A cohort of 11 MSWs completed the 18-month senior healthcare support worker level three apprenticeship. Combining practical hospital experience with learning at a local college, the apprenticeship offered the opportunity to gain skills and knowledge specific to maternity care. The scheme was supported by the Royal College of Midwives.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep women and babies safe. There were 6155 births in 12 months to October 2021 with 17 obstetricians in post. The ratio of consultant to birth was 1:362 per annum. This falls within national guidelines. However, we found that there was a high level of long-term locum usage to fill rotas.

The Jessop Wing is a tertiary centre specialising in caring for complex pregnancy and childbirth. As a consequence, complex births from around the region transfer to Jessop Wing resulting in a very high acuity of patients. Patient acuity can be defined as the intensity of care provided to a patient by a registered nurse (Habasevich, 2012). We were informed during our interviews that the service required two additional obstetricians to manage acuity levels. These positions had been advertised but not successfully filled.

Jessop Wing was staffed Mon-Fri with two anaesthetic consultants and at least one trainee or one consultant and at least two trainees (one of which will be senior/experienced). There was a resident consultant anaesthetist presence Monday to Friday 8am to 6pm. Outside of these times there was a non-resident consultant on-call. There was night cover Monday to Friday 6pm to 8am and at the weekend was 8am to 8am. No gaps in the on-call rotas were identified between 01 July 2021 and 06 October 2021.

The service had one resident consultant 8am to 8pm 7 days per week. Sunday to Wednesday 8pm to 8am there was one resident consultant (with a registrar) and a non-resident consultant. Thursday to Saturday 8pm to 8am the service had a non-resident consultant (with a senior registrar and a junior registrar resident). There were no consultant gaps between 01 July 2021 and 06 October 2021.

The theatre staffing rotas showed a significant number of unfilled shifts for both obstetrics and gynaecology across the months of July, August and September 2021. This included both registered, unregistered and supernumery staffing.

Managers frequently accessed locums when they needed additional medical staff. However, we were advised that locums did not always receive a full induction to the service before they started work.

There was an operational process to cover absence. We were told that from Monday to Friday the clinical administration team used the 'How to manage client activity standard operating procedure (SOP)' to ensure the emergency services, including the elective sections, were prioritised if an absence was reported.

Records

Staff did not always keep detailed records of women's care and treatment. There were multiple systems in place for staff to document in, which led to reduced oversight of patient care. However, records were stored securely, and most were available to staff providing care.

We reviewed 15 women's records during the inspection and found that records were held on multiple systems which did not flow effectively. To have a full overview of a woman's records staff had to access different systems, for example, community records were in the form of a booklet stored on a file, medication and pain relief was held on an electronic prescribing system, other information was held on a second electronic system and additional information was seen to be on single loose sheets not always secured in the file, such as yellow Venous thromboembolism (VTE) assessment.

During our previous inspection we found that when women transferred to a new team, the antenatal records had not always been incorporated within post-natal records. It was highlighted in an HSIB report that there has been occasion where 'There does not appear to have been a dynamic approach to capturing and managing the risks relevant to the mother across the maternity pathway. Risks from previous pregnancies, antenatal and intrapartum care … [were] documented in different formats. The clinicians caring for the mother were not aware of the full clinical picture'. We continued to find the same concerns during this inspection.

Further HSIB recommendations stated, 'the service to ensure that all antenatal assessments and identified risk factors are fully documented in the patient records in line with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) standard'. We did not see evidence to provide assurance that the service had acted on this recommendation at the March or October 2021 inspections.

During our previous inspection we observed that the application of the 'fresh eyes' approach had newly commenced, the process was not embedded, there was no continuity in practice, and not all records had 'fresh eyes' noted in records. During the inspection we reviewed five CTGs (Cardiotocography)and found that fresh eyes was still not embedded, that application of fresh eyes was inconsistent, they were not undertaken in line with national guidelines, and in two out of the five cases, fresh eyes was not undertaken at all.

We reviewed National Reporting and Learning System (NRLS) and found that, between 01 April 2021 and 01 October 2021, 25 incidents had been recorded relating to documentation (including electronic and paper records, identification and drug charts) and six breaches of confidentiality had been reported. Four of the six incident related to the misfiling of patient information. All were graded as no harm incidents.

Maternity

The service internal audit comprised of reviewing 30 sets of medical records of postnatal women which were randomly selected in April/May 2021 and assessed against the audit standards. Findings showed that 100% of women were assessed for VTE in pregnancy, 83% had a Partogram, 84% held an Intrapartum CTG review tool sticker (including fresh eyes) and 100% of any risks identified in a RA were escalated

Maternity records were stored in the midwife's office, within the maternity unit. The records where not locked during our inspection; however, records were in constant use.

Medicines

The service used systems and processes to prescribe, administer and record medicines. However, they did not always manage medicines appropriately.

Following the previous inspection, we made a recommendation that the service should ensure that there is a robust system in place for the safe prescribing and administration of all ongoing medicines for maternity in-patients. However, during the inspection we saw there had been minimal improvement.

We reviewed NRLS and found that, between 01 April 2021 and 01 October 2021, 36 incidents had been recorded relating to medication. Of the 36 incidents reported, 13 related to missed drugs (of which 3 were insulin), 15 referred to the wrong medication being administered, and five related to incorrect recording of medication given or required.

We reviewed the expiry dates of medicines on all areas we inspected and found epidural trolleys and other emergency trolleys contained out of date drugs, (which had been signed to say that they had been that day), the hypoglycaemic kit had expired, and some controlled drugs stored in a CD cabinet were out of date. We were told there were three monthly pharmacy audits undertaken.

Emergency medicines were stored centrally with ease of access for staff. During the inspection we reviewed the post-natal ward post-partum haemorrhage (PPH) box and found no concerns. All drugs according to checklist were in the box, in date, tags checked, and matched check sheet. However, the PPH box was untidy and disorganised.

We observed the controlled drug (CD) stock control book contained both patient and ward stock. The book was not clearly defined as to who the drugs belonged to and when the remainder of drugs were destroyed or given to the patient on leaving the ward. This meant that there was not a suitable control system in place for the management of controlled drugs,

Incidents

The service did not always manage patient safety incidents well. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there was concerns that there was a lack of transparency.

We were advised in March 2021 that the SIG would decide if an incident would be declared as an SI or not, then reported to the National Reporting and Learning System (NRLS) system. This delayed the incident reporting process, which was contrary to the serious incident framework requirements of reporting within two working days. We found there continued to be a delay in reporting incidents

Maternity

We reviewed NRLS and found that between 01 April and 01 October 2021 there were 592 incidents reported of which nine were reported as severe, five were reported as moderate harm, 69 low harm and 509 no harm. We were not assured that patient outcomes and the grading of incidents matched the impact or potential impact of harm to the patient or staff member.

After speaking with staff, we were aware of two further serious incident that could not be found on the NRLS system. Therefore, we did not have assurance that all incidents or serious incidents were investigated, the root cause identified, and that lessons were learnt.

NHS Improvement (2017) Learning from Deaths states "Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly". During our previous inspection we found that all cases had been considered by the service's internal serious incident group as potential serious incidents, but none had been declared as a serious incident. During the inspection we saw that the service continued to review cases at the internal serious incident group. We found that although reporting had improved, it was not timely.

Following our previous inspection, the service updated the escalation process 'incident management policy-including the management of serious incidents and never events.

The policy now reflected any actual or suspected serious incidents or never event to be escalated to the healthcare governance team within one working day of identification. We reviewed serious incident (SI) process for maternity services and due recommendations following our previous inspection, there were 15 serious incidents reported by the service between 01 April 2021 and 01 October 2021. All but four incidents were reported outside the serious incident timelines. Serious incidents were events in health care where there was potential for learning, or the consequences were so significant that they warranted using additional resources to mount a comprehensive response.

On inspection, we were informed all incidents were reviewed at the rapid review meeting prior to escalation at the service serious incident group (SIG). During our previous inspection we found that there were no terms of reference for the rapid review group, and there was no identification of when the meeting was quorate. However, during this inspection we were told that terms of reference were now in place and that all meetings were undertaken when quorate. We were unable to observe a review meeting as all were cancelled during this inspection. We were informed the meetings were cancelled as there was no incidents to review.

Staff said they understood the duty of candour process and would apologise to women if there had been an error in care. However, due to the inconsistency of the grading of incidents we could not assured that there was an open and transparent method which gave women and families a full explanation when things went wrong in all cases.

There were zero never events within obstetrics in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Maternity

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

All policies were in place and available on the intranet for staff to follow. However, not all were reviewed and up-to-date. We were informed that a benchmarking meeting took place to audit guidelines and to ensure that although out of date, they remained within national guidance. There was no documented evidence of the date the benchmarking was completed or an extension date for review added to the policies. CQC had no assurances that staff would not know the current practice/process to follow.

There is a perinatal mental health liaison service within the vulnerabilities team who attend the wards if needed, and when concerns are raised about a woman. The peri-natal midwives also follow up on discharge. There were mental health nurses and vulnerabilities midwives who provided support and referrals to mental health services when required.

Staff informed us that during handover meetings they routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed this during the inspection. We were also informed that when women were booked by community midwives, they were asked about history including any mental health needs. Family care assessments were also carried out with the community midwife, if required.

However, we did not find a formal monitoring of mental health in maternity. Staff ask women how they feel during routine observations and might note presentation on records, but there was not a formal assessment process or a formal risk assessment.

Nutrition and hydration

Staff did not always provide women with enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.

We observed women receiving adequate nutrition and hydration during our inspection. However, we received a concern about basic needs not being met, such as inadequate provision of food and drink. An example given was of a neighbouring patient giving someone the food and drink they required.

Women were welcome to bring their own food and drinks but there were no facilities available to re-heat any food. Women requiring something to eat between meals were offered snacks a small selection of items provide by the ward (for example fruit, toast, biscuits).

We observed women being given a choice of food and drink to meet their cultural and religious preferences.

We saw that leaflets were available on promoting healthy pregnancy, post-natal exercise, infant feeding plans for parents as well as breastfeeding and formula feeding guidance.

There were expressed breast milk (EBM) fridges on the postnatal ward for women to store milk for their baby. Women had access to the fridges as and when required.

Diabetes and pregnancy cards were available online which provide guidance on managing diabetes when planning pregnancy and actions to take when pregnant for example liaising with the diabetic antenatal clinic.

Pain relief

Staff did not always assess and monitor women regularly to see if they were in pain or give pain relief in a timely way.

Staff assessed women's pain using a recognised tool during labour and gave pain relief in line with individual needs and best practice.

Not all women reported receiving pain relief soon after requesting it. Women we spoke with and those who contact us independently, reported long delays in receiving analgesia during labour and postnatal care.

Several women spoken to following this inspection stated that understaffing on the ward had led to delays in receiving pain relief and antibiotics.

An independent review carried out by Healthwatch following our inspection found several women from a black and minority ethnic group were not being given the pain relief they asked for.

We did not see evidence of midwives monitoring the time between requesting epidural and receiving it.

There were minimal analgesia errors reported on NRLS between 01 April and 01 October 2021 suggesting that staff prescribed, administered and recorded pain relief accurately on the majority of occasions.

Patient outcomes

Timeliness of reviews and implementation of change was variable, which delayed improved outcomes for women.

The number of caesarean sections (CS) for this period is higher than the expected range. Caesarean section rate targets are based on England data for 2019/20 with no variation given for tertiary centres. The STH elective CS rate remains higher than the national average, however, has remained relatively stable. We were advised that the rates continue to be monitored and relate to complexity of the case mix and women's choice.

The service had a higher than expected readmissions than the England average. There were 181 unplanned maternal readmissions within 42 days between April 2021 and September 2021. The highest month for unplanned readmissions was July 2021 with 43. These figures do not include women returning to triage or 'healthy lodgers' (when the baby is on the neonatal unit and mother is required to stay).

The enhanced recovery protocol was an embedded practice within maternity services. There had been a sustained reduction in length of stay for elective caesarean sections. The percentage of women leaving the hospital the day after their elective caesarean has risen from just under 5% in 2013 to 33% in 2017. More recent data was not available at the time of the inspection.

We were informed that all neonatal deaths are reviewed by a multidisciplinary group using the Perinatal Mortality Review Tool. We reviewed four sets of perinatal mortality tools, none had any governance documented, minutes lacked detail and not all were complete with grading scores. As a result, we were not assured that there was a robust and embedded process in place.

Staff monitored the effectiveness of some care and treatment. However, they did not always use the findings to make improvements and achieve good outcomes for women.

Managers and staff carried out a programme of repeated audits to check improvement over time. Several audits and projects were undertaken by the obstetrics, gynaecology and neonatology directorate audit programmes. The service told us all projects had been through the service's clinical effectiveness committee and subsequent actions identified from the projects had been followed up to completion. All projects were now considered 'complete' and appropriate re-audits had been set or were already in progress. We were told the pandemic had interrupted some aspects of the audit cycle and national guidance had allowed some audit processes to be suspended.

We did not see evidence of information sharing or that managers made sure staff understood learning and improvements identified from the audits.

During this inspection we were provided with the service maternity quality dashboard. However, the dashboard did not benchmark against national indicators, nor did it provide target figures to achieve. There were no balances or checks for comparison and displayed more as facts of information than a dashboard or benchmarking tool.

The service used the dashboard template which was developed and supported by the local maternity and neonatal system (LMNS), this reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma),neonatal clinical indicators (cot acuity, preterm delivery), public health information and stats analysis. However, this did not cover all data in regional or national dashboards such as the monitoring of induction of labour. The service did not have a service specific quality dashboard to maintained oversight of the entirety of the care provided. The service participated in relevant national clinical audits. The service had contributed to the National Neonatal Audit Programme, MBRRACE UK (mother and baby: reducing risk through audits and confidential enquiries) maternal, newborn and infant clinical outcome review programme, National Maternity and Perinatal Audit and ATAIN (avoiding term admissions into neonatal unit) since the previous inspection.

The figures obtained during our previous inspection remained the same during this inspection as the audit programmes had not been repeated in the time frame between the two inspections.

The birth rate between 27 and 37 weeks as a proportion of all registerable births is higher than the expected level, which is likely to be related to STH's status as a specialist maternity centre. The birth rate between 24 and 27 weeks is at the expected level.

National Neonatal Audit Programme (information unchanged between March 2021 and October 2021 inspections)

In the 2019 National Neonatal Audit Sheffield Teaching Hospitals NHS Foundation Service's performance in the two measures relevant to maternity services was as follows:

Are mothers who deliver babies from 23 to 33 weeks gestation inclusive given any dose of antenatal steroids? (gestation range was 24 to 34 weeks on previous audit in 2017).

There were 159 eligible mothers identified for inclusion in this audit measure for your unit. Of the mothers with a recorded outcome, 96.9% were given a complete or incomplete course of antenatal steroids; this was above the national average, where 91.3% of eligible mothers were given at least one dose of antenatal steroids.

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

Maternity

There were 53 eligible mothers identified for inclusion in this audit measure for your unit. Of the mothers with a recorded outcome, 88.7% were given magnesium sulphate in the 24 hours prior to delivery; this was above the national average, where 82.1% of eligible mothers were given magnesium sulphate.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

For the perinatal mortality, the latest MBRRACE UK dad was published in October 2021 and was based on births in 2019. Based on this, the perinatal mortality rate was between five to 15% lower than the comparator group, and the rate excluding congenital anomalies was also between five and 15% lower than the comparator group. The service told us that data reported to MBRRACE UK at the time of inspection showed Sheffield Teaching Hospital NHS Foundation Service had better than expected notifications for perinatal mortality. The service had reported 3.65 (per 1000 births) notifications for perinatal deaths (still births and neonatal deaths) against an expected rate of 6.9 (per 1000 births) notifications.

Evidence provided during the inspection showed between 4% and 6.3% of births were complicated by an obstetric haemorrhage of over of 1500mls in the months of July August and September 2021. This was greater than the regional average.

National Maternity and Perinatal Audit.

The service has a higher than the national average rate for caesarean births overall, caesarean births (emergency), unplanned maternal readmission within 42 days and term babies with a five - minute Apgar score of less than seven.

Maternity Dashboard

From July to September 2021 the maternity dashboard data showed 12 stillbirths. However, it was not documented if these occurred antenatally or during labour or if there were any precipitating factors which led to the stillbirth.

The maternity dashboard did not include induction of labour data.

Maternity dashboard data for the hospital showed from July to September 2021 showed the average proportion of women who had a normal delivery experienced a third- or fourth-degree tear at the hospital was 2.4%. Over the same period, the average proportion of women who had an assisted delivery and experienced a third- or fourth-degree tear at the hospital was 3.9%. There were no trust targets (thresholds) for third- or fourth-degree tears displayed on the maternity dashboard.

From July to September 2021, 5.2% of the total number of births women experienced a postpartum haemorrhage of greater than 1500mls at the hospital. There were no trust targets (thresholds) for postpartum haemorrhage displayed on the maternity dashboard.

From July to September 2021 maternity dashboard data showed an emergency caesarean section rate of 18.8% which was worse than the national average of 15.8%. The elective caesarean section rate of 14.9% which was worse than the national average of 13.3%. The percentage of births by caesarean section for the trust was 33.7% which was worse than the national average of 29.1%. There were no trust targets (thresholds) for caesarean section displayed on the maternity dashboard.

Maternity

Competent staff

We were not assured the service made sure all staff were competent for their roles.

We reviewed NRLS between 01 April 2021 and 01 October 2021 and found 32 reports of lack of suitably trained / skilled staff. All 32 incidents were reported as no harm to patients. A training plan had been implemented to address training delays resulting from COVID-19. However, recognition of issues and implementation of action plans was not prompt or timely.

During our previous inspection we were made aware that there were no live skills and drills training, such as pool evacuation or simulations undertaken within the maternity unit. During this inspection, we were advised that live skills and drills training had recommenced.

Practical obstetric multi-professional training (PROMPT) training figures showed a medical staff compliance rate of 43% and midwifery compliance rate of 58.6% against a target of 90%. During the previous inspection we were informed that PROMPT, Multidisciplinary and CTG training was at 83% compliance rate.

Staff stated there was support available from the practice educators in developing and building their midwifery skills. However, many stated that they remained a band 5, rather than progressing to band 6 due to the lack of access to specialist tasks such as perineal suturing, and the administration of intravenous (IV) medicines.

During our previous inspection we were told that no additional training was provided for staff working in the Advanced Obstetric Care Unit (AOCU), which would be best practice. Midwives had not received additional accredited training in relation to seriously ill women in the AOCU, it was staffed by either the registered nurse (RN) or an experienced midwife. This meant, more junior staff did not have the senior support to develop their midwifery skills. These findings remained unchanged during this inspection.

During our previous inspection we were informed that managers gave new midwives a full induction tailored to their role before they started work. Staff were provided with a comprehensive induction and preceptorship logbook which provided information in relation to the preceptorship programme, what was expected of the staff member, linked strategies, each training element of the programme, and final sign off induction and preceptorship. However, there was no timeline or targets to achieve the competencies attached to the programme. Some members of staff had not progressed from band 5 for over five years.

In line with national policy the service had implemented the Advocating and Educating for Quality Improvement (A-EQUIP) system.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women.

During our previous inspection managers told us that staff held regular and effective multidisciplinary (MDT) meetings to discuss women and improve their care. The service provided evidence to support a collaborative working culture within the service which supported changes to pathways of care. Some of the improvements occurred formally through a number of forums i.e. labour ward forum, following publication of new guidance i.e. The Royal College of Anaesthetists Enhance Maternal Care Guidelines (2018) and following incidents in practice for example, joint working around neonatal hypoglycaemia and keeping babies warm in obstetric theatre.

A second example provided by the service in March 2021 highlighted improvement as a result of an RCM labour ward leaders workshop 'working together for safer care'. Members of the multi-disciplinary team (consultant anaesthetist, obstetrician, obstetric trainee, two labour ward co-ordinators and the consultant midwife) discussed and developed a standardised handover designed to maximise and embed a patient safety culture, as recommended by National Patient Safety Agency (2004). 'Focus 15' was developed, this was a set of key principles, including team introductions and a process for a protected 15 minutes of handover. All members of the multi-disciplinary team (MDT) had signed up to the principles and values. To embed this, a banner was developed which informed everyone that a protected handover was occurring. This remained unchanged this inspection.

MDT minutes provided for review highlighted minimal information was discussed for example, the fetal medicine MDT Minutes 26th May did not provide assurance of a comprehensive multi-disciplinary discussion with some patient details only containing one line of reference. There were no plans to re-convene until August 2021. Although more comprehensive, the August fetal medicine MDT Minutes did not evidence MDT input. The meeting was well attended but it was not clear the role of each attendee, their contribution to the meeting – evidence of discussion, any action plans or lessons to take forward.

Staff worked across health care disciplines when required to care for women. We saw evidence of cross agency working by means of the Yorkshire and Humber (Y&H) maternity focus group which ensured the core set of indicators relevant to maternity services in the Y&H region were reviewed. It provided a forum for identifying themes and cross networking.

During this inspection and within the data reviewed, we saw no evidence of staff referring women for mental health assessments when they showed signs of mental ill health, including depression. However, the service stated they did provide a dedicated mental health nurse who works in the service and carries out perinatal mental health clinics.

During the well-led inspection in November 2021, we reviewed patient records and found post-natal plans in place with good multi-disciplinary working evidenced. There had been a referral made to peri-natal services, but the referral was refused as not meeting the criteria. We also found that there was no mental health risk assessment or monitoring tool in place, and no escalation plan included.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway they required.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The smoking cessation midwifery team offered a bespoke service to women and their families. The service offered intense behavioural and psychological support. Since being established the services smoking at delivery rate has improved from 23% to 12.1% in 2017. However, data showed that improvement had continued, and service data reported that 9.6% of women remained smoking at the time of delivery in September 2021.

Maternity

Figures show that the breastfeeding initiation rate in September 2021 was 78% and the number of woman continuation to breast feeding on discharge was 72%. These figures remained stable over the previous three months.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle including public health initiatives such as obesity, and diabetes.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

We were not assured staff knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

We were not fully assured that all relevant staff understood the appropriate consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff were not up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw that training was at a compliance rate of 28% for medical staffing and 20% for midwifery staff having completed MCA and DoLS training.

Staff had gained consent from patients for their care and treatment. However, staff did not consistently record consent in the woman's records.

Staff could describe and knew how to access policy and get advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

We were not assured that managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Requires Improvement

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

Compassionate care

Staff did not always treat women with compassion and kindness, respect their privacy and dignity, or take account of their individual needs.

The friends and family (FFT) score for July 2021 was 74%, below the internal target of 95%. Response rates remain low and the service have advised that the use of feedback cards will be reintroduced once they have been re-established within inpatient areas. It was also stated that the patient experience team would be reviewing whether this had a positive impact on the number of responses and the scores across maternity services. The national maternity survey was currently underway. The service advised that the results of the survey would be used to inform future improvement work.

However, patients we spoke independently said that staff did not always have time to interact with women and those close to them. Patients said there was a lack of continuity with midwives.

A woman stated that “basic dignity and care have gone out the window” and that “women [were] not being cared for”. Another example shared with us following inspection stated that a woman was ‘left naked holding her baby, left with a dirty body in a dirty bed. Covered in bodily fluids and couldn't reach the buzzer or phone’.

Stakeholder feedback identified reports of women stating they had experienced a lack of compassion, with care falling short of expectations. One person described “a lack of experienced staff’ which they felt had made the birth longer and harder than it should have been.

Many formal complaints raised concerns about lack of care and compassion. We reviewed the last three months of complaints and found examples of women raising concern about being spoken to inappropriately, rude and abrupt responses, lack of support and guidance

Most women said staff treated them well and with kindness. Women we spoke with during our inspection reported having a positive experience with helpful and supportive midwives.

Even where negative experiences were reported, most people had something positive to say about their care during labour and birth, and overall, more positive experiences were shared about labour ward care than for antenatal and postnatal care.

We observed several thank you cards on the ward which said:

- “Thank you so much for looking after me on my stay and for delivery of my daughter”. You are all amazing under such clearly stretched resources”.
- “Thank you for all that you do”
- “Thank you for going above and beyond”
- “Thank you so much for everything during my induction. Your standard of care was amazing”.

We saw evidence of personal choice and religious preferences recorded on the tearoom boards.

Emotional support

Staff did not always provide emotional support to women, families and carers to minimise their distress. However, they did understand women's personal, cultural and religious needs.

Staff were able to access bespoke bereavement support for women and their families when required. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There was access to appropriate bereavement rooms for families.

We observed a member of staff support a woman who became distressed in an open environment and helped her maintain her privacy and dignity.

Staff said they understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Maternity

We observed an instance where a woman was inappropriately placed on an incorrect ward due to bed shortages. No action was taken in a timely manner and after several days the woman remained inappropriately placed. Understanding and involvement of women and those close to them

Understanding and involvement of patients and those close to them

Staff did not always support and involve women, families and carers to understand their care and treatment.

We observed staff ensuring women and those close to them understood their care and treatment during our inspection.

However, feedback from patients said that there was a lack of contact, and lack of information, disjointed care, with lack of opportunities to ask questions. Other feedback stated that "sometimes it is not clear that women have a choice about something during labour", and that "they are guided into agreeing with something by midwives using particular language and behaviours".

Feedback we received highlighted that continuing COVID-19 restrictions meant that the Jessop Wing was only allowed one birthing partner until the 02 November 2021. This prevented doulas or others access to provide support. We found this had added additional distress for those women experiencing complex births and their wish to have their spouse / support present prior to delivering their baby. The decision to continue tight restrictions on the Jessop Wing was not in line with national guidance and was far more restrictive.

Staff were able to talk with women, families and carers in a way they could understand, using communication aids where necessary.

Women and their families could give feedback on the service and their care and treatment. Formal complaints we reviewed stated many times that women were not always listened to, were "encouraged and felt pressured to have a caesarean section", which caused undue distress.

One woman stated ''as a black woman I felt I was dismissed, and my concerns were not taken seriously''. Three women described very similar themes of not being taken seriously and having their concerns dismissed.

Is the service responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people

The service worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.

Staff could access emergency mental health support from a neighbouring service 24 hours per day, 7 days a week for women with mental health problems, and learning disabilities.

Services were in place to help care for women in need of additional support or specialist intervention such as diabetes, endocrinology, haematology, neurology, rheumatology, renal and cardiac.

The Jessop Wing had disabled access and there were facilities for disabled people. However, we were informed of two occasions when carers were unable to support their partners before and after the delivery of their baby due to Covid-19 ward restrictions. This included wheelchair users.

Meeting people's individual needs

The service was not always inclusive of women's individual needs and preferences. The service was limited in the adjustments made to help women access services.

Staff tried to support women living with mental health problems, and learning disabilities. We were not assured that all staff knew how to refer to the most appropriate service or due to reduced staffing, have the capacity to do so.

We saw there was no specialist midwives for women who were identified as vulnerable for example teenage mothers and those from disadvantaged groups. Staff told us this was the purpose of the continuity of carer model. Continuity of carer was a model used in some maternity services to limit the number of different healthcare professionals a woman sees throughout their pregnancy, labour and postnatal period. However, at the time of our inspection we were informed continuity of carer had been suspended due to the challenges in midwifery staffing.

Staff understood the policy on meeting the information and communication needs of women with a disability or sensory loss.

Women, their loved ones and carers could not always get help from interpreters or signers when needed. We told of examples where family members were acting as interpreters. This is not deemed good practice.

The service had information leaflets available on the wards, but all were in English. We saw 44 available language options available on the service website, including an easy read version. Staff knew how to access these.

Following this inspection, we were contacted by a patient who had a neurological condition. They advised us that they were informed that the service had told them it was not equipped to meet their needs, as a result, the patient felt they needed to self-discharged to be cared for appropriately.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times were not monitored in line with national standards.

Information provided by the service showed that between April and September 2021 there were 273 occasions where a red flag event was declared for a delay in commencing or continuing the induction of labour (IOL) process. We also saw during the same time period there was a delay in eight delays in elective work.

During our inspection we saw several women who waited a significant amount of time to be seen in the LWAU. Data provided by the service showed that between 30 August and 27 September 2021 34% of women were triaged and their care prioritised within 30 minutes of their arrival. We saw 60% of women were seen and triaged within one hour 40% women waited over one hour to be triaged and their care prioritised. We sought clarity from the service as we recognised the percentages totalled more than 100%. We were told the initial metric on women seen within 30 minutes

incorporated with the women triaged in one hour, in essence this meant 26% percent of women were triaged and their care prioritised between 30 minutes and one hour. It was recognised by the service that the prioritisation tool had limitations, due to poor staffing as the process required two midwives; one to undertake the assessment and one to maintain flow within the LWAU.

The service did not monitor the time women spent in the LWAU and the time they waited for review. We saw evidence of one woman who was in labour and reported to wait over one hour to be assessed on the LWAU before being moved to a delivery room.

Daily situation reports (sitreps) highlighted that from 02 and 19 October 2021 there were between seven and 13 women waiting to be admitted to labour ward for induction or augmentation per day. During the same time period between two and five women were booked to attend the antenatal ward to begin their induction of labour. We also saw there were between four and 13 women who had been waiting for over 24 hours for their induction in addition we saw one day there was three women who had waited five days and one woman waiting four days for induction of labour. We also saw evidence where one woman who had spontaneous rupture of membranes and had waited 62hrs for induction of labour. NICE guidance [NG207] stated women who have had pre-labour rupture of membranes should have their labour induced 24 hours because prolonged pregnancy at term after rupture of the membranes can increase risks to the baby.

From 03 and 26 September 2021 there were between eight and 21 women waiting to be admitted to labour ward for induction or augmentation per day. During the same time period between two and eight women were booked to attend the antenatal ward to begin their induction of labour. We also saw there were between four and 18 women who had been waiting for over 24 hours for their induction. In addition we saw evidence that women had waited over 80 hours for induction following pre-labour spontaneous rupture of membranes, women who were 40 weeks and 15 days for induction NICE guideline [NG207] identified there was evidence that caesarean birth, perinatal mortality and neonatal intensive care unit admission are reduced by earlier induction of labour (at 41+0 weeks) compared to later induction (at 42+0 weeks or after). We also saw evidence where a woman with gestational diabetes had waited seven days for induction of labour and was 40 weeks and 4 days pregnant, a delay in delivery can increase the risk of stillbirth.

Data provided by the service showed that between May and October 2021 we saw the average induction of rate was 21.4%. We saw the lowest rate was 16.9% in September and 27.4% in May. This was better than the national of 34%.

Managers and staff worked to make sure women did not stay longer than they needed to. Staff told us that women were signed off as safe for midwifery led care by doctors before discharge. Paediatric reviews were completed as required and information was shared with women about safe sleeping, feeding, things to look out for in baby and also things to watch out for in themselves, prior to discharge. During pre-discharge talks with women, leaflets with emergency contact numbers were provided.

From April and September 2021, the service provided evidence which showed there were 181 unplanned maternal readmissions within 42 days between. The highest month for unplanned readmissions was July 2021 with 43. We were told these figures did not include women returning to triage or when the baby is on the neonatal unit and mother is required to stay. We were not assured the service had a grip of the numbers of women who were readmitted to the service and if it was preventable.

Maternity

Jessop Wing maternity unit had not closed to admissions in the three months prior to this inspection. In order to keep their service, open the service stated that they utilised all escalations available to them, such as transferring low risk women waiting for induction of labour to neighbouring NHS trusts, pausing continuity of carer and on occasions suspending the home birth service. There were 11 women transferred out to other hospitals between July and September 2021.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. The service did not always include women in the investigation of their complaint.

The Jessop Wing received 29 complaints between 13/08/2021 and 02/11/2021. We found that two of the 29 complaints had been reported as incidents. We reviewed all complaints and found that themes included delays in care, delays in receiving pain relief; concerns around safe treatment and inadequate staffing levels to provide support and basic care.

We reviewed all responses available and found that although most were timely, they often lacked compassion; did not always fully answers the complainant's questions and lacked lessons learnt. We did not see evidence of identified themes being monitored or learning shared to improve the service. There was no evidence that they were using complaints to drive improvement or change practice.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. We were told that complaints would be dealt with informally where possible and if necessary, the midwife would contact the ward manager or central team for support.

Staff said women received feedback from managers after the investigation into their complaint. However, staff could not give examples of how they used women's feedback to improve daily practice.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

We were not assured that leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety.

The maternity service was a tertiary service covering Sheffield, South Yorkshire and Bassetlaw (and some North East of Derbyshire). For some highly specialised services such as fetal medicine and primary pulmonary hypertension in pregnancy the catchment population extends considerably beyond that described. The service experienced a change in several senior posts in 2020. The service was led by an operations director, midwifery director and clinical director for

obstetrics, gynaecology and neonatology. The triumvirate were supported through clear professional arrangements. The operations director and midwifery director were line managed by the clinical director and have professional reporting lines respectively to the chief operating officer and chief nurse. The clinical director was directly managed by the chief executive and has professional reporting responsibilities to the medical director (operations).

There was a governance group in place which consisted of an 8a matron, one band 7 neonatal nurse, one band 6 gynaecology nurse, three band 6 midwives, supported by a gynaecology lead consultant, an obstetric lead consultant, an anaesthetic lead consultant and a neonatology lead consultant. Monthly directorate governance meetings were held and chaired by the clinical director. Relevant information was escalated to the trust executive group and healthcare governance committee. . We were advised that HSIB reports were discussed at the serious incident group (SIG) rather than the healthcare governance group.

During the inspection CQC were informed that some leaders within the service had been promoted without going through due process and recruitment processes.

Vision and strategy

The service corporate strategy was in the process of being updated during the time of the inspection. We were told it had been delayed due to the COVID-19 pandemic. We were also told that the maternity safety strategy would be updated once the service corporate strategy became available. As a result, the maternity safety strategy was out of date at the time of the inspection.

Culture

The service did not have a culture where staff could raise concerns without fear. We were not assured concerns were progressed appropriately. Not all staff felt respected, valued and supported. Staff were focused on the needs of the women receiving care.

It was evident during the inspection that the midwives and medical staff made every effort, under difficult circumstances, to meet the needs and care for women and babies on Jessop Wing. Staff worked hard, often on shift alone at night due to staff moves, and continually worked additional shifts to support the maternity department throughout Covid-19. Front line staff were not well supported by the local leaders and the wider organisation.

Information from the service national medical staff survey 2019, published 2020 highlighted that 88% (17% improvement since 2018) of staff often / always looked forward to going to work; 93% (decline of 1% since 2018) agreed / strongly agreed that they knew what their responsibilities were; and 83% (9% improvement since 2018) were personally pleased with the standard they were able to perform their work.

When asked, in the last 12 months had you personally experienced discrimination at work from a manager / team leader or other colleagues, the 'Jessop Wing national medical staff survey 2019' showed a 93% response rate for no discrimination. When asked, if the organisation treated staff who were involved in an error, near miss or incident fairly, the survey showed a response rate of 61% against agree or strongly agreed.

Information from the 'Jessop Wing national nursing and midwifery staff survey 2019', published 2020 highlighted that 58% (7% improvement since 2018) of staff often / always looked forward to going to work; 90% (same as 2018) agreed / strongly agreed they knew their responsibilities; and 72% (12% improvement since 2018) were pleased with the standard they were able to perform their work.

Maternity

When asked, in the last 12 months had you personally experienced discrimination at work from a manager, team leader or other colleagues, the survey 2019 showed a 90% response rate for no discrimination. However, when asked, if the organisation treated staff who were involved in an error, near miss or incident fairly, the survey showed a response rate of 46% against agree or strongly agreed.

We spoke with several staff who raised concerns of a bullying and intimidating culture. We heard about staff "being pulled to one side" or "spoken to in a cupboard" and staff "being spoken to informally, with formal actions being taken (no representative present)". Staff told us that they were "fearful of reprisal" and that they were cautious about incident reporting due to possible retribution. Others told us that they were "blamed" following the outcome of the previous CQC inspection.

Governance

Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.

During our previous inspection we found there was limited oversight of maternity services by the trust board and there were unclear processes of how ward to board assurances were gained about the quality and safety of services. Staff including some senior leaders could not clearly articulate the governance framework for the directorate and how information flows between directorate and the board.

Following the March 2021 inspection and imposition of conditions the trust developed a detailed action plan which we had seen through routine monitoring; evidence of executive oversight, and trust monitoring of the action plan. However, during this inspection, we found many of the same issues from the March 2021 inspection remained and actions taken had not been fully implemented or actioned. The trust has not delivered the required improvements to improve patient experience and safety. The trust had followed the conditions however, although reporting improvement, CQC did not see this on inspection.

The maternity services had a governance framework in place. This had been reviewed as part of the service's participation in NHS England/Improvement's (NHSE/I) maternity safety support programme. The review had identified several areas for improvement in the governance framework. At the time of the inspection the trust had not received the full outcome. Managers told us that they intended to complete the improvements to the governance framework within the next four weeks.

The maternity risk register was provided following the inspection. There were no mitigating actions evidenced on the register or accountable named persons responsible for monitoring or improving the risk / actions.

During our previous inspection we found that leaders lacked knowledge of national serious incident processes by following in-house methods, thus delaying investigatory processes which was contrary to the national serious incident framework requirements of reporting a serious incident within two working days. There were concerns that some serious incidents may have been missed, not appropriately investigated, the root cause identified, or correct lesson identified, learned and shared. During the October 2021 inspection we found that this extended process continued, however delegated authority had been given to the maternity services rapid review meeting to declare serious incidents. The reports were still discussed and heard through the trust's serious incident group. However, we saw serious incident investigations continued to be out with the national incident reporting timeframes. For example, a review of NRLS highlighted that four out of 15 reported serious incidents between 01 April and 01 October 2021 were reported within two working days. We found that although the service had changed the process, we continued to hold concerns that investigation and reporting of incidents was not timely.

We were informed that rapid review meetings were held three times per week, with clinical attendance which provided challenge.

However, we were informed during the inspection that this alternated between, every 72 hours, to twice a week depending on the number of incidents which had occurred. Attendance included the governance team, obstetric consultants, a consultant neonatologist, governance for neonatal, matron, anaesthetist, junior doctors, midwives, and deputy head of midwifery. However, it was established during previous inspection that the meeting had been running for 18 months with no clear terms of reference and did not identify when the meeting was quorate. This meant we could not be assured that appropriate scrutiny was given to the rapid review process. In addition, although a proforma was completed, the meeting didn't commence taking minutes until December 2020. During this inspection we found that a term of reference had been developed. We were unable to observe a review meeting as all were cancelled during this inspection. We were informed the meetings were cancelled as there was no incidents to review.

We heard that an audit midwife worked closely with the governance team to oversee national audits.

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and actions to reduce their impact were not timely.

We have seen significant risks in the service and still have concerns regarding CTG monitoring not being undertaken adequately, concerns with risk assessments and induction of labour.

The conditions we imposed on the trust required the trust to implement systemic improvements to governance in the service. The systems the trust implemented have continued to fail to identify and address the significant risks in the service.

Prior to our previous inspection we reviewed the findings and recommendations from 18 Healthcare Safety Investigation Branch (HSIB) reports. Sixteen of the reports had recommendations for actions to be taken pertaining to the service. The reports provided showed that there were 44 themes and five recurring themes. We were not assured that sufficient consideration had been given to address these concerns. The recommendations included:

- undertaking a 'fresh eyes' review (seven separate reports),
- placentas sent for pathological examination including histology (12 separate reports),
- CTG monitoring (nine separate reports),
- robust system for safe prescribing of all ongoing medicines (two separate reports)
- risk assessments/monitoring (14 separate reports).

During this inspection we found the following areas remained a concern:

- undertaking a 'fresh eyes' review,
- CTG monitoring,
- risk assessments/monitoring.

During our previous inspection we found that the maternity safety strategy (2017-2020) outlined the service's key priorities, measures and associated work-streams to deliver a safe and sustainable service to women and their families.

It provided a framework within the service's existing governance infrastructure and outlined the enabling conditions required to deliver the strategy for the period 2017-2020. The safety strategy was discussed at bimonthly meetings at board level and action plans were drawn from this and presented through governance meetings. On review of the action plan provided in March, it was evident that the plan had outstanding amber actions which had not been reviewed or updated since October 2018. Items on the plan had not progressed since and included actions such as, increasing neonatal nurse staffing, medical staffing, environmental refurbishment, NNAP standard temperature monitoring, and numerous external recommendations in relation to early pregnancy emergency access to services and the role out of electronic maternity records to name a few.

During this inspection we found that the service's new framework for risk management described the service's risk management processes and defined the role of all staff in managing risk with associated procedural guidance. It outlined an approach to the identification, evaluation and control of risk.

Maternity services now had in place a maternity services governance framework which articulated the local delivery structure in maternity services and helped staff to understand and apply the governance framework in this area. It provided an overarching guide to signpost to and support the practical application of service policies focusing on key areas of delivery including risk management, incident management, complaints, claims and inquests, feedback and experience and performance and quality monitoring.

Feedback received through the service's participation in NHSE/I's maternity safety support programme had prompted a review of the recently implemented STH maternity services governance framework. Conclusions from this feedback and areas for consideration had been detailed in a report which was under review by the directorate to support the evolution of the STH maternity services governance framework and to meet the requirements of a maternity risk management strategy. It was envisaged that the work would be concluded within four weeks.

A business continuity and internal incident plan was in place, and up to date. The plan described the procedures used by the service to respond to a business continuity or critical incident. However, the plan was generic and did not provide specific instruction or guidance for the maternity unit staff in the protection of labouring mothers, new-borns or babies requiring neonatal care, in the event of a major emergency.

The service recognised that data provided did not reflect the full list of red flags described in Safe midwifery staffing for maternity settings NICE guideline (NG4) 2015 introduced nationally six years previous.

The service did not have a tool to model or predict peaks in activity based on data from GP referrals and antenatal booking information. This meant the service could not plan taking into account succession planning and staffing requirements based on predicted activity and acuity.

Managing information

We were not assured that the service collected reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems in use. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.

During our previous inspection we found that when women transferred to a new team, the antenatal records had not always been incorporated within post-natal records. It was highlighted in an HSIB report that there has been occasion

where 'There does not appear to have been a dynamic approach to capturing and managing the risks relevant to the mother across the maternity pathway. Risks from previous pregnancies, antenatal and intrapartum care … [were] documented in different formats. The clinicians caring for the mother were not aware of the full clinical picture'. We continued to find the same concerns during this inspection.

Following the Ockenden Review, the service introduced a new benchmarking process in January 2021. Subsequent to further meetings of the senior midwifery team a bench-marking flowchart was agreed (February 2021) to ensure that a clear and transparent process was followed, regarding who was responsible for the benchmarking and contributing to the monitoring subsequent action plans.

The service provided examples of how practice has changed following benchmarking, include (one) HSIB report into neonatal collapse alongside skin-to-skin contact (HSIB 2020) and (two) MBRRACE UK rapid review into SARS-CoV-2-related and associated maternal deaths. For example:

New work streams identified included:

- Collaboration between the multidisciplinary teams to take forward a programme of work, called 'Skin to Skin Check-in'. Its combined efforts to reduce term admissions to the neonatal unit through attention to key principles and evidences around:
- Thermoregulation
- Skin to skin contact
- Safer holding and sleeping for babies

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The service had been working with the Maternity Voices partnership with regular meetings and communications via social media to engage with the local community and enable co-production of Sheffield maternity services.
- We received some stakeholder feedback from Healthwatch who had sourced patient feedback from several stakeholders. Themes of the feedback included:

Pregnancy

A lack of information in terms of interventions for example, induction and caesarean section. Disjointed care with a lack of continuity of care. Women experiencing long waits at in the LWAU of up to seven hours and antenatal clinic. Some women had praise for the midwives and their consultants.

Care during labour and birth

Women were positive about their care during labour both in hospital and out of hospital. There were some women who were concerned about staffing levels which led to the cancellation of homebirths, and discharge taking longer than needed. Some women identified their basic needs were not met.

Choice / advocating for yourself during labour and birth

Some women stated they did not feel listened to. We saw examples of poor experiences from those who felt that the lack of black representation in the health professionals which they believed impacted on the care they received when giving birth. Women were not given their choice of pain relief when asked.

Postnatal

First time mums felt they were left alone for long periods and there were delays in women receiving pain relief and antibiotics. Many women spoke of not being listened to. Women were also concerned that they had to travel to clinic in the days following birth instead of the midwife going to the home this included those who had a caesarean and were unable to drive. Others spoke of excellent care, on the ward and in the community and praised caring, attentive staff.

We were advised that engagement with the staff within Jessop Wing was shared using multiple formats to ensure visibility and availability to all staff groups these included:

Directorate learning forums via MS Teams with presentations provided on rotation from obstetricians and midwives.

Open questions and answer sessions were held with individual staff groups via an online platform. These were chaired by the Midwifery Director and head of midwifery.

Newsletters were shared with staff and circulated via email or social media and displayed in all office areas on innovation boards.

Nursing and midwifery matters meetings were chaired by chief nurse and deputy chief nurse via an online platform.

Schwartz Rounds (Schwartz Rounds are conversations with staff about the emotional impact of their work) were held virtually for the Jessop Wing.

Learning, continuous improvement and innovation

Frontline staff were committed to continually learning and improving services. Not all staff had a good understanding of quality improvement methods and the skills to use them.

During this inspection we found that the service had implemented the following actions following our previous inspection:

- Reviewed the maternity escalation divert and closure policy
- Implemented the maternity governance framework
- Reviewed the labour ward security
- Trained midwifery teams in the use of Birthrate + app
- Staffing levels were reviewed, and a 4-phase recruitment plan commenced
- MDT PROMPT and fetal monitoring training commenced
- Monthly completion and sharing of the maternity dashboard commenced
- Established a monthly learning forum
- A maternity oversight committee facilitated with the aim of monitoring improvement

Maternity

The maternity services were one of four trusts invited to implement and support the evaluation of the Tommy's National Centre for Maternity Improvement app in preparation of the for the planned national roll our in 2024. The tool offered personalised care for women and enabled greater continuity of care information throughout pregnancy and provide clinical decision support to health care professionals.

Royal Hallamshire Hospital

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Description of this hospital

The Royal Hallamshire Hospital is part of the Sheffield Teaching Hospitals NHS Foundation Trust. The hospital has around 850 beds for the care of inpatients and a number of specialist outpatient clinics.

A minor injuries unit offers services for people with injuries that that can be treated without the need for emergency care. There are two intensive care units; General Critical Care (GCC) which had eight beds and the Neuro Critical Care (NCC) that had 20 beds. Nearly 6,000 staff work at the Royal Hallamshire in a wide variety of clinical and non-clinical roles

Sheffield Teaching Hospitals NHS Foundation Trust provides acute and community services to an estimated population of 694,000. The trust provides specialist services for the populations of Yorkshire & Humber, parts of Mid-Yorkshire and North Derbyshire.

Medical care (including older people's care)

Inadequate ↓↓

Is the service safe?

Inadequate ↓↓

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

Mandatory Training

The service provided mandatory training in key skills to most staff and made sure they completed it.

The mandatory training was comprehensive and met the needs of patients and staff. It covered areas such as infection prevention and control, equality and diversity and resuscitation.

Ward managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training figures sent to us from the trust showed that the medicine division training percentages were at 80% for nursing staff, 87% for medical staff and 88% for additional clinical services.

Staff received and kept up to date with their mandatory training. Staff we spoke with confirmed they were up to date with their mandatory training, however 17 staff out of 45 (37.7%) on one ward had expired Mental Capacity Act level 2 training and 14 (14.2%) staff had expired Deprivation of Liberty Safeguard (DoLS) training. This meant staff were not always up to date with learning or current practice for those training areas.

Face to face training had been suspended at the trust due to COVID-19 except for manual handling and basic life support. Staff could participate in online training and staff told us they were given time to do this to ensure training was up to date.

Ward based pharmacy technicians said they did not receive basic life support as part of their ongoing mandatory training.

Leaders told us dementia training was part of job specific essential training for some staff, however the evidence sent to us after inspection did not include any dementia training figures and it was not listed as part of the training matrix, so it was difficult to ascertain which staff, if any, completed this.

Safeguarding

Staff had training on how to recognise and report abuse but did not demonstrate they knew how to apply it.

The service had systems and processes in place to protect children and adults from neglect or abuse and staff we spoke with had undertaken safeguarding training specific to their role.

The trust had up to date safeguarding policies for adults and children.

The trust had a lead for safeguarding, and they represented the trust at the local safeguarding boards. Staff we spoke with did not know who the safeguarding lead was which led us to question their visibility at ward level.

The safeguarding training figures sent to us from the trust showed that the medicine division had met the 90% compliance target for safeguarding training. 96% of additional clinical staff were trained to level one and 93% of nursing and medical staff had completed safeguarding vulnerable adults' level two.

Staff we spoke with knew that they could access safeguarding policies on the intranet.

The service had four safeguarding concerns that had been forwarded to the local authority in the last 12 months.

There was no safeguarding information displayed on any of the wards we visited.

Staff could not give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act despite the staff having received training.

Staff we spoke with did not demonstrate that they knew how to make a safeguarding referral or who to inform if they had concerns. For example, one member of senior staff said safeguarding concerns would be picked up before they were admitted to the ward so they would never need to raise a concern. This meant there was a lack of assurance around staff being able to recognise and respond to safeguarding concerns.

The trust's missing patient policy was out of date; however, we were told after the inspection that this was under review.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. There was a lack of assurance processes to demonstrate a consistent approach to infection prevention and control.

The service had infection prevention and control (IPC) training in place for all levels of staff to complete.

Although most clinical areas and equipment we observed appeared visibly clean the service did not keep comprehensive cleaning records. For example, there was inconsistent use of 'I am clean' stickers on stored equipment and on Q1 ward, the stickers on the emergency equipment and records trolleys indicated they had not been cleaned recently. Managers we spoke with were unable to provide equipment cleaning records on any of the wards or departments we visited. This meant we were not assured that equipment was always clean and fit for use.

The service was unable to evidence that fabric curtains were laundered and changed in accordance with their infection prevention and control policy. This stated all curtains were to be changed every three months or sooner if contaminated.

We did not see any IPC audit results displayed on the wards and departments we visited. Following inspection, the trust provided results of ward observational IPC audits. This data suggested 100% compliance was achieved in most areas. For example, wards G2, M2, Q1, Q2, P1 showed 100% compliance for hand hygiene, dress code and handling and disposal of linen. However, there were no numbers of observations recorded which meant we were unclear how the result of 100% compliance was achieved.

In addition, staff we spoke with on the wards and endoscopy unit told us they did not participate in any infection control audit activities. We saw an out of date IPC accreditation certificate on one ward dated 24th August 2019. This meant we were not assured that there was consistent compliance with trust policy and IPC best practice.

Endoscopy staff did not follow the trust scope traceability policy by keeping accurate records of when the scope was used. This meant patients were put at potential risk of harm

Medical care (including older people's care)

Patient Led Assessments of the Care Environment (PLACE) were suspended in 2020 due to the COVID-19 pandemic.

There were adequate supplies of hand gel and PPE in all areas we visited but we did not see prompts at some ward entrances to remind or encourage staff and visitors of hand hygiene. This put staff and patients at risk of potential harm from cross infection.

We observed staff followed infection control principles including the use of personal protective equipment (PPE) and adhered to bare below the elbow principles. Staff also had access to isolation rooms on the wards to help control the spread of infection amongst patients.

We saw patients deemed to be a high risk due to exposure of infectious disease or potential to infectious transmission were isolated (barrier nursed) appropriately.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff mostly managed clinical waste well, however cleaning substances were not always stored safely.

Staff disposed of clinical waste safely and waste segregation was available on all wards. However, we found that the sluice rooms that stored hazardous substances were not locked, and the hazardous substances were accessible.

The wards we visited did not have safe and secure storage for cleaning substances. This was raised at the inspection. When we revisited the service four weeks later, we found that the substances were still not being stored safely and securely despite the service saying they would act and mitigate the risk.

Cleaning substances were stored in the controlled drug cupboard on one ward. On the same ward, a cleaning substance was found to be leaking onto the floor with an incontinence pad being used to catch the fluid. This safety issue was raised during the inspection and the leaking container was replaced; however, staff did not identify the risk associated with a leaking chlorine substance.

On one ward, the door to the domestic cleaning cupboard was pulled open using a tie of fabric between the door and a drawer, this meant the cupboard was accessible to anyone and the propped open door posed a safety risk.

Resuscitation trollies were available on all wards we visited; however, the daily checks of the equipment were not up to date on all wards, and we found multiple gaps. This meant there was potential for the trollies to have inadequate or out of date items which put patients at a risk of harm

The wards we visited had secure entry systems to gain access and the wards had enough equipment for staff to carry out their role. However, wards were not always clutter free, during the inspection some wards had an excess of chairs, notes trollies and mobility equipment in the corridors making it difficult for patients with mobility issues to get around safely.

Wards we visited did not display any quality of care boards to display public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance and IPC performance.

The service had suitable facilities to meet the needs of patients' families. For instance, rooms set aside to break challenging news and rooms families could use when staying over with patients that were at the end of life.

Medical care (including older people's care)

The service had enough suitable equipment to help staff to safely care for patients and staff could order in specialist mattresses when required to address pressure ulcer care.

Fire extinguisher checks were in date and fire doors were secure and free from obstruction. Safety checks for all electrical equipment we checked were in date.

There was adequate, clutter free spacing between patient beds.

Sharps disposal bins were mostly dated, not overfull and sealed correctly, however two wards had bins that did not have dates of when they had been opened which was against trust policy.

Assessing and responding to patient risk.

Staff did not always complete and update risk assessments for each patient and they did not always accurately reflect risks to the patient. The risk assessments were not being transferred to risk management plans.

Staff used an electronic early warning score (NEWS) to assess the health and wellbeing of patients. This tool supported staff to identify if the clinical condition of a patient was changing and required early intervention or escalation to keep the patient safe. On all wards we visited staff had access to electronic whiteboards situated near the nurses' station. This provided staff with headline clinical information about a patient to help them keep the patient safe.

Staff had access to guidance on managing sepsis and access to a critical care outreach team.

Staff could track medical outliers using the trust's electronic patient record system. Medical outliers are medical patients who are being cared for on other wards that are outside of the speciality. Staff told us outliers were seen daily by a doctor for the speciality concerned.

Staff told us that completing risk assessments in a timely manner was a challenge. A staff member we spoke with told us that in order to try and maintain a consistent approach, all risk assessments were completed within 24 hours of the patients being admitted to the ward, followed by designated days to re-assess specific risk assessments.

Falls risk assessments were completed for patients, however risks were not always accurately reflected. For example, two patients admitted with a history of falls did not have this highlighted on the risk assessments and the assessments did not capture postural blood pressure drop as a falls risk.

Falls risk assessments highlighted staffing problems with comments including 'to put in an observing bay and monitor as and when staffing allows' and 'patient observed as much as possible but difficult due to staffing' for two patients at risk of falls.

Some patients who were at risk of falls were seen to be wearing anti slip socks and had mobility aids within reach.

Although we saw that whiteboards highlighted which patients were at risk of falls the individual care plans and assessments did not always reflect the risks.

We saw delayed risk assessment after people at risk of suicide had attempted to take their own life. This lack of timely assessment meant patients were put at the risk of avoidable harm.

We did not see any safety huddles take place during the inspection. Staff on one ward had recorded they had not completed safety huddles for four days and staff on a different ward stated they would resume the huddles the day after our inspection. Falls audit plans sent from the trust after the inspection indicated that safety huddles should take place every day.

The trust sent us pressure ulcer action plans which stated that staff should have safety huddles three times daily to discuss patients at high risk of developing pressure ulcers, we did not see any evidence of these on any wards we visited.

Daily pressure area assessments were not always completed for two patients on one ward. One patient had a pressure mark identified on 30 September and then no further assessments until 4 October.

VTE risk assessments were not completed for 6 patients. Neurological observations for a patient where not commenced in a timely way which meant the patient was at risk of complications of their injury going unnoticed.

When we revisited one ward after our initial inspection, we saw falls resource packs were issued to wards to prevent falls across the wards. The packs included guidance and fall prevention information for staff and socks with grip soles, which are to be provided to all patients deemed to be at high risk of falls. We saw these were in use at the time of inspection.

Nurse Staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, despite managers regularly reviewing and adjusting staffing levels and skill mix we were not assured this was safe. They gave bank and agency staff a full induction.

ing the inspection, most wards we visited were short staffed. For example, ward G2 was short of two registered nurses, ward O1 was short of one support worker and one nurse on the nightshift. Ward Q1 was short of two nurses on the day shift and one nurse on the nightshift. Ward P1 ward had no night staff, so patients had to be moved to other wards overnight and then back again for discharge the following day. Following the inspection, we requested rotas from the trust for the wards we visited. This information was not provided to us so we could not be assured that the staffing levels were safe.

We were told that staffing shortages remained an ongoing challenge and over the last month there were no days in which some wards met their full staffing establishment.

All managers and staff that we spoke with during the inspection spoke about the staffing pressures. We reviewed staffing rotas on some wards, and this confirmed what staff told us. Staff said that wards were often left unsafe and even if their ward was fully staffed, staff would then be moved to another ward to make up short staffing numbers on that other ward.

Patients that required 1:1 care did not always get this due to staffing shortfalls. This was reflected in some risk assessments that had been completed after patient falls and stated that the 1:1 care required was not possible due to low staffing.

A matron was available for any escalation of staffing issues, and they followed a policy of escalation. However, staff told us escalation of short staffing did not always work and they felt they were made to just get on with it if staffing wasn’t available. Staff reported being moved with inadequate training and support. We were not assured the way in which staff were being moved was safe.

Skill mix was not always considered, on one ward the nurses on shift included one newly qualified and one international nurse who had started that week with no suitably qualified nurse to do a second check on items that needed it.

Endoscopy procedure lists were frequently cancelled due to low staffing which had created a backlog, the list on the day of the inspection was cancelled due to low staffing numbers.

Staff reported difficulties in bank staff filling gaps in the rotas and agency staff did not seem to be used.

The current nursing staff vacancy rate in the medicine division was 21% which was 16.6 whole time equivalent (WTE) vacancies. The trust had recruited international and newly qualified nurses recently and recruitment was ongoing to fill the staffing gap but the vacancy rate for nurses was much higher than for support and medical staff.

The vacancy rate for support staff was 1.8% in the medicine division.

The medicine leadership team were trying to address staffing shortages by recruiting newly qualified nurses, international nurses, care support workers and the development of the nursing associate role within the nursing team

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

Data sent to us by the trust showed small vacancies in medical staffing. This was reflected in discussions we had with staff who all felt there was adequate numbers of medical staff and felt problems lied with lack of nurse staffing.

All areas we visited had medicine consultant cover and on call 24 hours for weekends and out of hours.

To support the medicine wards there were a range of junior doctors who reported good supervision, good learning, and good support from more experienced members of staff.

All the services we visited had a daily consultant attended board round and multi-disciplinary team meetings (MDTs).

Managers could access locums when they needed additional medical staff.

We were told that medical staff on the wards we visited matched the planned number and staff told us there were no rota gaps. However, we were unable to corroborate this as the trust did not provide us with the rotas we requested following the inspection.

Sickness rates for medical staff were lower than the trusts sickness target of 4%.

We did not receive assurances from the trust following inspection that the service had low or reducing rates of bank and locum staff.

Medical care (including older people's care)

Records

Staff kept records of patients' care and treatment, but this was not always accurate. Records were not consistently clear and up-to-date, electronic parts of the records were not as easily available to all staff providing care. Records were not always stored securely.

We reviewed 28 sets of records (including medicine charts), these were a mixture of electronic and paper records. We found that records were not easily accessible for staff and not being completed contemporaneously or accurately.

Of the 28 records we reviewed, six of them did not have all their personal details recorded and six were not easy to read.

The trust used paper records to record patient care, but some risk assessments were in electronic form. Staff told us that everyone was trained on the use of electronic risk assessments and staff knew which risk assessments were electronic and which were paper. However, we found that the details written in paper notes were not always reflected in the electronic assessments.

Records were not always stored securely; trollies were left unlocked and unattended on five of the wards we visited.

Records were not being completed contemporaneously or accurately. For example, we found intentional rounding documentation had gaps in for multiple patients. One patient who had a red pressure point identified did not have any intentional rounding completed again until four days later.

An unlocked storeroom on one ward had patient property books and controlled drug registers dated between 2018-2021, they all had patient identifiable information in.

A records audit had commenced in September 2021, however, the trust were not able to provide any evidence of outcomes by the time of publication

Computers with personal patient information on the screen were also left open and unattended.

We saw allied health professionals documented comprehensive care and treatment plans within the paper medical records that we reviewed. If notes had been made electronically there was a sticker in the paper notes to inform of this so staff knew where to look for the information about the patient.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff were not recording steps taken to avoid using sedative medications and after administration were not recording patient observations hourly. There were no audits in this area, meaning we could not be assured that this area of medicine was being used safely. Whilst staff told us these medicines were used as a last resort, we could not assess this. For example, staff were not recording steps taken to avoid using rapid tranquilisation medicine and after administration were not recording patient observations hourly. There were no audits in this area and staff were not following the policy, meaning we could not be assured that this area of medicine was being used safely. Whilst staff told us rapid tranquilisation medicine was used as a last resort, we could not assess this.

There were no care plans in place for ongoing management of agitation in patients to avoid use of rapid tranquilisation.

Medical care (including older people's care)

One patient who had been administered rapid tranquilisation did not have their NEWS2 monitored in line with national guidance.

Two wards visited did not have secure storage for emergency hypoglycaemia kits which included medications.

Double signatures that were required for administration of controlled drugs were missing, meaning it was unclear whether a second person had checked the drugs before they were given.

A random check of the controlled drug book found that two doses of Oxycodone had been administered and not been written up and signed for on one ward.

There were nine gaps in daily controlled book checks for one ward in September 2021.

We checked the storage of medicines, fluids and gases on the wards we visited. We found these were not always stored safely and securely. For example, on one ward the treatment room door did not lock.

Medicines, including Morphine on one ward were left out on a countertop in a treatment room that all levels of staff had access too.

Medicine cupboards that stored medications and injections were left unlocked on one ward.

Medicines that were not in any original packaging were left in cupboards in the treatment room on one ward.

Fridge temperature checks were inconsistent across the wards we visited. Fridge temperatures that were out of range were not escalated. One fridge that stored insulin and eye drops had been out of range since June. This meant the medications stored in the fridge might have been affected by temperature changes and be unsafe for use. This was escalated at the time of the inspection.

Treatment rooms where medication was stored did not have thermometers to monitor maximum and minimum temperatures.

There was no record of were a pain relief patch was applied on one patient despite these patches being contraindicated for use on the same area within 21 days.

We saw on medicine charts that allergies were not recorded for four patients that had allergies.

There was no up to date weight recorded for one patient who was prescribed a weight dependant anticoagulant.

Oxygen was stored securely on all wards visited. However, there were no medical gases warning signs with them.

Wards we visited benefited from a visit by a pharmacist technician each day and during core hours take home medications were being clinically checked and dispensed and patient medication reconciled. However, we were not confident that pharmacy had oversight of the issues affecting medicines, for example ward staff monitored fridge temperatures and were not escalating when out of range.

Medical care (including older people's care)

Incidents

The service did not manage patient safety incidents well. Mostly, staff recognised and reported incidents and near misses. Managers investigated incidents but evidence of lessons learned shared with the whole team and the wider service was absent.

The trust had an up to date incident reporting policy. Staff did not demonstrate that they reported incidents themselves. Staff we spoke with said they knew how to report, but rather than do this directly onto the datix system they would report incidents to more senior members of staff. This meant that learning and feedback was not always sent direct to the person who was involved in an incident. This meant staff could not be assured all incidents had been reported

Only one staff member could give an example of an incident they had reported. However, all staff we spoke with said they were encouraged to report incidents.

Ward leaders could not give any recent examples of incidents that had resulted in shared learning for the ward.

No staff meetings took place on any of the wards we visited so it was unclear how lessons were shared. We were told they are sent in email or sometimes a poster would be put up in the staff room. It would be difficult for managers to ascertain whether staff had seen the information they had cascaded.

Due to the absence of safety huddles and staff meetings, we were not assured that lessons learned were being shared safely with frontline staff.

Two wards we visited did not hold daily safety huddles, one of the wards was in the top ten highest wards where falls occurred and had missed the huddles for four days. Another ward team told us they were going to resume these huddles the day after the inspection.

Leaders of two wards we visited did not know the wards most recurring top three incidents.

Ward staff did not understand what duty of candour was and when it should be applied. One ward leader said it would only need to be used if a patient had a fall.

The trust had no never events on any of the medicine wards. Staff we spoke with could not give examples of any learning they had from other never events within the trust.

Following inspection, the trust sent us examples of investigations that had been done into serious incidents and these appeared to be detailed and identified lessons to learn and detailed communication with patients next of kin.

Safety Thermometer

The service had replaced safety thermometer information with a new digital dashboard..

Sepsis screening audits did not take place due to COVID-19 pandemic.

Is the service effective?

Inadequate 

Medical care (including older people's care)

Our rating of effective went down. We rated it as inadequate.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The trust had up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access these through the trust intranet.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There were systems and processes in place to identify changes to national guidelines and update policies appropriately. Staff had access to up to date policies online.

We saw the trust had a policy on implementing the national Institute for health and care excellence (NICE) guidance.

At handover meetings, staff did not routinely refer to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.However, fluid and nutrition charts were not always completed when needed.

The service had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition (MUST). However, nutritional risk assessments were not completed for four patients that needed them.

On admission, patients had a nutritional assessment and dietitian services could be accessed if needed. However, access to dieticians and speech and language therapists (SALT) was not available seven days a week meaning for example if someone needed a review on Saturday, they could potentially have to be nil by mouth until Monday.

One family member we spoke with told us their loved one had not been offered fluids (nil by mouth) for some time without explanation. Staff clarified the reasons for this decision, but the family did not feel this was done in a timely way.

Fluid balance charts that were in place did not always capture accurate fluid input, output, and total balance. For example, one patient who was incontinent did not have any fluid output monitored despite this being required. This was raised at the inspection and we were told how this should be being monitored by staff.

Patients were offered a range of meals to meet any needs arising from religion, culture, allergies or personal choice. There were specific huddles for meal needs for example cancer patients who needed irradiated food, and this was catered for.

Staff described how they tried to encourage patients to be independent when eating but would help if needed. We did not see any initiatives such as red trays to help staff recognise which patients needed help. We were told this would be information on a board above the patient's bed. We did not see these boards in use on the wards we visited.

Mealtimes were protected; however, family members were allowed in to support with care if the patient wanted that.

Patient's opinions of the food varied, patients mostly said the food was nice enough however one patient who was diabetic said the food choices weren't always healthy and another patient said the food was always cold, she said that she often left meals due to them being too cold and was not offered alternatives.

Patients said they didn't get offered tea or coffee in between meals very often.

Water jugs were in reach and staff and patients told us they were replenished regularly.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and give pain relief in a timely way. They did not always support those unable to communicate or use suitable assessment tools or give additional pain relief to ease pain.

We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients. However, on ward G2 a patient was not given Oxycodone for six days despite the patients notes saying he was in pain. This was raised with a nurse in charge who said this would be reviewed, the following day the patient had still not had the medication nor a review. This was raised with the chief nurse towards the end of the inspection and we saw evidence that appropriate action was taken.

A patient on the same ward said she was never offered her morphine medication that was prescribed to be taken when required and always had to ask for it once she was already in pain.

Staff on the same ward did not find alternative ways of assessing a patient's pain if they had communication difficulties. For example, one patient with dementia was recorded to be in visible pain in his care records, however when asked he told staff he was not in pain as could not articulate a pain score.

Some patients care records on ward G2, M2 and Q2 did not indicate that they had their pain assessed regularly meaning they may have been left in pain for periods of time.

Staff had access to the trust's acute pain team who could supply expert advice on pain and its management

Following inspection, the trust shared with us examples of audits undertaken to improve pain management in a range of different patient groups. This included audits of sickle cell anaemia and rib fractures.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The endoscopy unit held full accreditation with the Joint Advisory Group (JAG). This meant that the service had demonstrated that is has the competence to deliver against criteria set out in the JAG standards.

Performance dashboards were used to measure performance improvement, rank against benchmarks, identify improvements in metrics and trendlines for the previous four and 12 months to monitor performance.

Audits were carried out in 2020/21 despite the COVID-19 pandemic, outcomes of the audits that were completed showed good compliance. Audits that had outcomes that were not compliant had action plans in place or had the audit re-done.

E-referrals were well utilised within the trust and the percentage of appointments booked in this way was consistently above the trust target.

Some areas of the medical division did not meet the trust target for waiting less than six weeks for diagnostic imaging.

Mortality and morbidity reviews showed standards of care were looked at and actions for improvements identified. However, these were not done frequently for all specialities within the division.

The trust cascaded an electronic safety message of the month. However, none of the staff we spoke with told us about this, so it was unclear if staff were seeing these.

Information sent from the trust following inspection indicated that patient outcomes were monitored and investigated and used to improve patient safety. For example, cleaning schedules were altered to take place when the department had reduced patient activity.

The pressure ulcer action plan sent to us from the trust stated that ward level weekly audits of pressure area documentation should be completed, we did not see any evidence of this on any ward we visited.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients, however due to staffing vacancies, not all wards had the correct skill mix. For example, one ward had two newly qualified nurses and one new international nurse on one shift.

Staff were inducted and trained by the trust, including bank staff. Staff told us new nurses completed an introduction to professional practice and would have competencies monitored.

Managers supported staff to develop through yearly appraisals of their work. The trust shared appraisal data with us following the inspection and this showed most of the medicine care groups were at or around 80% for compliance with staff appraisals. Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal.

Staff were given the opportunity to progress, nurses on one ward had been promoted to more senior roles and a ward manager had been given the opportunity to move to another department to develop their skills.

New nurses had medicine competencies monitored and signed off when complete.

Staff explained that they received additional training relevant to their role. For example, health care assistants were able to do phlebotomy and cannulation training.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision and were well supported.

We asked the trust to provide clinical supervision rate data following the inspection. The trust told us that they do not collate clinical supervision rates routinely and safeguarding supervision rates are not collected as a data set, therefore we were unable to review this.

Staff were supported with professional revalidation, but all said that this is done in their own time.

Staff we spoke with said they were allocated time to complete mandatory training

The clinical educators supported the learning and development needs of staff.

Managers did not hold staff meetings on any of the wards we visited, managers said this was due to the COVID-19 pandemic.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

When we visited the wards, we saw a variety of staff working together, such as nurses and support workers, to benefit patients.

In all the records we viewed, we found detailed communication from non-ward based staff such as physiotherapists and dieticians.

We observed MDT board rounds. This was attended by a physiotherapist, dietician, consultants and junior doctors. All patients were discussed, and actions were agreed.

Patients had their care pathway reviewed by relevant consultants.

We did not see evidence that staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Only one of the seven wards and departments we visited offered a full seven-day service. The others we visited had on call consultants and no access to therapy staff including SALT and dieticians on a weekend.

Consultants led daily ward rounds on all wards, however only on weekdays. Consultants were available on call at evening and weekends. Of the 28 care records we looked at, only 13 showed evidence of a daily ward round.

Discharges were planned on wards before a weekend so these could still take place without delay.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives.

The service had no information promoting healthy lifestyles and support displayed on wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use measures that limit patients' liberty appropriately.

The trust had an up-to-date policy dealing with consent and mental capacity. At the last inspection, the trust was told that it must record best interest and capacity assessments in patient records. We did not see any evidence of best interest forms or formal capacity assessments in any of the nine records for patients with dementia that we looked at.

Staff did not always protect the rights of patients subject to the Mental Capacity Act or follow the Code of Practice. We reviewed nine patient records. All nine patients had a diagnosis of dementia and were experiencing confusion, however none of the patients had a completed mental capacity assessment in place. None of the files reviewed clarified if the patients were able to consent for their own care and treatment or had the capacity to do so.

Staff did not always evidence consent to treatment in line with legislation and guidance, of 28 care records we looked at we could only find evidence of consent in 10. For one patient who didn’t speak English, the records said, ‘unable to gain consent due to language barrier’.

Deprivation of Liberty Safeguard (DoLS) forms were not completed correctly. Staff were completing DoLS forms without the necessary assessments that should be completed prior

Staff we spoke with did not show a good understanding of DoLS and what they were used for.

Information sent from the trust following the inspection showed that an audit in May 2021 identified that of the 61 forms audited only four (7%) had a valid Mental Capacity Assessment attached to the DoLS form. This indicated that staff did not understand the purpose of the DoLS and when it should be applied. Concerns were initially identified in 2019 with the risk in 2021 deemed to remain the same according to the report.

One patient who had been previously sectioned was admitted with suicidal thoughts and delirium and had been diagnosed with dementia, had no capacity or suicide risk assessments completed.

Records did not show that decisions around DNACPR (do not attempt cardiopulmonary resuscitation) were fully informed. One patient, who was recorded to have agreed to a DNACPR was noted to have delirium and confusion caused by a urinary tract infection. Another patient record stated DNACPR was in place but that it had not been discussed with the patient. We further found no copy of a DNACPR in a patient’s records despite the record saying they had one in place.

Nursing and medical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Medical care (including older people's care)

We revisited the service four weeks after the inspection and looked at four patients' records. We found that capacity assessments, dementia care bundles and DNACPR consent were still not being completed for patients' that needed them despite this being raised following our inspection.

Is the service caring?

Inadequate ↓↓

Our rating of caring went down. We rated it as inadequate.

Compassionate care

Staff mostly treated patients with compassion and kindness, but they did not always protect their privacy and dignity when providing care.

Staff respected the personal and social needs of patients, for example we saw one nurse bring one patient in from another bay to see his sister who was also a patient on the ward.

Staff understood and respected the individual needs of patients. For example, on one ward we saw a member of staff write down meal options for someone who was hearing impaired, she then handed them a magnifying glass so that they could read the options and choose what they wanted.

Patients we spoke with mostly said staff were kind and they felt safe and looked after, however one patient who was unable to walk unaided said a staff member told them to urinate in an incontinence pad rather than take them to the toilet.

Staff were mostly discreet with patient care, however, there were isolated incidents where we saw patient dignity was not upheld. For example, one patient was left naked on the bed in a bay with other patients and no curtains pulled round for privacy, whilst the nurse left the bay. We saw that patients were transferred around the wards using a suitable stand aid with seat halves and slings that could support patients appropriately.

Staff did not always understand the individual needs of patients who were living with dementia, and we did not see any additional provision made for patients such as easily identifiable coloured cups and plates or visually adapted areas to support patients to navigate around the wards easily.

One ward we visited had a 'clothes library', this was for patients who were brought in without any belongings, so they did not have to just wear pyjamas or hospital gowns. However, on this ward and all the wards we visited patients were mostly in hospital gowns and pyjamas rather than clothes, even when they were sat up in chairs.

Patients could reach call bells and staff mostly responded quickly when called. However, on one ward we saw patients waiting eight minutes and 10 minutes respectively for call bells to be answered.

Emotional support

Staff did not always give emotional support to patients, families and carers to minimise their distress. They did not always understand patients' personal, cultural and religious needs.

We observed varying examples of emotional support for patients, on one ward we saw staff comfort a patient who missed her husband. However, on another ward a patient who was sleeping during lunch, was woken by staff and was very agitated. Staff made no attempts to calm him down and they walked away and said to 'just leave him'.

We saw one patient visibly agitated and wandering around the ward with a bedside trolley as a walking aid, but staff only intervened when prompted to do so by the inspection team.

We did not see signs on the wards we visited directing patients and families to counselling or support services. However, one ward had a resident psychologist that offered support sessions to staff to help with wellbeing.

Wards we visited had quiet rooms available which could be used for delivering bad news to patients and their families.

Staff we spoke with said the trust had a multifaith chaplaincy that was very responsive to patient needs.

Visiting had resumed on the wards with people being able to book time slots and visit for up to two hours, however, some visitors could stay longer at ward managers discretion.

Leaders told us they use John's campaign for patients who were living with dementia to allow a carer to stay with the patient if they wish. We did not see any family members of patients living with dementia on the ward nor did we see any posters to promote this, so unclear if this was cascaded to staff at ward level. (John's campaign is a national movement to promote the rights and choices of people living with dementia). However, during the factual accuracy process the trust provided assurances that patients with exceptional circumstances such as dementia, were allowed to have visitors.

Training in emotional support and delivering bad news was not part of mandatory learning, however staff could access this on the electronic learning system if they wished to do so.

Understanding and involvement of patients and those close to them

Staff did not always support patients, families and carers to understand their condition and make decisions about their care and treatment.

The trust participated in the Friends and Family Test (FFT). Survey results forwarded from the trust for June, July and August had less than 10 responses each month for three of the wards we visited.

Family and friends feedback posters were only visible on one ward we visited.

Care records did not evidence that staff had supported patients to make decisions about their care. However, we did see in care records that staff communicated with family well.

On one ward we saw the use of a mobile phone that could be given to patients for family to be able to speak to them.

Mostly patients gave positive feedback about the service and the care that they received. However, as numbers of responses were low this was not accurate reflection.

Two patients we spoke with did not know what they were being treated for whilst in hospital.

One relative we spoke with told us they found out the patient's diagnosis via a letter despite attending daily.

Medical care (including older people's care)

Relatives that stayed at the hospital, for example with family who are end of life were given passes to use in the canteen.

Is the service responsive?

Inadequate ↓↓

Our rating of responsive went down. We rated it as inadequate.

Service planning and delivery to meet the needs of the local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

We saw that each speciality had its own dashboard which looked at various patient markers such as length of stay, referral to treatment, and did not attend, and these dashboards were discussed at governance meetings to monitor and improve the patient journey.

On the respiratory ward, we saw how the team had implemented virtual clinics, to support use of technology and avoiding unnecessary face to face clinics.

Facilities and premises were appropriate for the services being delivered. The endoscopy service was JAG accredited.

Staff said they could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

There were no mixed sex breaches on the wards we visited.

Meeting people's individual needs

The service was not always inclusive and did not take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

On admission to the ward each patient received individual assessments, however these were mostly risk-based assessments, and they did not consider individual needs or preferences. For example, we saw one patient who had a stoma bag and there was no care plan in place for this.

We saw there were no personalised care plans for cultural or spiritual needs. Admission documentation included options to record faith but these weren't personalised for patents who wished to practice or follow their faith during their hospital stay. However, during the factual accuracy process the trust provided evidence which showed cultural and religious needs were part of the activities of daily living within the electronic care plan.

Patients were given a choice of food and drink to meet their cultural and religious preferences. However, staff said that choices were limited.

Wards were not designed to meet the needs of patients living with dementia. Corridors were cluttered with no contrasting colours. PLACE assessments were postponed due to the COVID-19 pandemic, however, the most recent audit in 2019 highlighted that the environment was not dementia friendly due its walls, floors and furnishings. This is also what we found during our inspection.

The wards we visited did not have activities to stimulate the minds of patients who were living with dementia, such as dementia boxes. Not all patients' bays had a television and some patients we spoke with said the days felt very long with no TV, radio or magazines to occupy them.

We reviewed five care records of patients that had the dementia icon highlighted on the whiteboard. We could not find any evidence that any of the care plans had individualised and correct assessments completed to ensure their needs were fully assessed and being met.

The use of interpreters was not consistent across the medicine division. Staff told us that they could access language interpretation services, however not all wards we visited made use of this.

There was no evidence of additional appropriate support for a patient that couldn't speak English. Despite the service having access to translators, no methods to communicate had been explored other than the use of a family member. Staff had a communication aid, however this only covered basic hygiene needs and was not kept in the patient's room for consistent use

Staff did not have any planned activities for patients or enough time to do something like that if a patient requested it due to short staffing levels.

We saw that staff would communicate with care homes and care agencies when planning patients discharge. Staff also told us about how they might refer patients for support from a charity that offers help with things like shopping.

Access and flow

People could mostly access the service when they needed it and received the right care promptly. Whilst staff used various methods to try and ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards, these were not always responsive.

The service had systems and processes in place to monitor access and flow.

There was a discharge team that supported staff with discharges and to improve patient flow out of the site. However, staff on one ward told us there was no discharge co-ordinator allocated to the ward. This meant nursing staff were responsible for all aspects of discharge management, adding to their current workload. Staff told us that discharges were facilitated across the weekend if the doctors had clearly recorded with in the patient notes that this was agreed.

Staff planned patients' discharge carefully, particularly for those with complex social care needs. For example, two patients that were medically fit for discharge were not sent home until arrangements had been made for their care at home.

Medical care (including older people's care)

Pathways were effective for the needs of patients. For example, the endoscopy pathway was clear, fit for purpose and safety focused.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, many staff told us that 'bed blocking' was a problem due to difficulties with arranging ongoing care in the community. We saw multiple patients that had been in hospital for over 40 days due to this.

Managers and staff started discharge planning as early as possible. Weekend discharges were planned to avoid any delays in patients going home.

Staff did not always show good communication when transferring patients between wards. For example, patients at risk of falls did not always have this passed over on transfer.

There was no discharge lounge to help support flow out of the service.

During a board round that we observed, staff identified patients that were medically fit to be discharged. This information was captured on the electronic whiteboard and the data would be used in bed meetings throughout the day to help staff plan patient movement.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Endoscopy clinic lists were frequently cancelled which created a backlog. A total of 19 lists were cancelled between July and September.

Information sent from the trust showed that patients were moved between wards during the night. 9.7% of the medical ward bed moves happened between 22:00 and 06:00 in the last 6 months.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

We saw the trust had a complaints policy that was in date.

Managers we spoke with said there were no recent formal complaints raised about their wards.

The service did not clearly display information about how to raise a concern in patient areas in all the wards we visited.

Staff we spoke with said they knew how to handle complaints and who to signpost patients too if they had one.

Information sent from the trust showed us that complaints were investigated, and themes were identified.

The trust acknowledged complaints and patients received timely responses from managers after the investigation into their complaint.

Medical care (including older people's care)

Only one ward we visited had friends and family test feedback (FFT) boxes. The FFT results sent from the trust showed low numbers of feedback received for most of the medicine division.

Managers said they cascaded feedback from complaints to staff for learning.

Is the service well-led?

Inadequate 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Staff told us they were not visible or approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We spoke with staff in leadership roles and they all described having been trained in leadership or having access to the header's leadership programme.

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced; however, actions were not always effective. For example, staffing pressures were evident throughout the medical division and the management of this was to move staff from fully staffed wards leaving that ward short staffed also.

Leaders we spoke with felt that they were visible. However, staff on the wards did not feel that there was leadership visibility aside from ward managers and matrons.

The trust supported staff to develop their skills and take on more senior roles.

We saw some effective ward managers. Staff spoke positively about their ward managers and matrons and said they were well supported by them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them, however monitoring of progress was not always robust.

The trust had a clear vision statement and had developed objectives and divisional workforce plans which linked to the vision, they focused on wanting to make the service a brilliant place to work a receive care.

The trust's vision was to be recognised as the best provider of health, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

Governance minutes we saw looked at spending money wisely to ensure services remained sustainable. Finances were one of the strategic aims and considered as part of the integrated performance report.

The values to support the vision were: patient first; respectful; ownership; unity; and deliver, (PROUD). Staff we spoke with knew that values were PROUD, however they could not articulate what the letters stood for and we did not see these displayed around the hospital.

The strategy to turn the vision into a reality consisted of five strategic aims, covered in the integrated performance report.

The trusts vision had a focus on supporting staff wellbeing and mental health.

Progress was monitored through the various governance meetings at operational level through committees such as, the patient experience committee, clinical effectiveness committee, or the safety risk management board and from there up to the board.

Culture

Not all staff felt respected, supported and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was an open culture and they felt confident to raise concerns with their managers.

During the COVID-19 pandemic, the trust had provided psychologist support to staff and they continued to do so, through drop ins or individual sessions.

The trust had a carers forum to support staff with caring responsibilities outside of work.

Staff in leadership positions spoke highly and with pride about their teams working on the wards throughout and beyond the pandemic.

Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the division. Staff said they felt that matrons could only do so much, and the low staffing wasn't always rectified meaning they were left to just get on with it.

The trust had annual thank you awards for staff. The chief executive officer sent round briefings and weekly email bulletins. However, ward-based staff did not mention these when asked about any positive incentives from the trust.

Following our inspection, we were told that staff were given a £200 thank you bonus to be paid in December.

Staff could access information and resources on the trust's intranet, including accessing the NHS wellbeing offer the trust participated in.

The trust also offered employee development programmes and several staff told us about how they enhanced their skills and progressed because of this.

The results of the most recent staff survey were being analysed as we were inspecting. However, the last staff survey in 2020 showed good levels of staff engagement within the medicine service.

There was a designated Freedom to Speak Up Guardian, however no staff that we spoke with knew who this was and some even asked what they were.

Overall, we found staff morale to be low. However, staff spoke proudly of their colleagues and the hard work they encountered during the pandemic, they said they felt valued by their peers but felt there was a disconnect between clinical and executive staff.

Governance

Leaders did not operate effective governance processes. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service.

In terms of local governance, the leadership team consisted of a nurse director, an operations director, and a clinical director. This ensured that all staff groups were represented at this senior level. The leadership team said they attend many meetings to operate effective governance processes.

All leaders we spoke with described having a written job description and were clear about the role they played in the governance of their area.

We saw minutes for a variety of divisional clinical governance meetings. We reviewed minutes of meetings for 2020 and 2021 of a selection of the specialities we visited. Agenda items were aligned to the integrated performance report so that local leaders and the board were looking at the same issues. We noted issues such as mandatory training, IPC, appraisals, complaints, incidents, and performance were considered at the meetings.

The risk register was discussed at governance meetings. However, it was unclear how actions around the risks were monitored appropriately.

We did not see shared learning from audits, incidents log or complaints.

Following our inspection, the service sent us assurances that they were undertaking clinical guideline audits.

Leaders said that ward meetings took place monthly, and learning was shared during these, however these meetings were just for the more senior staff and meetings with ward-based staff did not take place, information from these was said to be cascaded electronically to staff but it was unclear how managers were assured that all staff read these.

Mortality and morbidity meetings did take place; however, these were not done frequently for all specialities within the division and there was a backlog of cases that were to be discussed. Mortality governance meetings that took place showed they had no minutes from divisional mortality and morbidity meetings to ensure oversight of issues within the medicine division.

Learning from incidents and complaints was shared with the central care group, safety and risk management committee and patient experience committee but it was unclear how learning was shared with ward-based staff.

Management of risk, issues and performance

Leaders mostly used systems to manage performance effectively. They did not always escalate relevant risks and issues and did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

The service operated a framework approach to support leaders in managing risk, issues and performance which fed up from directorate meetings, through committees, and then onto the board.

Risk was reported at a local level and in accordance with trust policy. It was graded, with risks of lower grades managed locally, and medium grade risks featuring on the trust risk register. Such risks received focussed review by a validation group. Higher risks made their way onto an integrated risk and assessment report which was reviewed at board level.

The systems to identify and manage risk did not operate effectively and had not identified the risks we found during the inspection. This included: endoscopy staffing, deteriorating patients and the rights of patients that were subject to the mental capacity act. We therefore could not be assured that leaders understood the risks patients faced.

The risk register had current risk levels and the risks reflected those that the triumvirate told us about. However, not all the risks on the register had been reviewed within the given timescale, we saw many had overdue review dates for early 2020 and early 2021. The risk register was not being managed effectively.

There were multiple duplicated risks on the register, and many had long review dates, for example one risk listed in 2014 was not due for review until 2022.

When we spoke with leaders, they told us the top three risks were staffing, falls and medical patients on non-medical wards, this is known as ‘outliers’ or ‘hosted’ patients. These risks all had varying scores and the falls risk on integrated geriatric and stroke medicine areas had passed its review date (2020) and had a low-risk score despite these wards having the highest patient fall rates.

Leaders of the medicine division knew what the top risks were, they said senior staff on wards all knew of the risks, however, some ward leaders we spoke with did not demonstrate they understood the top risks of the ward. For example, one said that choking could be a top risk, but this was not on a risk register nor was it mentioned as a top risk by leaders.

Staff in endoscopy told us that their staffing was on the Trusts risk register due to the persistent issues which included having to cancel patients lists. However, during the factual accuracy process the trust provided evidence which showed it was reviewing the risks in endoscopy and that a high level of sickness absence had impacted the service.

Performance dashboards were used to measure relative performance improvement, rank against benchmarks, identify improvements in metrics and trendlines, data was added monthly.

On review of meeting minutes for the division, current risks featured as a standard agenda item.

Information Management

The service collected reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information management systems were used effectively in patient care. Managers used information to manage the performance of the department against local and national indicators.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards. For example, notes trollies were left unlocked on all the wards we visited and computers with personal information on were left open.

Staff could access IT systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system. However, staff spoke about the difficulties in using both paper and electronic records with many complaining of the system being too slow.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles. This was sometimes slowed down by connection issues with the software system that was in use.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about research, innovation and how to book an appointment.

Managers did not show how they used audit data to understand performance, make decisions and improvements.

Managers did not provide specific examples of what had changed and improved as a direct result of feedback, complaints or audit results. The service did not provide information to show that feedback or audit results were discussed at team meetings.

Data and notifications were submitted to external organisations as required.

The service had systems and processes in place to ensure notifications were made as required.

Engagement

Leaders did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We did not see staff engagement boards on the wards we visited to update staff on any concerns or general information.

Leaders said that feedback was important to them, and everyone was encouraged to complete the survey.

Managers told us the last staff survey had been completed in November 2020 and the trust was in the process of another one at the time of our inspection. Managers could not give any examples of 'You said, we did' to show voiced concerns had been addressed.

We only saw one displayed 'friends and family test' on the wards we visited. This was reflected in the numbers of returned responses to the questionnaire with the one ward with the display having a much higher number than the other wards we visited.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training and appraisals.

Staff we spoke with said they felt valued by their peers but not by more senior levels of staff.

None of the staff that we spoke with talked about the trust's annual awards. However, we did see information about these in information sent from the trust following the inspection.

Staff we spoke with did feel supported to professionally developed if they wished to do so, for example we were told about how international students were supported to do their OSCE (objective structured clinical examination) which is used to assess clinical skill at pre-registration and postgraduate level.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders told us about the pilot and roll out of patient information boards above bed spaces that would highlight specific needs and risks. However, we didn't see these being used during the inspection

Not all staff could give examples of innovations, however one staff member said the introduction and roll out of the none face to face services had vastly improved patient flow.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.

We saw effective meetings to address long length of stay and discharges.

Staff member on one ward told us how they were part of a team that designed the ward for high-risk haematology patients.

The respiratory department was a regional specialist centre and provides support to a wide range of research for the 'academic directorate of respiratory medicine' and undertakes high quality studies supported by the UK clinical research network portfolio with the aim of improving and developing treatments.

We spoke with some staff who had been given opportunities to develop their skills and enhance their careers.

Technology was used innovatively to ensure a continuity of services during the COVID-19 pandemic. Virtual clinics were being utilised and we saw the use of a mobile phone on one ward for patients to speak to relatives.

Surgery

Requires Improvement  

Is the service safe?

Inadequate  

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training, although mandatory training was not always comprehensive to meet the needs of patients and staff.

Staff usually received training face to face or via eLearning and topics included health and safety, moving and handling, and infection prevention control. Due to COVID–19 face to face training had been suspended and staff were not clear as to when this method of training would re-commence. Managers monitored mandatory training and staff compliance was monitored through an electronic platform. Staff told us they were sent a reminder by email when training was due for renewal. Some staff told us that they did not always have time to complete all of the training, however, ward managers told us they made every effort for staff to complete, where possible and the figures we reviewed onsite corroborated this.

We reviewed mandatory training compliance on F1 and saw it was 95% and F2 which was 96%. This met the trusts internal target of 90%. However, the overall mandatory training compliance across the health group was 89% for nursing staff and 79% for medical staff and therefore we were not assured that all staff received their mandatory training.

There was no requirement for clinical staff to complete mandatory training in learning disabilities, autism or dementia and training for dementia link staff had ceased since the onset of COVID-19. Dementia awareness was not listed as one of the mandatory training sessions in the information provided by the service, and no data for completion of this training was provided. We saw patients with dementia were cared for on every ward we visited, and staff told us that training to support these patients was only available if specifically requested.

Medical staff compliance was described by managers as ‘not as high as we would like’ although one directorate reported a 90% compliance rate. They said they ‘reviewed the position against targets and aimed to fill gaps’. There were plans to make more training ‘live’ with simulations and scenarios and medical staff told us they received support from nurse educators.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have training on how to recognise and report abuse, however, they knew how to report it.

Staff received training specific for their role on how to recognise and report abuse. We reviewed the surgical directorates overall training compliance rate for Safeguarding adults Level 2 and saw 94%. Safeguarding Children and Young People Level 2 compliance was 92%. This met the trust’s internal training target of 90%.

However, staff were not always trained in PREVENT and none of the newly recruited staff we spoke with knew what this was.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us that most patients arrived on the ward with safeguard alerts already in place. For example, concerns raised by ambulance crew as patients were admitted.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw contact numbers displayed on and around the ward and staff were able to describe who the hospital safeguard team were. Staff on I1 told us that they had recently submitted a safeguard for a patient who was a risk of abuse from a family member.

Ward staff knew how to access safeguarding policies for support. They used online forms to refer any safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern. Staff could add any safeguarding issues to patient care plans on the trust patient records system. Staff told us the trust safeguarding team were helpful and gave in-depth and engaging training.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment to protect patients, themselves and others from infection. However, control measures were not always in place.

The service acted appropriately to reduce the risk of COVID -19 transmission and managed flow and admissions to wards according to whether patients had isolated or not prior to surgery. Streaming of the wards was clarified through colour coding and we saw the function of each ward flexed regularly depending on the demand of patients and their COVID status. Visitors to the wards were reminded to comply with social distancing requirements and to wear a face covering at all times. Patients testing positive for COVID –19 were managed on 'red' wards and isolated accordingly.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We saw equipment with 'I am clean stickers' which were dated.

The provider told us they carried out monthly infection prevention and control (IPC) assurance visits across all wards. We reviewed the data submitted by the service, however this did not cover all surgical wards, and therefore did not provide clear overall compliance data for the service. The provider did not clarify why the data submitted was incomplete.

During inspection we saw audits were completely inconsistently. For example, we saw IPC compliance audits on N2 and H1 in December 2020 following COVID -19 outbreaks. It was not clear if actions identified during this audit had been addressed, as we were not provided with further IPC audits for theses wards. Neither of the audits included an overall score to measure the outcome of the audit. Therefore, we were not assured that robust IPC monitoring was in place.

There was no PLACE audit data as this was suspended nationally in response to the COVID-19 pandemic and had yet to be recommenced.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we observed followed the Standard Infection Prevention and Control Precautions policy, they were bare below the elbow and always wore surgical masks during the inspection. Hand sanitiser was available at the entrance of all wards we visited, and we saw these were regularly replenished.

We requested hand hygiene audits for the surgical health group, but this was not provided for all wards. We reviewed a sample of audits submitted which showed 100% compliance.

Staff did not always work effectively to prevent, identify and treat surgical site infections. In the time period between July 2020 and June 2021 the trust reported eight surgical site infections for neurosurgery patients at Royal Hallamshire Hospital. However, the trust was an outlier with higher rates than the England average for cranial surgery in all time periods since March 2020.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always store clinical waste safely.

We visited the main theatres which offered services to a range of surgical specialties. Theatres had been recently refurbished and all appeared to be well maintained. Four laminar flow theatres were available on Q floor which had been refurbished to comply with orthopaedic standards. There were 22 theatres over three floors. However, staff told us only 14 theatres were used, with two undergoing refurbishments.

During our inspection staff told us four further theatres on the top floor were set aside for elective orthopaedic procedures but were not being used at the time of our inspection because of the Trust response to COVID. However, during the factual accuracy process the trust provided evidence which showed theatres on top floor (Q floor) were being used at the time of the inspection by Breast and Plastics Directorate. One other theatre was used for minor procedures undertaken under local anaesthesia.

There was one dedicated theatre for emergency lists, including cases requiring acute surgical intervention within 24 to 48 hours of admission. Each theatre had an attached anaesthetic room, with separate preparation area and an integrated scrub area.

There was a central recovery area incorporating the post-anaesthesia care unit (PACU) with overnight stay facilities. PACU had two identified areas for grey and blue pathway patients. Curtains around cubicles had broken hooks and pins and did not appear clean or well kept. Staff could not provide evidence to show when cleaning of curtains was due or had last been carried out.

There were two robotic theatres at RHH which were used by the colorectal, urology and gynaecology teams.

Sterile supplies were kept off site at a business centre and there was a 12-hour turnaround for general theatre supplies with a four-hour fast track service.

The service did not always have suitable facilities to meet the needs of patients' families. We found ward environments were not always used for their intended purpose. At the Royal Hallamshire Hospital on ward F1 we saw patients in beds in an out of hours assessment area during the day. Staff told us this was sometimes due to having no discharge lounge, which resulted in patients having to wait in separate areas on the wards whilst they awaited discharge. However, there was also a patient awaiting admission. Staff told us there would be a bed available soon, but the patient was there

throughout our visit. We noticed the patient was trying to use the call bell and when a member of the inspection team found a member of staff to help, they explained the call bell did not work. Staff made no attempt to find another place for the patient with a call bell within the assessment area. During our visit we saw no nursing staff check on this patient. However, following our query we did see a housekeeper help them with a request.

Doors to patient side rooms had signs still on showing 'vacant' which were engaged. This meant there was a potential risk domestic staff such as cleaners could enter inappropriately thinking they were empty.

Staff did not carry out daily safety checks of specialist equipment. We saw on ward I1 oxygen, suction and tracheostomy trolley daily checklists had been completed by staff only on the Wednesday for week commencing 4 October 2021. Ward I1 sluice room had inconsistent equipment disinfection checks as some were monthly and others weekly.

We found no anaesthetic logbook or checklist with documentation to support checks of anaesthetic equipment and disposables as required in of Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.

Theatre records showed daily checks were carried out on emergency trolleys and one member of staff was responsible for maintaining medical devices. All equipment we checked showed in date service stickers.

The service did not always have enough suitable equipment to help them to safely care for patients. We saw electronic white boards were used on all wards we visited. These displayed the access and flow into the hospital, admissions on the ward and current status indicators. These indicators included potential patient risks. The N1 neurosurgery ward manager told us they had been waiting for an electronic whiteboard for over a year. As this had not been installed, they wrote their patient's confidential details on an electronic whiteboard manually available for any visitors or other non-staff to see.

We found no medical gas signs on the storeroom doors of all wards we visited. Entonox and oxygen was stored inappropriately on the floor behind the door. Storeroom doors were all unlocked which meant medical gases were accessible to anyone on the ward. This is not in line with (HTM 02-01) NHS estates guidance for medical gas pipeline systems.

We visited several wards with out of date or blank general information boards and panels. Information displayed did not always match what staff told us. When asked, staff on wards told us 'We don't display information anymore because of COVID-19'.

Staff did not dispose of clinical waste safely. Most dirty utility room doors did not have locks. Sluice room doors were unlocked on wards with confused patients. This meant anyone could enter and access harmful controlled substances hazardous to health (COSHH) chemicals stored inside.

The trust told us that following the CQC inspection in 2018 treatment room doors were fitted with electronic locks. However, we found on F1 the treatment room door was unlocked. On ward F2 we found the disposal room with signs that read 'keep locked' and 'no access for unauthorised persons' was open. On ward I1 we found a utility room door was wedged open with a bin. We also found cleaning chemicals on trolleys in the corridor and asked staff why they were not locked away. The ward manager called the domestic supervisor to discuss this and they said they would deal with it, then left the ward. It was not clear how this would be managed. Therefore, we could not be sure the ward environment was entirely safe for all patients, including those who appeared confused and wandered the corridors.

We returned to I1 to review this and saw that toilet cleaning chemicals were still left out in the corridor. We again raised this with the domestic supervisor and their manager, and we were told that none of the wards on E floor had a locked facility in which to keep COSHH chemicals safe. It was not clear why domestic staff had not taken steps to remove the chemicals from the unattended trolley to minimise risk. We escalated this as a matter of priority and the trust told us that an order had been placed to add secure electronic access to these cleaning cupboards. However, we were not assured that staff understood the importance of removing harmful chemicals despite raising this as a concern several times. We were not assured the trust had taken sufficient immediate action to minimise risk to patients.

At the last inspection we saw stock rotation was not in place with newer items at the front of cupboards and some stock was out of date. At this inspection we sampled 7 clinical stock items and saw that they were all in date and evidence of stock rotation.

On ward I1 we saw a roll of dressing material was unwrapped and unravelling on a shelf. When we asked the sister what this was for, she explained it was for a current patient who had undergone a large skin graft. She made no attempt to find a clean environment for it but simply rolled it up and put it back on the shelf.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimised risks. Staff did not always identify or act quickly upon patients at risk of deterioration. The trust did not have a systematic approach to assessing risk relating to patient's mental health.

Staff used a nationally recognised tool to identify deteriorating patients however they did not always escalate them appropriately. The service used the national early warning score (NEWS).

We reviewed patient records with completed NEWS scores recorded within the electronic database system. However, the trust electronic patient records system did not show patient NEWS scores or any flag to identify a deteriorating patient. Staff on a range of wards we inspected explained this would be shown on the e-whiteboard only, this meant not all ward staff were prompted to complete observations to assess patients who may be at risk of deterioration. For example, one I1 ward patient with a NEWS score of 2 who should have been observed every four hours was last observed nearly six hours previously. This meant staff could potentially miss signs of deterioration in patients, thus limiting their ability to respond promptly. However, NEWS observations were completed within required timeframes for another 20 records we reviewed.

During our follow-up inspection visit in November 2021 we saw no deteriorating patient symbols on any of the ward e-whiteboards we visited. After our inspection the trust's action plan stated these were due to be added by March 2022.

We requested the most recent NEWS audit information from the provider and reviewed information dated October 2021. However, this was not provided in a clear format in which to interpret accurate figures.

We saw clear protocols displayed across all wards in the event of a patient's sudden deterioration. Staff we spoke with were able to define these arrangements and knew how to access immediate assistance when required.

The provider had developed guidance for the management of sepsis; however, this was due to be reviewed in on the 6th November 2021.

Staff did not always complete or review risk assessments for each patient in a timely way, using a recognised tool.

Surgery

Staff told us they completed risk assessments for each patient on admission. These included pressure ulcer risk assessments and venous thromboembolism where appropriate. We saw these were completed.

Managers told us senior sisters on each ward had oversight of patient care plans and risk assessments, and they should know when these were required to be updated or re-assessed.

We reviewed the records of two patients on ward F1, both had a diagnosis of dementia.

Patient care plans did not reflect recognition of patient needs due to dementia or support provided, and staff told us this information was not recorded in risk assessments or care plans for these two patients.

Both patient records had completed moving and handling and falls risk assessments, however these risk assessments were not scored to show which patients were deemed to be high risk, leaving vulnerable patients at high risk of harm.

We saw staff did not complete and reassess weight monitoring charts for patients within required timeframes. For example, we saw 16 charts were overdue for review on ward I1. This meant staff had not reviewed the charts for over six days or as the patient's condition indicated.

Therefore, we were not assured that patients were appropriately risk assessed to protect them from potential or actual harm.

Shift changes and handovers did not always include all necessary key information to keep patients safe.We saw that key information was taken from the trust white board system which showed the butterfly symbol for any patient who had a diagnosis of dementia. However, staff we spoke with were not all able to identify which patients on their ward were living with dementia or delirium. Staff told us there were no risk assessments carried out for dementia and there were no systems to review, record, or support patients with a mental health concern or condition. As there were no risk assessments in relation to the challenging behaviour completed and there was no documentation for the risks, this information would not have been included within the handover. Staff we spoke with were not all able to identify which patients on their ward were living with dementia or delirium.

We asked ward staff how they knew what each patient's individual needs were and how to care for them.

Nursing staff told us they rarely used the electronic whiteboard for patient information or live updates, and they relied entirely on handover sheets produced by senior nurses for every shift.

Nursing staff told us the icons used were too small to follow and there were too many which added to poor interpretation. Ward sisters told us if a member of staff joined the team mid-shift, they would provide another handover sheet to ensure the new staff member had all the necessary information available to them.

'Nightingale' or safety huddles were completed on some of the wards we visited but this was not consistent. These huddles were supplementary to handovers and provided staff with key safety concerns for patients residing on the wards. We visited the surge ward who accepted both surgical and medical patients. Staff stated that patients were only admitted to this ward if they were stable, low risk and did not have any significant concerns such as dementia. We reviewed a patient noted to have the butterfly symbol, shown on the white board, indicating the patient had a diagnosis of dementia. Staff were not sure why the butterfly symbol was shown for this patient and thought it may be an error within the system.

Surgery

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe. On all wards we visited we saw the actual nurse staffing was consistently below planned nursing numbers. On some wards this was significantly lower. For example, during our inspection on the 9November 2021, I1 ward had only one registered nurse (RN) on duty supporting the ward manger. The planned number of registered nurses was five. We saw on the same ward that the registered nurse (RN) and clinical support worker (CSW) numbers were all significantly below those planned for the afternoon and night shifts. We saw the ward matron was arranging to bring additional staff across to the ward during our visit.

Matrons, ward managers and a nurse director we spoke with, confirmed there were very few days or shifts in the last month before our inspection, where they met their planned nurse staffing establishment.

Not all wards displayed planned and actual staffing numbers which were visible to everyone visiting the ward. Staff told us this was because staff were moved around constantly to meet the needs of the busiest wards and departments. All staff we spoke with were concerned about nurse staffing numbers and told us substantive and regular staff were always being moved to other wards from their own, which caused further destabilisation to the ward.

Managers reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the service's process to escalate staffing shortages was unclear. Matrons told us they would inform the deputy nurse director (DND) then the nurse director (ND). Staff we asked did not feel they could raise staffing issues with anyone more senior than their ward manager. However, a senior member of staff who came to speak with us told us the escalation process was very clear and staff should incident report staffing concerns but only when the staffing shortages had an impact on patient care. We asked if incident reports had been logged on I1 due to the significantly low numbers, staff told us they had not, as they would not have the time to do it and it would not change anything.

On some shifts ward managers could source additional staff such as an extra HCA to cover a shortage of RNs but staff told us the skill mix was regularly not appropriate, and this still contributed to a lack of nursing care and reduced governance time for ward managers. Some nurses told us they were regularly unable to give patients the care they needed, and some told us they could not carry out appropriate assessments and paperwork as required. Matrons told us staffing was never unsafe because they monitored it constantly. However, some nurses said they felt they were unable to care for complex patients properly.

Senior managers told us all off duty records were signed off by the senior sister and matron before they were given to nurses. Every unit had a bleep holder and once acuity was assessed they would escalate staffing needs to the duty matron. Matrons on both sites told us they liaised with the nurse director. However, we observed bed meetings where senior nurses across the care groups provided an overview of need when areas were understaffed. Senior nurses recorded evidence of discussions about nurse staffing concerns but risk assessments about staffing and acuity were not formally recorded. We regularly saw and heard about staff being moved from one ward or area to another. Ward sisters told us they knew if any shift was fully staffed on their ward, they would always lose a nurse or HCA to cover another ward where the need was greater.

Bed meeting discussions included expected admissions and discharges, wards with closed bays and newly cleaned bays that had previously held patients undergoing screening or isolation following COVID-19 infection. Several bays and specific beds were identified as clean or requiring deep cleaning and patients were moved between bays. However, the ward manager could not adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants rarely matched the planned numbers.

We looked at nurse staffing rotas across a range of surgical wards and found that, although bed numbers and acuity were measured, most shifts were understaffed by at least one registered nurse and one healthcare assistant.

Managers told us national nursing shortfalls were well known, and each winter and during the height of the pandemic they identified clinical activities that could be stalled without being counterproductive. For example, they monitored occupancy in Sheffield ataxia centre (SAC) at NGH and if patient admissions were lower, they would try more medium-term mitigating actions across the trust to keep moves for those needing ward care to a minimum. Several staff from a range of nursing grades told us there were insufficient staff due to sickness and some staff had left due to anxiety. Some staff told us they never finished shifts on time.

The service had also created five ward support facilitator (WSF) roles in different wards and specialties to pick up certain nursing tasks other than patient care to absorb pressure from the bay nurses. One WSF told us they acted as a common denominator of their wards to provide continuity of care for their patients. We heard the bay nurses had found this WSF role helpful at weekends to aid seven-day discharge. However, the WSF staff worked weekdays only, as this was when the need was greatest. Other nursing ward staff we asked on neighbouring wards were unaware of the WSF role.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Senior staff told us unfilled shifts were offered to bank staff and if these remained unfilled after two days they would go out to agency. Some staff we spoke with said they felt this was too long to wait and said they regularly found shifts could not be filled. Staff told us they knew agency staff often took shifts at other local trusts rather than Sheffield Teaching Hospitals because they knew conditions were better elsewhere and other trusts offered an uplift in pay.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. In March 2021, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England averages.

We saw the percentage of consultants at this trust were 61% when compared to 50% as the England average.

We saw the percentage of junior doctors at this trust were 13% when compare d to 11% as the England average.

In the same reporting period, we saw the following grades reported to be working at the trust were lower than the England averages.

We saw the percentage of middle career doctors at this trust were 5% when compared to 11% as the England average.

We saw the percentage of Registrar doctors at this trust were 21% when compare d to 28% as the England average.

The medical staff matched the planned number.

Doctors on the urology ward (F1) we spoke with told us there were no rota gaps and foundation doctors said they felt well supported by the senior medical teams.

Doctors were supported by the 'hospital at night' system with three advanced nurse practitioners and two support workers who could help with tasks such as cannulation and taking bloods.

We were unable to speak with specialist trainees because staff explained it was 'changeover day' and they were all attending trust induction.

Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw on the wards we visited sufficient numbers of medical staff to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Theatre Staff

Staff told us they had recently lost 14 staff from gynaecology theatres. However, managers told us following the inspection that 8 staff had left the team. A business plan had been approved to recruit staff and the service was awaiting new starters.

Staff reported theatre nurses were difficult to recruit so they had created an extra role for a Band 4 assistant theatre practitioner.

Staff worked varying shift patterns and provided sufficient cover for a twenty four hour service seven days a week.

Staff explained they could access further help with staffing through the matron on call.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear but not always kept up to date. Paper records were not always stored securely but were easily available to all staff providing care.

The service used an electronic patient record in which to record nursing care plans and risk assessments for patients. Nursing records were also held to supplement the electronic records. These included fluid balance charts, intentional rounding records and general nursing intervention records. Medical notes were paper based and were stored in document trolleys around the wards.

We saw allied health professionals documented comprehensive care and treatment plans within the paper nursing records that we reviewed.

Staff we spoke with on all wards told us records were kept in different systems and on paper. This made it difficult to find key information that would be required to deliver safe and effective care.

The trust did not utilise dynamic electronic systems which interlinked together. This meant that staff could not access records for all patients using the trusts current electronic system. For example, we saw some patients had been transferred to the neurosurgery ward from critical care, and that ward used an entirely different record system so care records from that care episode were printed out and placed in the patient's file. These were not secured in the records we checked.

Patient notes were not always comprehensive or up to date. We reviewed three patient records, all of whom had a diagnosis of dementia. In all three records, a cognitive assessment had not been completed by medical staff. We saw medical clerking assessment documents were unsigned in three of the five records we reviewed.

We saw in two patient records which included a do not attempt cardiopulmonary resuscitation (DNACPR) record. The DNACPR was located at the front of the notes ensuring easy access to this information. Records were found to be mostly legible, and entries were signed.

We saw the trust used an 'e- white board' electronic overview screen on all wards we visited. This provided ward staff with a digital overview of all patients on that ward at that time and any key indicators such as patients who were waiting for assessments or were ready for discharge were indicated. Staff were also able to see the flow of admissions into the hospital through accident and emergency. Most staff we spoke with told us the white board electronic system provided an accurate overview. However, electronic systems that supported this, were a barrier to care planning. We saw the system operated slowly and often crashed when staff tried to access specific screens. Staff told us that these problems had been escalated to senior ward managers several times, but nothing appeared to be done to improve this.

Junior doctors told us they spent an excessive amount of time waiting for the electronic system to access records, and the system crashing before all patient information could be input. They told us that because of this they felt hampered in providing sufficient medical care on any shift.

We asked ward staff how they used the e-whiteboards and what different icons meant. Few staff we spoke with could identify patient specific needs from the whiteboards and several staff said icons were too numerous and too small to see. Several staff told us the handover document was created using information from the e-whiteboard, but few staff used the whiteboard stating it did not hold information on individual needs. Instead staff used patient information from nursing handovers.

Managers however said they used e-whiteboards constantly to check daily updates and to inform ward rounds. They said it was a workable tool that made life easier. It had provided a platform to check and monitor and audit patient nutrition, and actions had been taken to make improvements.

Managers told us that a trust wide audit of clinical records had not been undertaken since November 2018 due to ongoing electronic patient record work streams and the impact of COVID –19. We saw that the overall compliance rate for the inpatient record keeping at the audit in 2018 was 87%. However, during the factual accuracy process, senior leaders said records audits would be done as part of an investigation and a Trust wide record keeping audit was underway at the time of our inspection for Inpatient, Outpatient and Community Services, which had commenced in September 2021.

On N2, neurosurgery ward we found entries in medical records had been written in retrospect. In one set of records there were four entries and another set had two entries, with 'written in retrospect' added by medical and allied health professional staff. The entries were dated as the day they were written, during our inspection, but only one included the date or time the notes related to. We asked a senior nurse if this was a regular occurrence and they said they had never

seen it in all the years they had worked at the trust. Records were not stored securely. In all wards we inspected, records were not stored securely. On several wards, notes were stored in suitable trolleys, but none were locked. On some wards, records were stored on open shelves. These records clearly showed patient identifiable information and observations including details of their personal care.

Staff on the neurosurgery ward (N2) told us they had no ward clerk so patient records were not filed as they should be. We looked at four sets of paper records and all had unsecured record sheets within the files.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

The hospital used an electronic system to prescribe medicines for patients. Staff did not always follow current national practice to check patients had the correct medicines. We saw the alcohol withdrawal regime within the Trust's policy had not been followed and the assessment for the risk of alcohol withdrawal had not been fully completed. We also found that when a person was given an injection to relieve anxiety, staff had failed to monitor their physical health observations in accordance with national guidance.

Staff described some aspects of medicines administration as unsafe due to staffing shortages. For example, administration of controlled drugs which require two registered nurses, with only one registered nurse on the ward. One nurse in charge told us they were often disturbed when undertaking drug rounds by the need to provide personal care to patients due to staff shortages.

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. Wards we visited only had current temperatures recorded on medicines fridge checklists, with no minimum or maximum. The times of daily checks varied. For example, on ward I1 medicines fridges' external and internal temperatures varied greatly with no action taken by staff. Fridge 1 was 7 degrees external but 22.9 degrees internal for patient's own medications. The last date temperature checks were recorded for fridge 1 was 28 September 2021, and fridge 2 was 17 September; 20 days before the date of our inspection. Fridge temperature checks should be recorded every 24 hours.

Some medicines to be used in an emergency were not stored in a tamper proof container. Medicines in the medicines room were not locked away and access to the room was not restricted, allowing any member of staff with a badge to enter.

However, medicines used in theatres, including controlled drugs were stored appropriately. The controlled drugs book we reviewed had been completed according to trust policy and we saw medicines audit entries completed by pharmacy staff.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw pharmacy technicians were allocated to each ward and were based on each ward full time. They did not prepare or administer medicines, and the Trust confirmed that these tasks were not included in their job description. A pharmacist was available 24 hours a day with one pharmacist working through the night.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, we talked to several members of staff, but their responses were varied in how safety alerts and incidents were discussed. Staff said that alerts would be relayed via email, however they did not have time to read their emails all of the time.

Surgery

Decision making processes were not in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. In one record we reviewed in neurosurgery staff described a deteriorating trend in terms of the patient's delirium, confusion and orientation. The doctor had prescribed PRN (as necessary) Lorazepam or Zopiclone but noted four days later that although the patient continued to display signs of confusion and agitation, neither medication had been administered.

Incidents

The service did not always manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report but did not always report them. Most ward staff we asked could not give us recent examples of any shared learning from incidents. They could not list the top three incident-related risks on their ward or department beyond broad categories such as falls. Non-nursing staff told us they would not use the incident reporting system but would report an incident to ward sisters.

Staff we asked knew where and how to access the trust incidents reporting system.

Staff did not raise concerns and report incidents and near misses in line with trust/provider policy. Staff were not always encouraged to report incidents relating to staffing shortages or pressures by ward managers and matrons. Several staff we asked had either stopped raising incidents around staffing as they felt no action was taken, there was no solution or felt the response was inadequate. For example, one staff nurse told us they reported an unforeseen incident involving a young adult falling in the toilet. In response they were told to place their patients more appropriately. Staff told us they would only raise incidents about staffing if they or colleagues were left as the only registered nurse to cover the ward.

We reviewed 41 incidents which occurred across a seven-day period in the specialities that provide surgical services at The Royal Hallamshire Hospital. We saw the highest number of incidents related to slips trips and falls with clinical care issues as the second highest. Other themes included discharge issues, medical equipment and staffing.

Staff told us action plans from incidents around falls and pressure sores were available on the trust's electronic system. However, venous thromboembolism specific incidents would have alerts in a different internal database which fed into the ward E-whiteboards.

The matron's dashboard for key performance indicators (KPIs) was where matrons reviewed monthly data metrics. During the factual accuracy process the trust informed us the dashboard could also be accessed all staff with a trust log-in, however we were told staff below band seven could not access it. The service had never events in theatres and on wards. The service reported eleven never events since 1 September 2020 to the 31st August 2021. Of the eleven, six were reported through NRLS and 5 through STEIS.

Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers. The most common theme was retained foreign objects. The service had three such never events during this period, at this hospital.

Surgery

CQC had written to the Trust in June 2020 and again in July 2020 following concerns about the number of Never events reported by the Trust. They had responded to CQC with a letter in July 2020 detailing how they would disseminate learning throughout the trust of previous never events. It was apparent during this inspection that lessons had not been learned and Never Events continued to occur.

Managers shared learning with staff across the care group about never events that happened elsewhere. However, no ward staff we asked could detail any shared learning from never events. The nurse director told us they were responsible for "signing off" never events in their area. They mentioned two recent never events involving insertion of a wrong lens and two wrong site injections. They said they had carried out some action planning and took plans back to governance meetings every six months.

Managers described how a team had learnt from a never event. A wrong site incision had been reported within the care group and the team had carried out a simulation of all the elements that contributed to the outcome. They found there had been several human factors involved. They carried out a debrief to understand all five steps for safer surgery. This involved the multidisciplinary team and included senior managers and resulted in themed work being carried out within the care group.

We found a patient record in neurosurgery where a patient had undergone a surgical procedure and the five steps for safer surgery were not all completed on the checklist. There was no signature in the sign out column after completing the procedure. This showed learning from the errors found in some never event investigations elsewhere in the trust had not been improved.

The trust's safety message of the month in June 2021 related to incident reporting. This was sent trust wide to staff about reporting incidents, raising awareness of what constitutes an incident, the metrics and reporting information promptly.

Staff reported serious incidents clearly and in line with trust policy. Staff we asked knew where and how to access the trust incidents reporting system. However, they were not always encouraged to report incidents relating to staffing shortages or pressures by ward managers and matrons. Several staff we asked had either stopped raising incidents around staffing as they felt no action was taken, the response was inadequate, or there was no solution. Staff told us they would only raise incidents about staffing if they or colleagues were left as the only RN on their ward.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. However, no ward staff we asked mentioned duty of candour although, when prompted staff said they were aware of the importance of being open and honest with patients and their families.

We reviewed the service's musculoskeletal care group minutes from September 2021. This confirmed duty of candour training was available, and all senior nurses were encouraged to attend. Staff could book this through an online learning delivery platform and were referred to the CQC website for duty of candour updates.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw shared information on surgical wards from incident investigations. For example, the I1 head and neck ward had a monthly action plan in response to incidents relating to collection of blood products identified at ward level and on the trust's incident reporting system. This showed all staff had to ensure they were fully trained and competent with E-learning completed by all. The lead responsible would then assess all staff's understanding with questions. However, the review date was June 2021, and the plan did not show if this action had been completed and signed off.

Surgery

We saw some shared incident information on surgical wards from incident investigations.

This ward also displayed one missed dose of drugs in April 2021 as recorded by the pharmacy electronic prescribing and medicines administration system (EPMA). Staff were reminded to ensure they shared this information and learning following the incident with the ward team, ensured correct supplies were ordered, and staff completed EPMA accurately.

Staff met to discuss the feedback and look at improvements to patient care. Managers told us that a rise in incidents such as falls. and pressure ulcers were escalated to the governance team. There was an incident review groups trust wide. Matrons attended meetings to develop the root cause analysis. Wider learning was then shared across the organisation.

We asked managers how they were assured that learning would be embedded in practice and they gave an example of how a trust wide falls group worked to embed learning. They had seen a reduction of falls by half as a new system ensured 'certain things' were given on admission. Triumvirates checked incident data monthly to spot any trends arising and would challenge directorate teams if there were any rising numbers.

Managers debriefed and supported staff after any serious incident. A matron we asked about learning from incidents said their directorate used 'five points in five minutes' communication at their ward huddles. This was a way of sharing quick feedback focusing on the main learning from RCAs and investigations. However, no ward staff mentioned the 'five in five' approach when describing shared learning from incidents. A matron told us they highlighted the MAJAX training and overview video to their staff and had good uptake. They checked in with teams often about how to access their battle bags and action cards. There had been a local push to complete this training in the musculoskeletal department and an internal trust system recorded the actual uptake.

The matron for surgical services told us they had allocated extra staff to support the recent electronic patient record downtime, with bronze and silver command in place. They had heard no concerns or feedback from staff and confirmed it went smoothly.

Safety information

The service did not always use or monitor results well to improve safety. Staff did not always collect safety information and share it with staff, patients and visitors.

Safety information data was not always displayed on wards for staff and patients to see. No safety information was displayed on any wards we visited. After our inspection the trust sent us data confirming they had stopped compiling 'safety thermometer' data in June 2019. Matrons and ward managers we asked, said data for these metrics were available on an internal trust database where they could pull monthly reports. Weekly nurse in charge bulletins included latest themes or issues.

We also did not see any safety information displayed in ward areas on our last inspection in October 2018.

We asked nursing staff what safety information was available to patients and those we spoke to could not say although some matrons told us this could be accessed through the electronic reports.

Some staff did not use the safety data to further improve services. Staff we asked did not see their ward's latest patient safety figures for falls or pressure damage. This meant we could not be assured leads had governance oversight or review with all ward or lower band staff to monitor and improve safety performance.

However, allied health professionals said they were updated daily about safety information figures, but these were raised informally and by exception. For example, pressure sore updates were covered at handover. One physiotherapist told us they worked with the onsite team of tissue viability nurses to prevent pressure damage.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff monitored the effectiveness of care and treatment.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

We saw the trust had a policy on implementing The National Institute for Health and Care Excellence (NICE) guidance. The trust employed a NICE Information Co-ordinator who assessed the relevance of guidance for the trust.

Managers told us they ensured staff followed the latest NICE and other national clinical guidance using the clinical effectiveness department. Clinical directors also appointed consultants to oversee guidance, which was shared at management directorate meetings. One clinical group had incorporated guidance into a clearly documented pathway and reported they found this easier to manage when any deviation from guidance occurred. They carried out close monitoring to provide assurance that clinical practice was delivered in line with this guidance

Managers told us they ensured national guidance was incorporated into practice through MDT checks and compliance was made clear to staff. An Annual Report of NICE Implementation was produced each year by the Clinical Effectiveness Unit and approved by the Trust Executive Group. We saw NICE guidance implemented into several health group audits and documents including the surgical site infection surveillance programme, open fracture – time to debridement, antibiotic prophylaxis and the national vascular registry 2018.

We saw a notice in patient records showing the patient was included in the national surveillance of surgical site infection programme, which was in line with best practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. However, the service did not always make adjustments for patients' individual needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients requiring additional hydration and nutritional intervention were monitored through fluid balance charts and nutritional intake records. However, staff did not always accurately complete patients' fluid and nutrition charts where needed. Staff did not total the daily intake and output on fluid balance charts we reviewed. For the three fluid balance charts we reviewed, we noted they were not fully completed, and the daily intake and output was not recorded.

Surgery

We saw food and fluid charts were not always completed accurately on our last inspection in October 2018.

We saw patients were not provided with different colour lids, trays or plates to help to identify them as needing support at mealtimes. We also saw no equipment was available to help patients living with dementia to eat, for example- coloured plates or cutlery. Staff were able to describe the equipment that was available, but it was not in use at the time of the inspection.

Following learning from a serious incident in 2020, a package of E learning was implemented at NGH and later Trust wide, to ensure patients received food and drink of the correct texture for their needs. The trust reported this was audited in 2020 and compliance achieved. Following this, staff told us they held nutrition safety huddles before meals. Kitchen assistants had access to a standard operating procedure showing how to prepare meals and thickened fluids. We spoke with two kitchen assistants who confirmed this and showed us the information they were given with pictures on how to present meals.

Staff trust wide used a knife and fork symbol on whiteboards to identify patients with additional needs around eating and drinking. Staff told us they had a lot of patients with swallowing difficulties. The trust had employed nutritional assistants to help patients at mealtimes.

Staff told us volunteers on a different ward had completed dysphagia (swallowing problems) training. However, there had been no volunteers on wards since the COVID pandemic began.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition (MUST). We reviewed three patient files and saw that they were completed and up to date.

Specialist support from staff such as dietitians and speech and language therapists were available. Support was offered through specialist meal plans, nutritional advice and dietary specific risk assessments.

The I1 head and neck ward could access their own specialist dieticians and speech and language therapists (SALTs). However, at the time of our inspection they only had two SALTs available for a 32-bedded ward which was often full of patients.

Patients waiting to have surgery were not left nil by mouth for long periods. We requested the most recent fasting audits from the provider, but they told us they had been unable to find any audits related to fasting carried out in the past 12 months at either NGH or RHH.

All patients we spoke with told us they enjoyed the food and drinks that were provided with a good choice offered every day.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The provider used a standard pain scoring tool which used a numerical indicator to assess and measure patients pain levels.

We reviewed nine patient records and saw that pain relief was delivered in accordance with prescribed times. However, we observed a patient in a side room on I1 who was clearly in pain when trying to adjust their position in a chair. We pointed this out to the ward sister walking with us and asked if staff checked pain relief regularly for patients and they replied 'Yes, that's a very painful procedure' but they took no actions to address the patient's pain at the time.

However, we saw pain nurses actively reviewing patients with complex or ongoing pain issues. Ward staff told us that they were available on the wards most days and were invaluable members of the team.

We asked staff how they gathered information about pain from patients with difficulty in understanding. The nurse director told us they had learning disability (LD) links who were mainly matrons and physiotherapists, and that information would be sent to all these staff. They described some adaptations and reasonable adjustments that could be made for those living with learning disabilities. However, ward staff we spoke with could not say how they ensured accurate pain scores were obtained from patients with dementia, delirium or a learning disability.

We spoke with one matron who showed us a booklet which could be used as a visual aid to communication. This booklet could assist patients with specific needs, but this was kept in the nurses' station and not used by staff to support patients at the time of inspection.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make some improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. However, the data we received regarding clinical audit referred to services at Northern General Hospital only.

Outcomes for patients were mixed when compared to England average. From March 2020 to February 2021, all patients at Royal Hallamshire Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

At specialty level, urology patients had a higher than expected risk of readmission for elective admissions when compared to the England average.

All patients at Royal Hallamshire Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.

At speciality level the expected risk of readmission for non-elective urology and neurosurgery admissions was similar to the England average, whereas the risk of readmission for ear, nose and throat patients was lower than the England average.

Ear, nose and throat patients at Royal Hallamshire Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Managers and staff carried out some audits to check improvement over time. These included IPC audits with accreditation given by the Trust IPC team. Reports within the trusts electronic recording system had been maintained to provide oversight for managers who carried out regular one to one meetings with matrons for the 'How safe is your ward?' dashboard.

However, we saw no dashboards displayed (staff told us this was due to COVID) and staff told us most audits including the record-keeping audit had ceased during the COVID-19 pandemic and they knew of no plans to restart them. However, following our inspection senior managers said that a Trust wide record keeping audit had commenced in September 2021.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. The provider reported one outlier for mortality.

Provisional PROMS data provided for the Trust for the period 1st April 2020 – 31st March showed a marked reduction in arthroplasty operations due to the COVID-19 pandemic. However, the department looked at various digital ways to support communication with patients.

A number of actions were put in place including commencement of point of care testing (POCT) of all emergency admissions (in Feb 2021) and a protected and dedicated pathway for fractured neck of femur patients.

We also requested the providers recent audit 'Five Steps to Safer Surgery. The provider told us the policy was being revised. We were told the Safer Procedure Committee had agreed changes to the audit methodology and the programme of re-auditing would re-start as the more 'blue' elective COVID-19 free patient operating slots become available.

We reviewed four 'Five Steps to Safer Surgery' checklists and found two had been fully completed according to recommendations. However, the remaining two checklists reviewed in the theatre recovery area did not have a fully completed 'sign out' section. This meant only two thirds of the required checks had been documented in theatre for these patients.

No audit information was available or displayed in theatres.

The service was accredited by the Royal College of Anaesthetists in July 2021.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. However due to COVID-19 the use of volunteers had been suspended. It was unclear when they would be reintroduced again.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were not always experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers told us that matrons could view a spreadsheet showing red, amber, green (RAG) rated sections for nursing staff competencies in all areas they managed.

The nurse director told us newly recruited international nurses had a one to one meeting with the nurse educator. When nurses struggled with competency the educator worked with them. Sometimes the setting was not suitable for them and the educator held an honest conversation before the nurse lost confidence.

We saw a lack of ward staff awareness and understanding of how to use and access basic observations and data from the E-whiteboard. We spoke with a senior nurse within the neurology ward who was not aware that digital information from the white board could be used to create an up-to-date patient handover document. Currently this staff member produced this manually for staff every day.

Managers did not always make sure staff received any specialist training for their role. The trust told us that link nurses were in place across wards and departments and had specialist training in areas such as tissue viability, dementia, and falls. We requested the names and the training dates for the link staff on all wards we visited but this information could not be found. Staff told us that no training for link nurses had been provided since the start of the COVID-19 pandemic. During the factual accuracy process, senior leaders told us most specialist nurses had been redeployed to support the staffing during the pandemic. This meant ward staff could no longer access specialist support within their teams.

We requested data to show what training was offered to staff in addition to the mandatory training programme. We saw the trust provided fourteen courses deemed as essential training in areas such as falls, mental capacity, NEWS and mental health awareness. The trust's internal compliance target for completion of this training was 90%. However, we saw that staff met the compliance target for only three of the fourteen courses offered staff met this target. In some areas the compliance rate was significantly lower. For example, 62% of nursing staff had completed pressure ulcer REACT training and 65% of medical staff had completed falls training. These figures are concerning considering the risks we found around pressure ulcers and falls during our inspection.

Managers gave all new staff a full induction tailored to their role before they started work. However, this was informal as there was no document to confirm an induction had been undertaken. This meant that induction content and quality varied across the trust and was inconsistent.

Managers supported staff to develop through yearly, constructive appraisals of their work. Accountability for training compliance was with managers. Staff appraisals could not be completed without mandatory training completion although managers told us they ensured compliance. A matron told us staff impact assessments were covered as part of their appraisals with line managers. Trust wide staff appraisal data was submitted by the provider for nursing and medical staff. We saw that the overall appraisal compliance figures for nursing staff ranged between 79% in neurosciences to 98% for plastic and breast surgery care groups. The trust compliance target for medical staff was 90%. The medical staff compliance rate ranged between 68% for general surgery to 94% in urology. The trust did not collate this information by site.

One ward manager told us they used the 'how healthy is your ward?' checklists when carrying out supervision with senior ward staff. This summarised health and safety, fire, legionella, caring, responsive, effective, safe. This provided consistently in discussion and areas for improvement.

The clinical educators supported the learning and development needs of staff. Ward staff feedback about clinical educators was positive. We heard they were supportive and booked staff onto relevant courses to help develop their skills such as cannula and electrocardiogram competence. One staff nurse had recently completed their peripherally inserted central catheter line training, as their ward undertook total parenteral nutrition. They were given details about study days at their appraisal, for example in palliative care.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. All managers we spoke with told us that trying to bring staff together due to staffing shortages was challenging but they sent key information by email and through WhatsApp channels.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager however they were not always supported to develop their skills and knowledge. Many staff told us that there was not enough time to prioritise this as the wards were short staffed. They told us this affected their opportunities to improve competencies.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We observed a multidisciplinary team patient review meeting and saw proactive contributions made by all members of the patient care team which included consultants, junior medical staff, radiologists, and nurse specialists.

Allied health professionals including occupational therapists, physiotherapists and SALT all provided care as part of each ward team and contributed to patient records. They attended ward handovers, nutritional huddles, and safety huddles.

Allied health professionals worked closely with ward staff, junior doctors and pharmacists on most wards we visited. For example, a rotational physiotherapist on an integrated ward had working hours to match the nursing staff. They attended and could arrange MDT meetings as well as falls huddles. They heard about incident updates and actions on their ward.

Seven-day services

Key services were available seven days a week to support timely patient care.

Ward staff told us consultants led daily ward rounds on all wards Monday to Friday. Consultant advice was available at weekends. Staff told us patients were reviewed by consultants depending on the care pathway.

The service offered seven-day 24-hour discharge and the pharmacy was open seven days a week.

AHP and ward staff we asked said diagnostic imaging scans were usually reviewed and reported quickly. For example, a physiotherapist told us urgent chest x-rays could be done overnight if necessary.

Staff could not always call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Although following our inspection senior leaders said the Liaison Mental Health Team provided assessments seven days a week in hours and out of hours.

However, we heard the I1 head and neck ward had challenges discharging ear, nose and throat (ENT) patients transferred from neighbouring acute trusts out of hours at weekends. Patients transferred to the ward on a Friday are

transferred back on the Monday to their respective hospital. Patients transferred after 5pm on Friday were sometimes still on the ward Monday morning as the short-term intervention team only attended if patients needed specialist input. Patients awaiting discharge back to care homes could often be kept in hospital another night, if all arrangements were not in place before 6pm.

Ward staff told us medicines could delay their patients on weekends, as they could not always access doctors or locate their bleep numbers. This was because doctors did not always update the E-whiteboard with their numbers. Staff said medical outlier patients could also be held up as doctors could not contact their teams.

We requested information regarding the review of seven-day services. The trust told us in March 2020 we were advised by NHS England & NHS Improvement that due to current and anticipated increasing pressures upon systems in responding to the coronavirus (COVID19) pandemic, the spring Board Assurance Framework (BAF) submission requirement for the region had been deferred to Wednesday 30 September 2020 and in June 2020 a further communication stated that a September BAF would be unreasonable and would not necessarily reflect business as usual in regards to the 4 priority 7 day service review standards and advised that the September return was cancelled with no plans to collect a Regional BAF return that year. The trust told us they were awaiting the audit to restart.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff we asked gave patients information on managing their diabetes, pressure area care and smoking cessation to raise awareness and patients could be referred for smoking cessation support upon discharge.

Patients could be referred for substance misuse detox programmes where appropriate.

We saw on I1 ward staff gave one patient smoking patches to manage their cessation. A health support worker told us they gave patients information about stoma care and maintenance. They also gave information on catheter use to urology patients if needed.

Wards we visited had information available for patients on leaflet racks. However, we did not see any staff giving patients leaflets post-procedure or before discharge. The trust was working to implement a system-wide smoking cessation programme

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. Staff did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff did not always protect the rights of patients subject to the Mental Health Act or follow the Code of Practice. During inspection we reviewed three patient records. All three patients had a diagnosis of dementia and were experiencing

confusion, however none of the patients had a completed mental capacity assessment in place. In two of the records, we reviewed we saw families were contacted to gain consent for the clinical procedures and decisions undertaken. None of the files we reviewed clarified if the patients were able to consent for their own care and treatment and had the capacity to do so. However, staff told us that general consent for all treatment was assumed at the point of admission. This is not in line with the Mental Health Act Code of Practice.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. In two of the records, we reviewed we saw families were contacted to gain consent for the clinical procedures and decisions undertaken. None of the files were reviewed documented a clear process to determine how consent for treatment was obtained. They did not demonstrate if the patients were able to consent for their own care and treatment and had the capacity to do so.

We reviewed four patient records in N2, neurosurgery ward, two of which showed mental capacity assessments were not routinely carried out in a timely way. In one case a patient had been on the ward for six days and in another case for eight days before capacity assessments were completed. A patient displayed agitation and aggression towards their spouse and therapy staff, had struck a nurse, and had experienced three falls before staff took this action. The first fall took place overnight after transfer to the ward and notes stated, 'patient confused as baseline' and compromised GCS'. We were told the incident report for the first fall was completed 5 days after the fall took place. The trust provided incident reports following the inspection and these confirmed the incidents and completion dates.

Staff told us restraint would not be used until behaviours were assessed and medical options considered. However, we saw records written in retrospect that appeared to show staff had spoken with a patient's wife to explain why the patient could not leave the ward to go outside before the DoLS form was completed.

We reviewed the records of a patient who had suffered a brain injury which showed staff had not carried out a mental capacity assessment until six days after admission to the ward, despite documentation in the patient records referencing 'no capacity'.

The provider had undertaken an audit of mental capacity assessment and best interest decision making documentation in response to Regulation 28 served by HM Coroner in relation to poor understanding and application of the Mental Capacity Act 2005, including the promotion and use of the hospital passport for people with learning disabilities. We reviewed the audit which was dated August 2021. Four patients receiving care within the surgical care group were selected as part of the audit. The results of the audit showed poor compliance with the Mental Capacity Act and staff lacked knowledge and understanding of their responsibilities within the Act. The audit also showed there was an inconsistent knowledge of the health passport which is a document used to support the care needs of individuals with a learning disability.

Staff told us they had good access to the trust's specialist palliative care team who gave them a realistic idea of how soon the team could arrive on wards. Staff could add end of life (EOL) additional needs to the care core plan on Lorenzo. However, EOLC information boards we saw had no information on how staff should gain consent or complete mental capacity assessments (MCAs).

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. We found consent for a neurosurgery intracranial pressure monitor was not completed appropriately. A specialty trainee

level 3 recorded they had telephoned the patient's relative to gain consent and had signed the form, but it was not countersigned with a second opinion by a consultant, no risks of the procedure were documented, and a paper copy was not given to the patient's family. However, we did observe good compliance by staff in theatres when completing the second stage of the consent process.

Staff did not always make sure patients consented to treatment based on all the information available. Staff did not always clearly record consent in the patients' records. In urology we reviewed two patient records and found consent in one of these was not fully completed. The handwriting was not legible, mortality figures were not quoted, and the venous thromboembolism form was visible but not validated on the paper copy. This meant the patient may not have understood all the risks involved in the procedure before giving their consent.

However, for patients without dementia, delirium or confusion, general consent around personal care and treatment was not a concern.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us that they received training in mental capacity and consent. We requested training compliance figures from the provider and saw that staff did not meet the trusts 90% compliance target rate. We saw nursing saw had a 56% completed compliance rate and medical staff had a 42% compliance rate

When patients could not give consent, staff did not always make decisions in their best interest, taking into account patients' wishes, culture and traditions.

We found physiotherapists documented carrying out treatment in best interests of patients who lacked capacity. However, a mental capacity assessment was not recorded until some days after treatment.

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff treated patients with compassion and kindness. Staff did not always respect patient's privacy and dignity but worked hard to meet patient's needs. Staff told us due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.

Staff followed policy to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

Patients could also be transferred to side rooms to provide privacy and to respect their dignity. However, staff told this was not always possible due to COVID-19 pressures and patients requiring isolation.

Surgery

Working call buzzers were not always placed within reaching distance of patients meaning they could not always call for help. We spoke with a patient waiting in the urology assessment unit with no access to a working call buzzer, so they could not call for help. Staff explained the buzzer did not work but took no action to move the patient to another area where they could access a working buzzer.

Feedback from people who used the service and those who were close to them was mixed. Some relatives told us they had not been informed about what was happening to their family member.

The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received.

The trust provided Friends and Family Test data gathered from the musculoskeletal surgery wards that showed a range of scores trust wide. At RHH ward P2 scored 100%.

The number of responses were very low with 1 response out of 36 discharges on Huntsman 2 to 18 responses out of 75 discharges from Huntsman 6. The information provided did not include details of feedback given or any qualitative data.

Emotional support

Staff did not always provide emotional support to patients to minimise their distress. They did not always understand patients' personal, cultural, or religious needs.

We reviewed three patients who required additional support due to a diagnosis of dementia. In all three patient records that we reviewed we did not see any care plans to support the emotional needs of these patients.

Staff told us that additional care was always provided, for example, additional observations but none of the records we reviewed demonstrated personalised care planning for specific needs or emotional support.

Staff recognised that time providing emotional care including enhanced interaction was limited. All staff we spoke with found the lack of staff to be a significant barrier to delivering quality emotional support. However, all staff were motivated to provide this care whenever they could and feedback from patients during the inspection was positive.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. However, we did not see any care plans which supported patients cultural or spiritual needs. Staff told us the system did not have these types of care plans, but experienced staff could develop bespoke care plans if they knew how to create them on the electronic system.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.Staff supported patients to make informed decisions about their care.

We reviewed the records of five patients and saw clear communication recording between medical staff, allied health care professionals such as speech and language services and patients' families

Surgery

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff relaying information to patients across all wards we visited and saw that staff shared information in a calm and clear manner. Patients we spoke with told us staff were professional and friendly and although they sometimes had to wait to receive information it was provided to them clearly.

The trust supplied an action plan produced following a difficult situation where a deaf patient had been unable to understand information a doctor was providing, and staff had to ask a family member to interpret. The action plan showed what actions were required, who was responsible, and timelines for achievement. Some completion dates had passed, and some actions showed evidence of change, but it was not clear if later changes had been completed.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service undertook some planning and provided care in a way that met some of the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.

Managers spoke of an unmet need that was hard to quantify, the trust was treating many patients who were less fit but still required complex surgical care. Bed capacity was a big problem, so staff were trying to 'create community capacity regarding virtual beds'. They were also concerned about their ability to sustain the non-elective pathway. Capacity planning was a constant piece of work, with consideration of the use of side rooms and planning throughput to ensure patients had their surgery. The trust had introduced 'demand-based scheduling' which had been a great ambition but in practice staff said this was hard to execute. They were 'still redesigning the methods used for allocation' as they said they 'don't have all the information'.

Medical staff told us they were required to escalate all surgical cancellations before contacting patients to ensure organisation wide management were aware.

At a wider level, bed managers met daily and senior surgeons worked on a rota as surgical commander to ensure balance between specialties for demand versus capacity.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

We asked several staff if their wards had any mixed sex breaches in the last six months and none told us they had. However, we found wards at Royal Hallamshire hospital were informally divided into male and female bays, but staff told us patients could access any bathroom or toilet at either end of the ward. This brought into question whether accommodation and facilities were used appropriately.

Surgery

We requested data regarding missed appointments and how they were managed from the provider, but it was not submitted.

The service relieved pressure on other departments when they could treat patients in a day. We saw the health care group continued to provide day surgery for a number of procedures.

Meeting people's individual needs

The service was not always inclusive to take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

Wards were not always designed to meet the needs of patients living with dementia.

The service had recently refurbished a ward with signage and brightly painted areas to help patients with dementia. However, there were no other adaptations to meet the needs of these patients and other wards we visited had no dementia friendly signage or adaptations. staff told us they discussed patients with any dementia needs at handover, so all staff were aware. However, staff we asked did not always know which patients suffered from dementia or delirium. AHPs mentioned they had access to resources to comfort patients with dementia. However, this was not a formal process as no patients had personalised dementia care plans in place.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Ward staff we asked described how they would give patients with dementia or learning disabilities extra support. However, these answers varied greatly between staff and staff understanding of dementia was poor. We saw the butterfly scheme being used for one patient with dementia. However, when we asked the matron about this, they said the patient was 'just confused'. Staff told us some wards no longer had a dementia champion due to COVID-19.

One nurse in charge told us their ward had higher numbers of medical outlier patients with dementia. This meant these patients could potentially be more disorientated and overlooked at times of high acuity or when the ward was understaffed. They would try to nurse patients with dementia in the same area to concentrate staff. On our last inspection in November 2018, we advised the service it should improve the experience for patients who need extra support, such as those living with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

We saw chaperone posters in clinical neurophysiology for patients who wanted to have a chaperone present during their test.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Ward staff told us they could access an interpretation machine/interpreter on wheels. This could facetime an interpreter onscreen so patients could see their upper body and hand gestures. A physiotherapist said this was helpful for one of their long-stay patients who only spoke Cantonese.

However, no staff we asked had used this but two had seen it in use on their ward. They reported it sometimes had problems connecting to the trust's internet. Staff told us they would allow relatives or family members to translate on a patient's behalf if they had completed a phone assessment first.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with some national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and some national targets.

Managers reported growing waiting lists which they said was worrying but they said this was in line with national direction. Theatre cases per list were lower due to COVID-19 safety measures they followed, and staff said they needed to find ways to complete the same number of cases as pre-COVID. Staff said it could take years to reduce most challenges due to the scale of the problem, complexities of ward types (grey, blue and red). They said there were tight recovery plans in place and staff had attended a performance summit led by the CEO. We asked to view these plans, but they were not made available to inspectors during or following the inspection. Directorate staff met to discuss key deliverable target measures. Managers said staff understood and contributed to good recovery action plans.

Staff told us they mainly kept up with time critical patients; specialties held fortnightly meetings to review patients with long waits to see if they needed reprioritisation.

A service manager we spoke with could not remember the exact numbers of P3 and P4 patients waiting for procedures but would be able to provide a list if inspectors required it. We requested this data from the provider, but we did not receive it.

Medical staff we spoke with said their elective procedure waiting lists were growing but felt 'the senior leadership team did not seem to have a plan' or contingency to tackle the waiting lists. They said there was no weekend or waiting list initiative work planned to help clear the backlog. One consultant told us 'all consultants are more or less doing clinical harm reviews'.

Managers told us they had run a caseload management exercise to understand their current situation. Managers told us waiting lists were reviewed regularly with caseload management discussions for those patients waiting 52 weeks and above to ensure patients were safe.

Senior clinicians had noticed that more orthopaedic patients than before had chronic health issues, so staff had to carry out extra work to triage and manage patients before surgery was imminent. They noted there had been increases in post-surgical complications.

Managers told us there was recognition that patients waiting for surgery were coming to harm, so they monitored risk and, where possible, they utilised social support and better pain management, but some patients were simply deteriorating.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff told us they mainly kept up with time critical patients; specialties held fortnightly meetings to review patients with long waits to see if they needed reprioritisation.

Surgery

Clinicians recognised cancer patient procedures and Priority 2 procedures were ongoing and uninterrupted.

Managers and staff worked to make sure patients did not stay longer than they needed to.

We spoke to a patient flow coordinator (PFC) based on the N2 neurosurgery ward. They worked to reduce patient's average length of stay by case managing and querying complex pathway delays with surgeons and anaesthetists. They joined the board round with the neurosurgery matron using a traffic light system of patient needs for next steps.

Many wards we visited had high numbers of medical patient outliers.

The PFC said the biggest patient flow issues in neurosurgery were internal hospital and trust bed transfers. Neurosurgery only had 20 beds for the trust's region including these transfers so at times flow would come to a standstill. The service had no neurosurgery emergency beds available unless the PFC transferred out another patient. We heard they had neurosurgery outliers once every two months on average. They also had challenges if their post-operative neurosurgery patients were moved onto other wards, as they were too specialist so only neurosurgical nurses would recognise some of their symptoms. They told us orthopaedic and arthroplasty patients were being treated on the neurosurgical ward in the few days after our inspection as these waiting lists had increased, especially P3 and P4 patients. Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards.

Managers monitored the number of delayed discharges, and knew which wards had the highest number. Staff identified 10% to 15% of current patients who no longer needed acute surgical care. All patients were reviewed for their suitability for transfer to the discharge lounge. However, managers and staff, including patient flow coordinators told us they worked to make sure that they started discharge planning as early as possible.

Staff supported patients when they were referred or transferred between services. We saw clear documentation of neurosurgery patient transfers between the emergency department at Northern General Hospital to critical care at Royal Hallamshire Hospital and then on to the neurosurgical ward.

Managers did not monitor patient transfers to follow national standards. We requested data in relation to the number of patients who were moved between wards and at night, from the provider bit did not receive it.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service did not clearly display information about how to raise a concern in patient areas.

No PALS information was displayed on any wards we visited. Support staff told us ward staff would offer PALS contact details to patients who asked to raise a complaint or concern.

Wards we visited did have friends and family test feedback boxes visible near the entrance/exit. However, patient and visitor information around this was out of date. For example, on the F1 ward we noticed the percentage of patients who would recommend the ward was dated August 2017-18.

Surgery

The trust supplied a log of complaints for the general surgery care group that showed 21 complaints had been received from patients and relatives, with eight ongoing. There was a process which ensured managers of wards not subject to a complaint undertook independent investigation of patient complaints.

The complaints that we reviewed varied in theme and included delays in medical decision making and investigations, poor medicines management and storage, faulty equipment, poor infection prevention and inappropriate conduct of night staff.

Staff told us they understood the policy on complaints and knew how to handle them. Managers told us they investigated complaints on behalf of other wards to retain an independent view, investigation and any identified themes.

Managers shared feedback from complaints with staff and learning was used to improve the service. However, the complaints spreadsheet provided to us did not show what actions had been taken or any changes made as a result of complaints.

Managers told us senior sisters had oversight of complaints and would review them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. One ward sister we spoke with described the process they followed with examples of how they had responded to a complaint and the lessons they had learnt and shared with the ward staff.

Staff could give examples of how they used patient feedback to improve daily practice. This included access for ward staff to interpreter equipment to help patients whose first language was not English and for patients who used sign language.

Is the service well-led?

Requires Improvement 

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

The trust provided limited evidence when requested by inspectors during and following the inspection. This was a concern highlighting a lack of oversight of the surgery services.

Leadership

Leaders had the skills and abilities to run the service. They took steps to try to understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgical services were separated into directorates so there were multiple leaders throughout the Trust. The theatre services managers had an overview of all surgery activity and the trust told us the medical director, chief operations officer (COO) and deputy COO had overall leadership responsibility and were reported to be well sighted on all issues escalated to them.

Surgery

The trust told us specialities worked closely together to provide patient focused care and were consultant led. Surgical services were separated into care groups so there were multiple leaders throughout the Trust. Theatre service managers had an overview of all surgery activity and the Trust medical director, COO and deputy COO had overall leadership responsibility and were reported to be well sighted on all issues escalated to them.

Nursing leadership at ward level consisted of nurse directors who managed a team of matrons. These matrons managed nurses in charge of wards. Each care group had a Director of Nursing who reported to the Chief Nurse.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The chief operating officer and deputies had the overall vision for the organisation with networks between directorates all the time. The operations director for OSCCA (Operating Service, Critical Care and Anaesthetics) had a clear insight of the vision and strategy regarding operating pathways for surgical directorates. However, managers told us each surgical directorate had its own vision.

There were different strategies for each directorate. We requested the current vision and strategy documents and the provider submitted three separate strategies for general surgery, urology and plastic and breast surgery. However, these were all dated 2017 to 2020. There were no newer strategies provided.

Theatre managers reported good theatre provision and recovery plans were being met for priority 1 and 2 patients. However, clinicians reported frustration around theatre availability and being unable to provide a service for their priority 3 and 4 patients.

Managers told us staff had completed an interactive session prior to the pandemic to look at the five values of the trust strategy and medical staff had contributed to the production of a document. The urology department had held a structured day describing the strategy. No work had been carried out since then, but managers reported there had been little change and had been looking into new ways of sharing staff ideas and updates.

Culture

Not all staff felt respected, supported and valued, although they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients and their families could raise concerns without fear. However, some staff we spoke with did not want to be identified and were wary of repercussions when raising concerns.

Staff morale and wellbeing varied, and a few staff told us their morale was quite poor.

Medical staff, in particular foundation doctors, said they felt valued and supported by senior clinicians and the ward teams and that, apart from the constant struggle with IT and records systems, they were able to provide care for patients.

Senior clinicians we spoke with expressed frustration about the lack of theatre access and availability to tackle their waiting lists for P3 and P4 elective operations, although they said the senior leadership team, including executives were receptive and listened to any concerns.

Surgery

Nursing staff felt well supported by their managers and other staff nurses who checked in with them often. Some staff nurses we spoke with felt the duty matrons were not approachable and did not listen when they tried to raise staffing issues which they felt were unsafe. Ward staff told us they knew of colleagues seeking other jobs to leave the trust due to stress and high anxiety from being one staff nurse under establishment every shift. Staff reported support staff had similar feelings. They felt service leads lacked compassion for staff who were off sick.

Managers explained that staff voices regarding health and wellbeing were recorded in staff surveys and managers heard and understood staff needs. A wellbeing support survey had been sent to all staff and psychology and debriefing sessions had been implemented for staff. Following a tragic event, the trust had brought in specialists to work with the team.

Staff and managers described morale as being 'really tough'. The trust held a silver command meeting weekly with staff feedback at the beginning and end of every session. The main issues raised were about staff capacity, leaders being visible to staff and able to support teams with limited finances. Staff told us they felt relieved about the nursing recruitment programme, but this brought additional work for ward teams to train and support the new staff. Managers told us the new nurses had given good feedback because they felt settled and part of a team.

Managers told us the trust had a 'Give it a Go week' where humour played a part in managing change and adversity. However, many people were exhausted, and due to ward moves, continuity of teams could not be maintained throughout the pandemic. Managers said leaders were positive and helped staff 'see the horizon'.

Medical staff reported the lowest point in morale earlier in 2021. In response to staff concerns, leaders had formed a restructure and a follow up meeting was held to check measures regarding concerns were in place.

Staff spoke highly of the Chief Nurse and CEO and said they provided information regularly via bulletins.

Some staff reported extreme difficulties in managing increasingly complex patients undergoing elective surgery, in particular those with alcohol dependency.

Staff reported that the difficulties with the IT system affected morale as it made the job more difficult and had 'tipped a few over the edge to take retirement'. Some staff said the OSCA system worked very well but was only available for a small number of specialties. They said the patient record system caused multiple problems especially in the time it took to use the system. However, staff said record keeping had not been good prior to using this system.

Staff said inpatients from other specialties were cared for on surgical wards, and e-whiteboard functionality had had to be amended. Managers said this had been achieved quickly to keep better track of patients boarding elsewhere.

Governance

Leaders did not always operate effective governance processes. Staff were not always clear about their roles and accountabilities, and there were inconsistencies whether staff had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework provided by the trust showed a range of trust wide groups and meetings that fed into governance processes. However, there were no clear lines of accountability shown. The trust provided minutes of governance meetings from several specialities which included information about performance, risks identified and engagement. Actions had been agreed and staff identified to address them. We saw some actions had been completed but very few timeframes for expected completion were recorded.

Surgery

We observed the matron's daily 'bed' staffing meeting with representatives from all care groups and the two duty matrons from each site. No clear acuity of patients was reviewed, and no safe staffing models were used. An operational matron had told us any overnight risks were fed back into this meeting, but only skill mix was discussed. The matron said they had responsibility to update the other matrons about surge areas by capacity and feel. This meant the service used no formalised recorded process for managing staff numbers and skill mix to meet patient acuity.

An operational matron told us mental capacity and risk assessments for patients could often be pre-empted by their staff. It was not clear what they meant by this. They felt nurses were good at getting to know which patients were at high or increased risk. The N2 neurosurgery ward manager told us occupational therapists often completed their MCAs. The patient flow coordinator said they completed deprivation of liberty safeguards (DoLS) for neurosurgical patients on their N2 ward. N2 ward staff could access training sessions with the safeguarding and DoLS lead.

Senior staff told us there was a standing agenda item on the monthly management board meetings to review all serious incidents and never events. All clinical directors attended these meetings and would present cases from their directorate to the group. An example of this was a case with a retained guidewire in urology. This was taken to the monthly management board meeting, then it was discussed at the safety and risk forum which was open to all staff. The trust then distributed links to training to all staff.

Managers told us senior leads met with matrons to discuss patient safety information. However, they also said different governance teams had different approaches. Most staff we asked did not hear about falls, PUs etc outside huddles or ad-hoc informal updates.

Management of risk, issues and performance

Leaders and teams used some systems to observe performance. They identified and escalated some relevant risks and issues but did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Managers told us they were aware of risks across the surgical directorates. They told us the 'parent' risk was the inability to provide sufficient theatre time to support surgical pathways. 'Child' risks included insufficient staff, the inability to recruit or retain theatre nurses, staff wellbeing post-COVID, and insufficient post-operative beds. They had created an 'extra type of bed' to help manage this but felt they had not yet reached a final solution.

Managers spoke of an 'unmet need that was hard to quantify', the trust was treating many patients who were less fit but still required complex surgical care. Bed capacity was a big problem, so staff were trying to 'create community capacity regarding virtual beds'. They were also concerned about their ability to sustain the non-elective pathway. Capacity planning was a constant piece of work, with consideration of the use of side rooms and planning throughput to ensure patients had their surgery. The trust had introduced demand-based scheduling which had been a great ambition but in practice staff said this was hard to execute. They were still redesigning the methods used for allocation as they said they 'don't have all the information'.

Managers talked about having undertaken lots of work in recent months to mitigate the risks around staffing levels with a national lack of nurses. However, some ward staff told us the trust could not attract agency staff because they chose to work at other local trusts with better working conditions and an uplift in pay.

Staff reported theatre nurses were difficult to recruit so they had created an extra role for a Band 4 assistant theatre practitioner.

Managers explained they identified risks within care groups which went to governance for greater oversight. This had been reinforced over the years to ensure action plans were dealt with promptly or reviewed. Staff said there was not always capacity to reduce risk there and then.

Some staff told us they obtained the right support to identify risks, provide a strategy to address them, regular reviews, and engagement with the COO.

At a wider level, bed managers met daily and senior surgeons worked on a rota as surgical commander to ensure balance between specialties for demand versus capacity.

Managers told us they mitigated risks regarding the shortage of registered nurses. The trust was investing in Band 4 nursing assistants, supporting new nursing recruits, and holding performance management meetings to ask staff about their worries. The trust was recruiting overseas nurses with plans to recruit 330 qualified nurses by the end of March 2022. At the time of our inspection this recruitment project was well underway with overseas nurses completing induction and ward-based competencies. There was a central team to provide these staff with pastoral support and to complete their OSCEs quickly.

Managers described support to nurses as 'imaginative' and used ward support facilitators, additional band 6 nurses, and matron provision over 7 days a week. However, they felt the workforce was incomplete and there were scant finances to support full establishment.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated, and records were not secure.

Staff told us that electronic systems were not cohesive and separate log in processes were required for each system. During our inspection we observed three separate patient database platforms which did not share patient digital information. Staff were therefore required to access each system separately to review the information they needed. W

e saw on the e-whiteboard system that alerts were not accurate and basic observations which showed as being overdue on the main screen were found to be inaccurate.

We saw e-whiteboards were used on all wards we visited. These displayed the access and flow into the hospital, admissions onto the ward and current patient status indicators. These indicators included potential risks. Staff told us that training to use the e-whiteboards was inconsistent across the trust and some staff reported a lack of training despite the system being in operation for several years.

We visited several wards with out of date or blank general information boards and panels. Information displayed did not always match what staff told us. When asked, staff on wards told us 'We don't display information anymore because of COVID-19'.

We observed the main electronic system crash on several occasions, when we asked staff to access patient records on our behalf. Staff told us this was a recurring issue that they had escalated to senior staff.

Ward managers told us they could access performance reports, however not all managers we spoke with knew what reports they had access too. Staff told us training in these systems was inconsistent across the trust.

We also saw patient data was not always managed appropriately. We saw care rounding and 24-hour fluid monitoring charts were left hanging from rails outside patient bays which could be potentially read by anyone coming onto the ward. This meant patient confidential information was identifiable and not managed securely.

Engagement

Leaders and staff actively undertook some engagement with patients, staff, the public and local organisations to plan and manage services. They collaborated with some partner organisations to help improve services for patients.

Managers told us the last staff survey had been completed in November 2020 and the trust was in the process of another one at the time of our inspection. The results centred around topical questions relating to the pandemic and staff from different care groups did not always feedback the same concerns. Some staff groups had gone on to develop their own staff surveys following up on results. For example, urology staff had done extra work on areas where the scores had been below the trust average.

Senior medical staff told us the staff survey had highlighted areas that managers had addressed through 'You said, we did' examples including provision of quality food and drink for out of hours staff, coffee room refurbishments and wellbeing champions who liaised with directorate leads.

Managers told us staff feedback really mattered and they were driving this forward. Managers said they listened and took any feedback as a positive step, encouraging an ongoing feedback loop rather than an annual exercise. They said staff liked to see a connection between their suggestions and measures put in place.

Managers said friends and family test questionnaires had continued, albeit irregularly. These identified themes such as delayed prescribing for discharge, so a sister had completed a nurse prescribing course. A patient had made a claim after being unable to access an interpreter. As a result of this managers reported the equipment libraries now held signing equipment.

Managers told us a patient representative sat on the Executive MDT meeting. They had attended face to face monthly meetings prior to the pandemic and continued to attend virtual meetings. Patient representatives sat on the Patient Experience Committee. Managers told us patient representatives used to be associated with care groups.

We reviewed an action plan developed in response to feedback from patients, where communication had been an issue. We saw seven separate points to be addressed as a result of information provided from patients. However, we saw only three of the seven areas had been actioned by the directorate.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Managers reported major changes in some surgical pathways with 'day of surgery' admissions for more patients than previously, and more day case surgery work in all specialties.

The trust had implemented a new role for a cross trust extra duty matron which managers reported helped with hospital out of hours work. There had also been surgical night practitioners appointed.

Surgery

The trust had introduced computerised surgery pre-assessments so that patients would only have to attend for clinical observations. There was provision of some enhanced care beds for patients with additional needs but did not require critical care.

A multi professional clinical abdominal aortic aneurysm (AAA) had been set up, allowing for quick decision making.

Expansion of investing in vascular nursing specialists to provide a better link between hub and spoke sites at Rotherham. They had introduced nurse-led intermittent clinics for better patient compliance.

A Royal College of Anaesthetists, anaesthesia clinical services accreditation assessment had highlighted several areas of good practice.

The trust had provided trained quality improvement coaches from the microsystem and flow coaching academies and a new improvement lead, so staff felt these were becoming embedded in directorate work.

Staff told us the trust had reduced its carbon footprint by changing the anaesthetic gases used.

Staff were reducing variation in care, building on getting it right first time (GIRFT) group work. Clinical leads were aligned to patient pathways.

The trust had implemented an Enhanced Care Unit at both hospital sites. Senior staff said this provided quick, decisive care, driven by patient need.

The trust used a colour coded system to identify ward types; a Blue elective ward was a dedicated ward for elective patients only and had helped the trust to sustain elective activity.

There were identified places of safety for patients with chest drains and tracheostomies on dedicated wards where staff had enhanced training.

The trust had instigated the use of photography prior to discharge to support patients with sternal wound management and to help reduce infections.

Community health inpatient services

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Mandatory Training

The service provided staff with mandatory training to ensure patients were cared for safely.

Staff we spoke with told us they kept up to date with their mandatory training.

Staff completed job specific essential training, this was comprehensive and met the needs of patients and staff.

We reviewed training data submitted by the trust for the integrated stroke pathway this included data from other wards within the stroke pathway and was not exclusive to staff specifically employed at Beech Hill. We found 100% of staff completed level 2 safeguarding training, 75% of staff completed Mental Capacity Act training, 88% of staff had received falls prevention training and had completed pressure ulcer prevention training, React to Red.

Staff were encouraged and supported to access additional training to complement their role and further develop their skills.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

Staff understood how to protect patients from abuse. Staff told us that they received training on how to recognise abuse. We reviewed the training data submitted by the trust which confirmed all staff had completed safeguarding training.

Patients told us they felt safe and secure, one patient said, 'I don't have any worries about safety or security here'.

Staff we spoke with told us they knew the procedure for reporting safeguarding concerns and confirmed they had received safeguarding training. One staff member said if they had concerns they could report these to the nurse in charge as well as log the concerns via the trusts internal reporting system.

At the time of the inspection, there had been no safeguarding concerns reported within the last 12 months.

Leaders had oversight safeguarding incidents if they did occur this was a standard item for discussion in governance meetings.

Community health inpatient services

Cleanliness, infection control and hygiene

The service controlled infection risk well the premises were visibly clean. Staff did not always follow control measures to protect patients, themselves and others from infection. Staff did not always label equipment once it had been cleaned.

Ward areas were visibly clean and well maintained. Staff followed a cleaning schedule and conducted deep cleaning of patient rooms when they were discharged using hydrogen peroxide vapour (HPV) decontamination methods.

We observed staff following infection prevention and control guidance and using appropriate personal protective equipment (PPE), this included face coverings, aprons, gloves and visors where required.

Staff had access to adequate amounts of PPE which was positioned in various accessible areas across the wards.

Visitors were encouraged to make an appointment prior to visiting and were encouraged to wear face coverings as well as regularly washing and sanitising hands.

We spoke with an infection, prevention and control (IPC) nurse who told us that staff completed IPC training and that the IPC team were on-hand to provide advice and guidance.

Infection, prevention and control nurses carried out audits, the last one was completed in September 2021, Norfolk ward achieved 96% and Shrewsbury ward achieved 94% compliance. Actions from audits were placed on an action plan and addressed and shared with staff.

We found that equipment was not appropriately labelled as clean. In the storeroom on Shrewsbury ward we found two wheelchairs and two stand aids that had no clean label in place. This was also a concern at our previous inspection in 2016.

Staff did not always ensure food was stored in a safe way. In the Norfolk ward kitchenette, we found milk and butter that had been opened and used with no open date attached to it.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service was at full capacity. Patients had their own room, with en-suite shower, toilet and washbasin. One of the rooms on Norfolk Ward had been adapted and had appropriate equipment and space to support a bariatric patient.

Beech Hill was a listed building and had various original features. The overall premises were well maintained, and estates work was carried out when required. During our inspection new vinyl flooring was being laid in various rooms.

We spoke with the facilities manager who told us that regular health and safety checks were carried out, some of these included visual checks on furniture and the environment, legionella water checks, electrical safety, moving and handling equipment and fire risk assessments.

The trust had not carried out a fire drill at Beech Hill since July 2018. We reviewed the trusts fire policy where it stated staff should undergo a fire drill annually. As this had not happened since July 2018, we recommended the trust consider following their policy and conduct a fire drill to ensure staff have current knowledge in order to respond in an emergency.

We saw medical equipment that had been serviced and checked, items in the ward kitchens had undergone portable appliance testing.

We checked emergency resuscitation equipment and fire grab bags, these were stored in clinic rooms on each ward and staff knew where to access these in the event of an emergency.

Patients spent most of their time in their rooms. The trust had reduced the time patients spent in communal spaces in response to the coronavirus pandemic. Patients would be welcome to eat their meals in the dining room however this was done on a rotational basis to ensure that social distancing could be maintained.

There were various communal spaces and accessible outdoor spaces. Indoor facilities included dining areas, a common lounge, therapy kitchen and gym.

We reviewed the trusts environmental risk assessment for Beech Hill dated August 2019, this was due to be reviewed in August 2020 however this had not happened, this means that the current environmental risk assessment was not up to date.

Assessing and responding to patient risk

Staff completed risk assessments for each patient however, some were not always reviewed or updated. risks were not always removed or minimised and staff did not always act on deterioration quickly.

We reviewed five patient electronic care records. Risk assessments were completed for patients on admission and these were included within patient care plans.

Staff reviewed risk assessments after every incident.

Risk assessments included the views of the patient as well as support and input from therapy staff where patients had cognitive impairments or communication difficulties.

During our last inspection told the trust they should review the need for an early warning tool to recognise a deteriorating patient. During this inspection we had found the trust had introduced the National Early Warning Score (NEWS2), developed by the Royal College of Physicians to improve the identification of clinical deterioration in patients.

Staff attended daily handover meetings, as well as weekly multi-disciplinary team (MDT) meetings where patient risks were reviewed and discussed. We observed an MDT meeting which was comprehensive between medical, nursing and therapy staff.

However, staff did not always ensure that where risks were identified these were mitigated appropriately and that deterioration was escalated. The trusts template for monitoring pulse rates was not correct which meant staff had not identified and escalated low pulse rates. We raised this with the trust during the inspection to ensure immediate actions were taken. The trust took action to update their template, communicate with staff and conduct an audit.

On Norfolk ward we saw that the information relating to a patient's dietary needs differed from the handover information to the information displayed on the board used by staff. This inaccurate information could result in the patient receiving the wrong meal and increase the risk of choking.

Staff did not always ensure patient's skin integrity was assessed and managed appropriately. We reviewed pressure care for one patient, they had no current pressure damage however; we found no evidence of staff completing positioning checks to reduce the risk of pressure damage.

Waterlow assessments used to assess pressure area risks had not been consistently completed weekly. We spoke with staff who confirmed this should be done weekly. A poster was also on display in the ward office informing staff of this requirement.

One patient we reviewed used an air flow mattress, we found that staff did not always ensure the mattress settings were appropriately set in line with the persons weight. This meant there was an increased risk of the patient developing pressure damage.

Staffing

The service did not always have enough staff to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The trust used the Safer Nursing Care Tool (SNCT) to assess acuity and patient dependency to ensure staffing resources deployed were safe. Staffing levels were assessed by a co-ordinator and adjusted based upon patients' individual needs. Staffing information was displayed daily on each ward, this showed the planned and actual staffing levels throughout the day.

Medical staff were available, this included a consultant for four sessions per week, a geriatrician for four sessions per week, GPs were contactable during evenings and weekends.

Staff we spoke with told us that there were regular shortages of nursing and clinical support staff. Staff also told us that they were concerned because they would regularly be loaned to the acute wards, staff said some staff had been leaving as a result of this. The trust told us that they did share staff across the stroke pathway however, there had only been three instances within the last three months where clinical support workers from Beech Hill were moved to support acute stroke wards.

The service had a number of vacant posts including; four nurse vacancies and three clinical support worker vacancies. The trust was actively recruiting to these posts.

Relatives we spoke with commented that staffing was an issue during weekends.

Some patients we spoke with also told us that they had to wait a long time for staff when they pressed their call bell. One patient told us that they intentionally pressed the emergency call bell as only by doing that staff attend quickly.

We reviewed call bell wait times as patients told us they waited a long time. We reviewed wait times for a period of six days in October 2021. We identified 91 instances where patients waited over 6 minutes for assistance from staff. Some patients waited more significant periods of time, there were 41 instances of patients waiting over 15 minutes.

The trust was aware of the staffing concerns and had plans for mitigation which included; an integrated ward approach, utilising the skills of staff across the stroke pathway. Therapy staff were utilised to support nursing and care staff with care delivery. The trust also held recruitment events and education sessions to attract new staff to the stroke pathway.

Staff we spoke with felt this approach was not working and reported a divide between therapy and nursing staff. Managers had demonstrated they had listened to this feedback and engaged with staff to explore how this could be improved.

We looked at the safe staffing reports for a period of three months, out of those three months over 80% of nurse shifts were filled. In relation to care support staff, figures fell to 74% in July, 77% in August then increased to 96% in September.

Managers reviewed staffing resources across the pathway daily. When planned staffing levels did not meet safe staffing establishment, these were released to bank staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely however therapy staff told us they struggled to access computers to review and update records.

Patient records were stored within a centralised computer system this meant that records were stored securely and could only be accessed by staff using their individual access rights.

Therapy staff we spoke with told us they struggled to access IT equipment to enable them to review and input information into records which often meant they were delayed and unable to record notes in real time which may lead to key information being missed.

Staff had access to review patient results and x-rays and, records were accessible to GPs and community teams.

Medicines

Systems and processes were not always followed to enable safe management and administration of medicines.

Staff administering medication on Norfolk Ward were not following best practice. We observed staff on six occasions sign for medication before this was administered, on five of these occasions staff recorded that patient had refused the medication however the patients were not asked if they wanted this medication.

During the last inspection we told the trust they should ensure all medication charts and controlled drugs checks were completed in line with policy.

During this inspection we found staff were consistently completing checks on controlled drugs and we saw records which demonstrated these checks were being carried out.

We observed medication administration rounds during the first day of our inspection on both wards however, we continued to find issues with medication management on Norfolk Ward.

We found multiple issues with medication administration records, these included; staff administering medication, which was not in line with its prescription instructions, medication given at the incorrect times of the day, and poor recording of the use of compression devices.

There was a pharmacist in post who had been recently appointed who completed medicines reconciliation checks.

We checked clinic rooms on both wards and found that medications stored in fridges were stored appropriately, staff carried out fridge temperature checks and these were recorded.

We checked Clinic rooms were clean, and medication was stored appropriately however clinic room temperatures were not being checked this could impact the integrity of medications stored within the clinic. Thermometers were present but staff did not record the daily room temperatures. Staff we spoke with said that clinics can get hot and there had been instances where the temperature exceeded the recommended temperatures.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support. The trust learned lessons from incidents and shared learning with staff.

Staff were aware of the procedure to follow in the event of an incident occurring. We reviewed incident reports for the last twelve months, these included slips, trips and falls and other injuries to patients.

There had been a total of 266 incidents in the last twelve months, none of these were near misses or never events. Two incidents were categorised as major in relation to incidents of a slip, trip and fall. We reviewed the trusts incident and investigation reports and found these were appropriately investigated by the person in charge and any learning and actions were followed up

Leaders we spoke with told us that any lessons learned from incidents were cascaded to staff in operational meetings, staff who could not attend these meetings were given the opportunity to play back the recording or review the meeting minutes. Leaders told us that items of learning that identify ways the service can improve are also added to the service improvement plan and discussed in service improvement meetings. We found evidence of incidents being discussed in governance meetings.

In November 2014, the Duty of Candour statutory requirement was introduced and applied to all NHS Trusts. The regulation sets out specific requirements that regulated providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The trusts incident reporting system used at Beech Hill had a Duty of Candour prompt field, which staff had to complete when reporting incidents. It was also possible to attach a copy of any letters written to patients or their families in relation to Duty of Candour. We saw examples of when the trust had written to patients and families of when the Duty of Candour had been used.

Community health inpatient services

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The trust policies and procedures reflected national best practice and National Institute for Health and Care Excellence (NICE) guidelines.

We spoke with nursing and therapy staff who were aware of best practice. One therapist we spoke with told us they follow Royal College of Physicians guidance relating to Spasticity, this is a condition people who experience stroke may experience with symptoms such as stiff or tight muscles preventing normal fluid movement. Therapy staff told us they work with the patient to engage in activities to improve mobility.

We completed a comprehensive review of five patient records, we found that some records included standardised care plans, and some were more detailed however these were not always holistic in capturing the patient's involvement or their preferences, likes and dislikes and, these were not always reviewed or updated.

We found records that included individual risk assessments for falls, pressure damage, hydration and nutrition.

Therapy staff records about patients were comprehensive however, from a nursing perspective patient notes were focused on supporting and meeting clinical and physical needs rather than a holistic rehabilitation approach. One of the records we reviewed was recovery orientated and clearly described the rehabilitation goals. The record did not detail specific activity the patient carried out within the day in conjunction with their likes, interests or hobbies, how the patient was feeling, their mood or any input from other care support workers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

We saw that patients were offered sufficient amounts of food, drinks and snacks. Some patients we spoke with told us they enjoyed the food and that staff brought drinks regularly. Food menus could be adapted where required to support a patient's dietary requirements such as vegetarian and halal options.

We spoke with staff who were aware of patient's dietary requirements, they knew which patients were on fortified diets as well as the patients who had texture modified diets.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Staff were able to access advice and support from a dietician as well as on-site speech and language therapists.

Community health inpatient services

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain. Staff did support those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using the World Health Organisation (WHO) analgesic ladder.

We observed three occasions when staff on Norfolk Ward were administering medicines where patients prescribed as and when required pain relief were not offered this however it was documented as refused.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes. Staff used recognised monitoring tools to assess patient outcomes.

The trust participated in the Sentinel Stroke National Audit Programme (SSNAP) to measure the quality of stroke care. This is the single source of stroke data in England, Wales and Northern Ireland.

Staff we spoke with told us they contributed to the SSNAP audit and we saw evidence of leaders reviewing recommendations and action plans in governance meetings.

Therapy staff we spoke with told us they used the Barthel Scale, this is an ordinal scale used to measure performance in activities of daily living.

Speech and language therapists used the Therapy Outcome Measure to measure impairment, activity, participation and wellbeing.

Competent staff

The service made sure staff completed training and had access to professional development opportunities to ensure staff were competent for their roles. Managers did not consistently complete supervision meetings.

Staff, including bank staff and students completed a comprehensive induction before starting work on wards.

Staff we spoke with told us they had access to training and professional development opportunities to ensure they had the right skills and knowledge to meet the needs of patients.

Leaders we spoke with told us they had strong links with local universities to attract and develop staff within the trusts stroke pathway. Nursing and therapy staff were supported by the trust in completing MSc level qualifications.

Staff training compliance rates for stroke pathway was 96% across all mandatory training. We spoke with managers who told us training compliance figures were reviewed every month and any actions were shared with nurse managers to action in their clinical areas.

Staff did not receive regular supervision or appraisal. Some of the staff we spoke with told us that supervision and appraisal was not consistent. One staff member had not had a supervision since June 2021, another staff member told us they have regular informal supervisions. The trust provided no data to demonstrate supervisions were carried out. We did find 91% of medical staff had received an appraisal however received no appraisal data for nursing or support staff within the stroke pathway.

Community health inpatient services

Leaders held monthly operational management meetings to discuss operational issues including incident, reviewing performance, staffing, governance and improvement plans. Information from these meetings was shared with staff via a newsletter. Nurses held quarterly meetings that had been postponed during the pandemic however, these resumed in July.

Multidisciplinary working and seven-day services

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care.

Beech Hill is a Stroke Pathway Assessment and Rehabilitation Centre (SPARC). Patients are transferred to this unit from acute wards to receive rehabilitation.

Multi-disciplinary team (MDT) meetings took place weekly on both wards. These were attended by nursing staff, Consultant Geriatrician and General Practitioners (GPs), physiotherapists, Occupational Therapists, Speech and Language Therapists, with support is also provided by a Pharmacist. We observed one of these meetings on Shrewsbury ward, colleagues spent time having detailed discussions about patient outcomes and goals as well as any other clinical treatment.

Consultants were present at Beech Hill on weekdays. Patients were reviewed by specialist stroke consultants twice per week during ward rounds as well as a review during weekly MDT meetings.

Staff were also able to seek support from GPs 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. Staff did not always follow national guidance to gain patients' consent. Some staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff did not always display an understanding of the Mental Capacity Act and the associated Code of Practice. We found 75% of staff had completed Mental Capacity Act training and 96% of staff completed Mental Health Awareness training.

Patients were not able to leave the wards freely. Staff told us that all patients were assumed to have capacity, and only one patient had a Deprivation of Liberty Safeguard. However, the doors to stairways had high and low handles to prevent confused patients from leaving. Staff had not followed the Code of Practice when applying for a Deprivation of Liberty safeguard because they had not conducted a capacity assessment with a patient prior to making the application.

We spoke with therapy staff who told us they were often involved in supporting patients in decision making. Therapy staff told us they worked collectively with nursing staff considering the patient’s wishes as far as possible, using alternative communication methods where required such as talking mats.

Leaders did not have oversight over mental capacity and best interest decision making. Consent, capacity data and best interest decision making was not collected centrally, there was however a team who was responsible for overseeing Deprivation of Liberty Safeguard applications.

Community health inpatient services

We found that only one patient at Beech Hill was subject to Deprivation of Liberty authorisation. There was no evidence of audits or quality assurance checks being carried out to ensure capacity assessments were being carried out in accordance with best practice.

Is the service caring?

Requires Improvement ↓↓

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

Compassionate care

Patients did not always feel staff treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During our inspection we observed staff interacting positively with patients, staff were caring and compassionate. We observed staff knocking on doors before entering patient rooms, one patient told us 'they always knock on the door'.

We spoke with nine patients during our inspection, the feedback we received was mixed. Some patients told us that they felt safe and that staff encouraged their independence. One patient told us that 'they [staff] are always friendly and kind'. One patient said there was a 'pleasant atmosphere' at Beech Hill. Another patient told us that 'the support workers are brilliant, they keep you safe, they are friendly and listen, I feel like they know me'. All patients spoke positively about the care and support they received from therapists.

The trust monitored the experience of patients using the service. The trust conducted a patient survey in 2019 to understand about the patient experience of the stroke service, a total of sixty-two surveys were completed, twenty-seven of these were completed by patients and the others, were completed with support from a relative or health care professional. The survey results showed that 50% of patients felt they received excellent care, 28% felt they received very good care and 17% felt they received good care.

However, one patient told us that 'staff are not good at answering the buzzer'. One patient told us 'the staff don't take notice, if you press the emergency buzzer they come quick, there is no point pressing the ordinary one'. One patient felt that they were ignored by staff and that staff had no time to spend with them. Two patients we spoke with told us they did not get their medication on time and felt there was not enough staff. Another patient we spoke with said they were not told where to get help when they arrived, they had no induction when arriving on the unit. The patient said Beech Hill was an institutional environment as staff had said 'it's how we do things around here'.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Patients told us that staff were understanding and promoted independence, one patient told us 'they have helped me to be more independent, they have looked after me, so I have improved'.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We observed a board round, staff had observed a patient low in mood and withdrawn, staff sensitively discussed this concern whilst protecting the patient's wishes.

Carers we spoke with spoke highly of the emotional support they received from staff, one carer told us, 'the support I receive when I visit has been very helpful'. One carer also said that 'staff reassured me things were to be expected when I was upset'. Another carer told us that 'the nurses are very good, and we have confidence in Beech Hill'.

Leaders we spoke with told us they had continued to facilitate a carer support group during the pandemic virtually, staff were able to support carers providing advice and emotional support.

Leaders told us they worked with the Stroke Association and that there were longer term plans to do more community focus work with stroke survivors and their families.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients who needed additional support, advocacy services could be accessed as well as support from speech and language therapists to help with decision making.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients and carers we spoke with told us told us they felt involved in discussions about care and treatment.

Is the service responsive?

Good 

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

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Patients were transferred to Beech Hill for stroke rehabilitation following discharge from acute hospital wards.

Facilities and premises were appropriate for the services being delivered. Patients had access to outdoor spaces, gym and an activities of daily living kitchen.

Staff reviewed patients in daily board rounds to review and discuss patient discharge arrangements.

Community health inpatient services

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and trusts.

The needs of patients were taken into account when planning and delivering services.

The facilities and premises were appropriate for the services being delivered.

Therapy staff told us a significant part of their role was engaging with people and their chosen representative to get to know about a patient's likes, dislikes and what they feel is important to them.

Patients were supported in making decisions about their care. Therapy staff told us they worked collectively with nursing staff considering the patient's wishes as far as possible, using alternative communication methods where required such as talking mats.

Food menus could be adapted where required to support a patient's dietary requirements such as vegetarian and halal options.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients who required stroke rehabilitation were transferred from acute hospitals and admitted within 24 hours of being assessed as ready for transfer. Staff at Beech Hill followed specific admission criteria and continually reviewed and assessed bed capacity daily.

Discharge planning for patients commenced upon admission, we found that staff worked with external teams and services, including GPs to co-ordinate discharge. The maximum length of stay within Beech Hill was 28 days.

We reviewed the data provided by the trust and identified the length of stay at Beech Hill from October 2020 to September 2021 was 30 days. During this time there had been 251 admissions, 192 of these patients were discharged back to their home with community support, the other patients were either re-admitted to acute hospital beds or discharged to care or nursing homes.

Staff told us that patient discharge could sometimes be delayed and exceed the usual 28-day length of stay due to external factors such as obtaining specialist equipment or awaiting suitable social care support.

Leaders maintained oversight of discharge rates, we looked at governance meeting minutes and found this was a standard item for discussion.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Community health inpatient services

We reviewed complaints from the last twelve months, we saw evidence that demonstrated complaints were investigated and outcomes shared with the complainant.

We saw minutes from governance meetings where complaints were discussed as well as any learning actions to be shared with teams.

Information was displayed throughout the service for visitors and carers outlining the process for raising a complaint.

Patients and carers we spoke with told us they would speak to the person in charge if they had any complaints or concerns and, they felt reassured this would be investigated.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Leaders were not always visible. Leaders did however support staff to develop their skills and take on more senior roles.

Managers understood the direction of the service and had listened to staff when they said that there were issues with the integrated wards approach. Managers worked collaboratively with staff to further explore issues and consider further improvements.

Leaders had defined roles to ensure that staff knew who was leading on the clinical and therapy aspects of the service.

Staff did not always feel that leaders were visible. Some staff we spoke with felt that leaders were approachable however some were more visible than others. Therapy staff told us that they felt a divide between clinical and therapy teams.

Leaders operated an open-door approach that we saw was effective during our time at the service.

Staff told us that leaders encouraged professional development. One staff member told us that at the start of the pandemic their role became more challenging, leaders provided additional areas of responsibility to develop skills and experience.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Community health inpatient services

The trust had developed their 'Making a difference strategy' with their vision to be recognised as a brilliant place to work, the best provider of health care, clinical research and education in the UK and a strong contributor to the aspiration of Sheffield to be a vibrant and healthy city region.

The trusts vision and PROUD values were understood by staff. Staff we spoke with were able to describe the trusts values:

- Patient first: ensure that the people we serve are at the heart of all we do
- Respectful: Be kind, respectful to everyone and value diversity
- Ownership: Celebrate our successes, learn continuously and ensure we improve
- Unity: Work in partnership and value the roles of others
- Deliver: Be efficient, effective and accountable for our actions.

The trust carried out an annual review of their strategy in 2020 to reflect on what had so far been achieved. The trust requested feedback as part of their 'Making a difference strategy: the next chapter' by inviting patients and members of the public to share their views to help shape the future strategy.

Leaders engaged with staff and were open to feedback on ways to develop the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they felt valued and that managers were approachable and supportive.

Staff told us that if they had a concern they felt they could raise it and that it would be listened too.

During our inspection it was 'Freedom to Speak Up' month, the trust had a dedicated internal intranet page for staff that provided access to the speak up policy as well as various speak up advocates.

Leaders we spoke with recognised this was an area they wanted to promote further and would be looking at embedding this into staff meetings moving forward.

One of the therapists we spoke with told us about a mood group that had been set up to help colleagues speak about how they were feeling and offer support and guidance to peers.

Some of the staff we spoke with felt deflated. Staff commented on the staffing issues, staff leaving and a change in team dynamics since the integrated working commenced as some staff felt there was a divide between nursing and therapy staff teams.

Governance

Leaders did not always operate effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance systems were in place; however, these were not always effective.

Multiple incidents had been reported in relation to issues with medication management. Audits had been carried out where action needed to be taken to address shortfalls, these actions had not been undertaken in a timely manner to mitigate further incidents.

Audits in relation to documentation and record keeping did not always take place, this meant that leaders lacked oversight of the documentation errors we identified during the inspection for example in risk assessments and documentation relating to the Mental Capacity Act.

However, we saw meeting minutes from the last three governance meetings. Actions from these meetings were reviewed and any information from these meetings was shared with staff teams.

Leaders told us that they had been working on making improvements to their systems and processes. Staff we spoke with told us they felt action to address the issues was slow.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, however these were not always used effectively. Not all risks identified were escalated to ensure actions were implemented to reduce their impact. However, plans were in place to cope with unexpected events.

Leaders maintained a risk register and had oversight of the directorate performance dashboard for the integrated stroke pathway.

Risks entered onto the register were reviewed regularly in governance meetings and actions were shared with the trusts wider Safety and Risk committee.

The risk register for the service contained 21 risks, the highest rated risk was in relation to access to group activities which had been impacted by the COVID-19 pandemic. The service had taken action on this risk by developing a new standard operating procedure for this in line with COVID-19 guidance. We saw staff carrying out group-based activities with patients, being mindful of social distancing and room capacity.

However, other issues we identified during the inspection as having a direct impact on patient care such as; staffing and pressures recruiting to vacant posts, responsiveness to call bells, medication management shortfalls, record keeping, access to supervision and the management of risks had not been escalated to the risk register at the time of the inspection. This meant that oversight of the issues within the service was limited and not always escalated to senior leaders in order to improve the service. The trust submitted an updated extract of the risk register for Beech Hill during the factual accuracy process."

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff had access to the information they needed to provide safe and effective care, however, therapy staff had difficulty accessing computers and equipment to review and update patient records. Therapy staff told us that they often had to spend time updating records after their shift as they were unable to access computers whilst on wards with patients.

Staff completed training on confidentiality and ensured information was stored securely in accordance with the trusts information management policy.

Patient information was stored securely in a central electronic system that staff including colleagues in the multi-disciplinary team and therapy staff could access.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients and their carers had opportunities to provide feedback. We saw evidence of patients and carers providing feedback on the stroke pathway. The trust also continued to seek feedback on how they could develop and improve services through the carer and stroke survivor panel.

Leaders told us they had looked at diversity and health inequalities and that they had been working close with local universities, mosques and local councils to support patients and carers whose first language was not English.

Staff participated in the trusts staff survey, the trust analysed the data and compared this with the previous survey results to identify any themes or trends.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders had commenced a service improvement stocktake. The aim of the project was to centralise and bring together improvement work across the stroke pathway.

Staff were involved and engaged in improvement work however some of the improvement work had been placed on hold during the pandemic.

We saw evidence of staff being asked to share their ideas on what could be improved. Ideas were categorised into core themes patient and family experience, communication and culture.

Therapy staff had obtained funding to increase the use of technology within the service. The funding enabled the service to purchase iPads, this allowed therapists to use software to better support patients who had a diagnosis of Aphagia. Aphasia is when a person has difficulty with their language or speech usually caused by a stroke. The technology and software had been effective enabled therapy staff to use visuals to support further understand their condition.