East and North Hertfordshire NHS Trust

Inspection report

Lister Hospital, Coreys Mill Lane
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
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

The East and North Hertfordshire NHS Trust provides a wide range of acute and tertiary care services from four hospitals, namely the: Lister in Stevenage; New Queen Elizabeth II (QEII) in Welwyn Garden City; Hertford County Hospital in Hertford; and the Mount Vernon Cancer Centre (MVCC) in Northwood, Middlesex.

The area served by the trust for acute hospital care covers a population of around 600,000 people and includes east and north Hertfordshire, as well as central Bedfordshire. The MVCC provides specialist cancer services to some two million people from across Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

Since October 2014, the Lister has been the trust's main hospital for specialist inpatient and emergency care.

The New QEII hospital opened in June 2015 and provides outpatient, diagnostic and antenatal services, along with a 24/7 urgent treatment centre. Hertford County provides outpatient and diagnostic services. The MVCC provides tertiary radiotherapy and local chemotherapy services. Through the Lister, New QEII and Hertford County hospitals, the trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including emergency department and maternity care. The trust offers regional and sub-regional services in renal medicine, urology and plastic surgery. The trust is also a provider of children's community services.

The trust has four clinical divisions – Planned Care, Unplanned Care, Women's and Children's and Cancer, each led by Divisional triumvirate, of Divisional Director, Divisional Medical Directors and Divisional Nursing Director. These are supported by a corporate infrastructure.

We carried out this unannounced inspection of the Lister Hospital location inspecting 4 of the acute services provided:

- Urgent and Emergency Services because we had concerns about the quality of services.
- Medical Care (including older peoples care) because we had concerns about the quality of services.

Our findings

- Surgery because at our last inspection the safe domain was rated inadequate and the service was rated requires improvement.

We also carried out an unannounced focused inspection of Maternity Services because at our last inspection carried out as part of the national maternity inspection programme, the safe and well led domains were rated inadequate. We also issued a Section 29A Warning Notice. At this inspection we found that the Trust had met the requirements of the Section 29A Warning Notice.

We also inspected the well-led key question for the trust overall.

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

- We rated safe, responsive and well-led as requires improvement, and effective and caring as good.
- We rated 4 of the trust's services we inspected as requires improvement. **In rating the trust, we took into account the current ratings of the 4 services not inspected this time**.
- Staff did not always complete mandatory training and there were not always enough staff to meet the needs of patients.
- People could not always access the care and treatment they needed in a timely manner. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The trust had recently agreed a Full Capacity plan describing actions to be taken when there were excessive patient delays. However, this was yet to be embedded.
- The service did not always manage safety incidents well and did not always ensure that lessons were learnt from them.
- Leaders identified and escalated relevant risks and issues but they did not identify actions to reduce their impact. There was no evidence the outcomes recorded, what mitigation actions had been completed or if the risk had reduced or increased.

However:

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and provided emotional support to patients, families and carers.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

We carried out the core service inspections on 20 and 21 June 2023, and the well-led inspection on 2 and 3 August 2023.

Our findings

We visited areas relevant to each of the core services inspected and spoke with a number of patients, staff and patient representatives.

We spoke with 87 members of staff at all levels of the organisation across various specialities and including healthcare assistants, nurses, midwives, junior doctors, pharmacy staff, consultants and administrative staff.

We also spoke with 10 patients and 4 relatives. We observed care and reviewed 50 sets of care records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments, training records and audit results. We attended staff handovers and daily safety huddles.

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.

Outstanding practice

We found the following outstanding practice:

The maternity voice partnership was active and engaged well with women and the service to drive improvement. The MVP team included mothers who received care and birthed at the service which made them passionate about making the voices of women and maternity staff heard.

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 17 legal requirements. This action related to 4 services.

Trust wide

- The service must have systems in place to ensure staff complete their mandatory training and that mandatory training is monitored to meet the trust's target completion. (Regulation 12(2)(c))

The Lister Hospital – Urgent and Emergency Care

- The trust must ensure that children receive an initial clinical assessment with 15 minutes. (Regulation 12 (2)(a))
- The service must have systems in place to ensure staff complete their mandatory training and that mandatory training is monitored to meet the trust's target completion. (Regulation 12(2)(c))
- The trust must ensure that risks to patients are not increased by caring for them in crowded and unsuitable areas of the emergency department. (Regulation 12(1))

Our findings

The Lister Hospital – Medical Care (including older people's care)

- The service must have systems in place to ensure staff complete their mandatory training and that mandatory training is monitored to meet the trust's target completion. (Regulation 12(2)(c))
- The trust must ensure that auditing systems and processes enable staff to effectively monitor the safety and quality of the service provided. (Regulation 17(2))
- The trust must ensure that information sharing and planning with social care providers is timely to ensure safe and timely discharge from the service. (Regulation 12(2))
- The trust must ensure that investigations in incidents are completed in a timely manner to allow actions and learning to be shared with the relevant staff to prevent possible future occurrence. (Regulation 12(2))

The Lister Hospital – Surgery

- The service must have systems in place to ensure staff complete their mandatory training and that mandatory training is monitored to meet the trust's target completion. (Regulation 12(2)(c))
- The service must ensure all single use consumables are in date. (Regulation 12(2)(e))
- The service must ensure all COSHH cupboards are locked and not accessible to the public or patients. (Regulation 12(2)(d))
- The service must continue working on reducing the waiting lists. (Regulation 12)
- The service must ensure there is an effective system for checking the airway trollies outside the theatre room and the plastic adult cardiac arrest trolleys in the day surgery unit. (Regulation 17(2)(b))
- The service must ensure they have a comprehensive risk register where risks are identified, the service must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. (Regulation 17(2)(b))
- The service must ensure their policies are the most up to date version and reviewed within the timeframes stated within the policy. (Regulation 17(2)(d))

The Lister Hospital – Maternity

- The service must ensure incidents are investigated without delay in line with trust policy. Regulation 17(1)(2)
- The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that governance systems continue to improve. (Regulation 17).
- The trust should ensure that they have a clear equality, diversity and inclusion strategy and action plan (Regulation 17).
- The trust should ensure that they improve the whole-hospital approach to access and flow. (Regulation 17).

Location/core service

Our findings

The Lister Hospital - Urgent and Emergency Care

- The trust should ensure that on-call medical teams are able to respond quickly to urgent and emergency referrals. (Regulation 18)
- The trust should ensure that senior staff meet regularly to discuss operational performance. (Regulation 17)
- The trust should ensure that Internal Professional Standards (agreed and unambiguous principles and times around specialty engagement) are implemented. (Regulation 17)
- The trust should ensure that staff comply with Control of Substances Hazardous to Health regulations. (Regulation 12)
- The trust should consider ways to enable visiting psychiatrists to use ED prescribing systems. (Regulation 12)
- The trust should ensure that all staff are familiar with the new electronic sepsis screening tool. (Regulation 17)
- The trust should ensure that pain scores are recorded and re-assessed. (Regulation 12)
- The trust should ensure that accurate records of staff appraisals are maintained. (Regulation 18)
- The trust should ensure that it continues to implement a full capacity plan and staff are provided with clear guidance for the action to be taken when there are delays for patients to be admitted to a ward. (Regulation 17)

The Lister Hospital - Medical Care (including older people's care)

- The trust should ensure that relevant information and learning is shared to the appropriate staff and ensure it is understood. (Regulation 17)
- The trust should ensure that they are able to demonstrate that all equipment and premises are properly maintained. (Regulation 12)
- Staff should ensure that allergies documented on patient wrist bands match those documented on the EPMA system. (Regulation 12)
- The service should consider allowing a safe space for families to use whilst visiting and to use for having difficult conversations. (Regulation 15)
- The service should ensure that all patients with dementia have their needs assessed and recorded as per policy to allow safe care in the absence of regular staff and the premises are suitable to meet these needs. (Regulation 12)
- The service should ensure that patients referred to specialist doctors from the emergency department are seen in a timely manner. (Regulation 12)
- The service should ensure that mental capacity assessments are decision specific to the patient by demonstrating specifically how they were unable to consent. (Regulation 11)

The Lister Hospital – Surgery

- The service should ensure lessons learnt from incidents are shared with the whole team. (Regulation 17)
- The service should continue working on recruitment and retention of staff. (Regulation 18)
- The service should continue working on optimising hospital flow and taking any necessary steps which are in their control to improve flow. (Regulation 12)

The Lister Hospital – Maternity

Our findings

- The service should have systems in place to ensure medicines are stored according to manufacturer's guidance. (Regulation 12)
- The service should continue to improve the compliance of mandatory, maternity specific and safeguarding training. (Regulation 12)
- The service should have systems in place to for all staff to receive an annual appraisal. (Regulation 18)
- The service should have systems in place to continue to improve the compliance of safety checks of specialist equipment. (Regulation 15)
- The service should continue to work on the culture and staff morale within the service. (Regulation 17)

Is this organisation well-led?

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

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders generally had the skills and abilities to run the trust and its services. They understood the priorities and issues the trust faced and were identifying actions to address them. They were visible and approachable in the service for patients and staff. They generally supported staff to develop their skills and take on more senior roles.

Leaders generally had the skills, knowledge and experience they needed to deliver quality sustainable care. This was confirmed through our interviews with senior leaders and review of documents and personnel files. The trust had a process in place to ensure that senior leaders were appointed in line with Regulation 5 of the Health and Social Care Act 2014 (Fit and Proper Persons required) and that there was on-going review. There was also clear support for leaders to develop through mentorship and access to training.

The trust board included a group of experienced non-executive and executive directors. Its members had an appropriate level of operational and financial experience and expertise across both non-executive directors (NEDs) and executives. For example, the finance and performance committee (FPC) and the audit committee were chaired by NEDs with considerable financial skills, which they gained from previous roles in the private sector. Both NEDs joined the trust during 2017.

Following on from our last inspection, there had been some changes to the trust leadership. This included the chief executive officer (December 2021), chief nurse (September 2022), medical director (April 2023) and chief operating officer (April 2022). There had also been changes in leadership in divisional and heads of department level. This meant that whilst the leaders had the skills, knowledge and experience required, they still had some work to do in becoming a collective leadership team who understood the unique qualities and needs of their team. Our interviews with the

Our findings

executive team demonstrated that the trust were aware of this challenge and had embarked on a programme of development exercises for the senior leadership team which was on-going at the time of the inspection. Senior leaders we spoke with confirmed that this was an effective process which was allowing the team to develop the relationships that would see them become a collective leadership team that would deliver the strategic objectives.

Leaders were approachable but they were not always visible to staff. We found that the visibility of senior/executive leaders was variable during the core service inspections. This had been identified as an area for improvement prior to our inspection. The trust had a board improvement plan which included an action to increase visibility of board members in operational areas. This was yet to be fully implemented and embedded. Our interviews with staff during the core service inspections and with senior leaders confirmed that staff felt able to approach their leaders and escalate concerns.

The trust was developing clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The chief people officer had developed a leadership and development programme which included succession planning at all levels of leadership. However, this was yet to be fully implemented and embedded. This was confirmed during the core service inspections where some leaders told us that there was a need to improve leadership training for managers at all levels. Our interview with the CEO confirmed that succession planning was in place at an executive level. There was a recognition that the board was not representative of the community they served both from a workforce and population perspective. The trust was keen to ensure that the diversity in the leadership team was strengthened.

Leaders understood the challenges to quality and sustainability and were identifying the actions needed to address them. Leaders had started to work collectively to understand challenges and identify actions. This meant that during the core service inspections we found that there were areas where actions to address challenges were under-developed. For example, the lack of full capacity plan for the trust to help manage access and flow.

Vision and Strategy

The trust 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 were aligning to local plans within the wider health and care economy.

The trust had a clear vision and a set of values with quality and sustainability as the top priorities. The trust 5 year strategy was published in October 2019 and their vision was 'Proud to deliver high quality, compassionate care to our communities'. Our review of documentation and interviews with senior leaders confirmed that the vision and strategy were developed in consultation with staff and other external stakeholders. The trust values had been re-launched in 2022, over 500 staff had been involved in creating the new values of 'Include, Respect and Improve'. Throughout the core service inspections, staff told us about the trust values and these were displayed throughout the organisation and linked to the vision.

The strategy outlined priorities which under-pinned overall delivery. These were 'Quality, ease of use (re-design), improving pathways, investing in people and sustainability'. The trust had continued to build on the strategy since 2019 to develop strategic objectives and themes to take the trust to 2030. The themes were:

- Quality - Consistently deliver quality standards, targeting health inequalities and involving patients in their care.
- Seamless Service - Deliver seamless care for patients through effective collaboration and coordination of services within the Trust and our partners.

Our findings

- Thriving people – Support our people to thrive by recruiting and retaining the best and creating an environment of learning, autonomy and accountability.
- Continuous improvement – Continuously improves services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities.

Each of these themes were directly related to specific strategic objectives and workstreams. For example, strategic objectives related to 'Quality' included enhancing the ward accreditation scheme and improving responses to complaints by March 2024.

Another example of how the trust was aiming to achieve these strategic objectives was the restructure of the clinical divisions for better oversight and clinical leadership. Since our last inspection in 2019 the Trust has had 2 divisional restructures – one in 2020 and one in 2022/2023. The first restructure saw the Trust go from 5 divisions to 2 divisions. The transfer to 2 divisions was implemented in November 2020. First division included 'planned care': surgery, CSS, and cancer care. The second division included 'unplanned care': medicine, women and children's (W&C) services.

A consultation for the second divisional restructure was launched in September 2022 which proposed a third division for W&C services, and a fourth division for cancer services. The latest divisional structure consisted of planned care, unplanned care, W&C services, and cancer services which was fully embedded in April 2023. This demonstrated that the trust had reviewed the strategic objectives and listened to staff to make strategic changes when needed.

Underpinning the Trust's overarching strategic objectives were a number of enabling and bridging strategies. These included estates and facilities, organisational development and digital transformation. Some strategies were evolving and being further developed in line with wider plans such as environmental sustainability and others were well established. Progress against delivery of the strategy and local plans were monitored and reviewed. The trust executive programme board was responsible for oversight of delivery of strategic objectives. This included monitoring of enabling and bridging strategies.

The Trust had identified the need to align their strategy to the wider integrated care system (ICS) plans and were in the process of doing this. This included reviewing the trust strategy to ensure it sufficiently describes how it is aligned to the ICS strategy and exploring shared back office functions across the ICS.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust was working to promote equality and diversity in daily work, and provided opportunities for career development. The trust worked hard to promote an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they mostly felt respected, supported and valued. Our interviews with staff at all levels demonstrated that the culture was mainly centred on the needs and experience of people who used the services. Staff told us they were proud of the work they did. However, the increased demand and pressures on services had impacted on staff well-being with some staff experiencing 'burnout'.

Staff we spoke with told us that there was not a strong enough emphasis on the safety and well-being of staff. This was reflected in the themes from concerns raised within the organisation to the Freedom To Speak Up Guardian (FTSUG) and in the trust's 2021/2022 NHS staff survey.

Our findings

The results of the most recent NHS staff survey were mainly in line with the England average. There had been some areas of decline such as in engagement and morale. Divisional leaders had taken a number of actions to address the concerns, this included having team talks and developing service line action plans. There was a trust-wide action plan with set of agreed targets to monitor against. Senior leaders told us that staff action plans were reviewed as part of accountability review meetings (ARM).

Equality and diversity were not sufficiently promoted within the organisation. The trust had a diverse workforce. As of March 2023, the trust reported that 56.8% of the workforce were from a white background, 34.5% of their workforce was from a black and minority (BME) and 8.7% of their workforce were from unknown ethnic origin. The trust board and senior leadership team was not reflective of the workforce or community served.

The Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reports for the trust demonstrated there was a lack of diversity in senior leadership posts and the experience for some people with protected characteristics was not consistently positive. Of the executive board members at the trust, 0% were from BME background.

Senior leaders had identified the need to have a more detailed equality, diversity and inclusion strategy and this was being developed at the time of our inspection. The trust was taking some actions to promote equality and diversity, this included the re-launch of equality networks. Equality and diversity also featured in the trust's board development programme. Our interviews with the chief people officer confirmed that a programme including reverse mentoring and cultural intelligence sessions was being undertaken and further developed.

Staff we spoke with generally felt able to raise concerns. The trust NHS staff survey demonstrated that percentage staff who felt that they were bullied or harassed by managers or other colleagues was consistently higher than the England average since 2018. Senior leaders were working to address this however progress had been slow, some staff told us that the processes for addressing behaviour that was not in line with the trust values was not consistently applied. The trust has a speaking up policy and one full-time FTSUG. The trust had recently increased capacity within the FTSU team and had 28 champions throughout the trust to support the FTSUG. Our interviews with staff at different levels and their representatives confirmed that champions were from all areas of the trust and was having a positive impact on staff speaking up. There was a NED sponsor for FTSU who was fully engaged with the process and accessible for staff.

Senior leaders we spoke with recognised that there was some changes to be made in relation to the culture of the organisation to help drive inclusion. The trust was making a significant shift in the culture from 'grip and control' to 'empowerment'. Senior leaders told us that 'grip and control' had been necessary since 2019 to maintain financial stability whilst delivering services during the pandemic. Senior leaders were focused on empowering divisional and junior leaders within the organisation to develop and manage services within their own teams with support when needed. This was yet to be embedded; however, there was a plan in place.

People who used the services were able to raise concerns openly. The trust had a complaints policy in place, as well as a policy in relation to Duty of Candour. Our review of complaints and serious incident investigations demonstrated that the process for patients to make a complaint was simple. Investigations were thorough, outcomes explained, including any learning/actions from concerns raised, and formal records were kept by the Trust. There was openness and transparency in how complaints were dealt with and complaints and concerns were taken seriously.

Our findings

Governance

Leaders did not always operate 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 trust had structures, processes and systems of accountability to support the delivery of the strategy and sustainable services. The governance processes had recently been reviewed (June 2022) and an action plan developed in September 2022 to strengthen governance processes. This was still in progress and included training for managers at all levels and strengthening governance capability and capacity at divisional level.

All levels of governance and management generally functioned effectively. However, during the core service inspections we found that there were some gaps in governance and assurance systems. Where areas for improvement were identified, senior leaders took action to address these. For example, before our inspection (September 2022) the trust had undertaken an external review of governance. One of the actions as a result of the review was to commission training for leaders to produce assurance reports.

The board assurance framework (BAF) was focused on strategic risks in line with the trust's corporate objectives as outlined in the trust's annual report. There were links to the corporate risk register and risk owners provided updates on any mitigating actions and control measures through the relevant committee. There had been a review of the BAF in April 2022 and recommendations included streamlining information. The trust had an external auditor to provide them with assurances with regards to their risk and assurance processes.

Management of Risk, Issues and Performance

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

The trust identified and escalated relevant risks and issues and identified actions to reduce their impact. The trust had a corporate risk register which contained the board level risks. Each clinical service line reviewed their risks and rated them using a specific matrix. There had been a focus to review the level of risk allocated to recorded risks.

Risk management was overseen by the audit and risk committee. This group reviewed each clinical service line's risk and identified if they met the threshold for escalation to the corporate risk register. There was a risk management group chaired by the director of finance and deputy CEO. The group was developed to raise the profile of risk management in the trust and improve the assessment of risks on the risk register. The trust had been through a process of reviewing all risks in order to make the risk register fit for purpose. There was an ongoing challenge of risk scoring. The trust risk report from April 2023 showed that the number of risks graded 20 or above have been reduced by 49%.

We found examples across all the directorates that risk management processes and the use of risk registers as a dynamic tool with mitigations and actions to reduce risk were in place. The approach of check and challenge was maturing. Trust wide risk training for staff commenced in March 2023. The risk training was aligned to the Trust's risk strategy focused on risk scoring and rating.

There were processes to manage current and future performance. This included clinical service leaders attending regular quality and performance review meetings with executive team members. There was a quality strategy in place

supported by a quality assurance oversight framework. Leaders at all levels attended system-wide meetings to discuss the trust's performance within the ICS and to develop future performance models. For example, the trust was working with the wider system including primary care, community as well as the mental health trust to find pathways to support this patient group better.

The trust was in the process of rolling out agreed terms of reference for the accountability and review meetings (ARMS) across the trust in order to assist with the consistent delivery of trust objectives. The trust was in the process of standardising meeting agendas as part of the well led action plan to ensure a consistent review and escalation of risk through the trust quality and performance oversite structure.

A risk identified during our core service inspections related to access to and flow through the hospital. We found there were delays for ambulance offloads, delays for patients in the emergency department and delays to discharge patients from the wards that no longer met the criteria to reside. The trust's full capacity protocol was not fully embedded and therefore there was not a whole hospital approach to support patient flow. The challenges relating to access and flow within the hospital had been identified as a risk to patients by the trust. The trust had identified that there was an opportunity to make improvements by reviewing internal professional standards and share the risk across the trust and the wider health care system. Internal professional standards are a clear, unambiguous description of the values and behaviours expected in an organisation.

There was a programme of clinical and internal audit to monitor quality, operational and financial processes. However, this was not always effective in identifying and escalating risk. During our core service inspection, we identified areas where internal audit was not being used effectively to identify, escalate and address concerns and share learning. During our inspections leaders told us that identification of risk and escalation had not always been as effective citing the findings at our previous inspection of the maternity service identifying risks that the board were not aware of.

The trust participated in national audits. The Lister Hospital has been named as a National Joint Registry (NJR) Quality Data Provider for the fourth consecutive year, after successfully completing a national programme of local data audits. The registry collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care, and overall cost-effectiveness in joint replacement surgery. The NJR Quality Data Provider certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety.

Information Management

The trust 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. Data or notifications were consistently submitted to external organisations as required.

There was an evolving understanding of performance to sufficiently cover and integrate people's views with information on quality, operations and finances. The trust was in the process of upgrading their information management systems to enable better oversight, more collaborative working and better data to support improvements.

The trust reviewed the effectiveness of information received at board. At the time of our inspection, papers and reports for committees were being reviewed to ensure they were effective and efficient.

Quality and sustainability received sufficient coverage in relevant meetings at all levels. The trust used a range of performance indicators and used statistical process control analysis and identified special cause variation. Senior leaders told us they had sufficient access to information, and they challenged it appropriately.

Our findings

There were clear service performance measures which were reported and monitored in various forums. There were effective arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.

The trust had an IT strategy to develop the integrated information systems across their locations. The trust was also involved in the system-wide planning to align data systems.

There were effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

Arrangements were in place (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

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 trust is part of the NHS Hertfordshire and West Essex Integrated Care System (ICS). This system was formed in 2021.

We identified during our core service inspections the ongoing risk due to the delays of patients with mental health needs staying in the emergency department for extended periods of time and there were delays in reviews carried out by staff from the mental health trust. The medical director described effective working relationship with medical director at the mental health trust to escalate individual patients directly in an attempt to find resolution. The trust was working with the wider system, including primary care and community, as well as the mental health services to find pathways to improve services and support for this patient group.

The trust had established relationships with the trade unions. The trust had a monthly trust partnership group meetings between executives and senior managers and staff side representatives. However, staff side representatives told us that this meeting was not always well attended and they reported that the Chief Executive Officer did not attend the meetings. However, they reported that they met regularly with the chief people officer and with their deputy to discuss emerging concerns.

The trust participated in an annual staff survey and staff engagement had increased by 5% to 47% from the previous year. The trust also sought ongoing staff feedback via the quarterly people pulse survey.

The trust has launched a “positive Leadership walk around every Friday to observe care and gain feedback from staff.

There was a biweekly leadership forum and a monthly all staff briefing to engage with the trust workforce, update on key messages and deal with queries. There were various forums for staff to engage with the CEO using an “Ask Adam" email, “chat with the CEO meeting and coffee catch up meeting attended by different members of the senior leadership team. Findings from our core service inspection showed that leaders were visible and accessible.

The trust engaged with patients and service users.

Our findings

Learning Continuous Improvement and Innovation

All staff were committed to continually learning and improving services. They were developing a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had engaged an external provider to implement organisational systems to support improvement and innovation. Working with this organisation the trust was establishing daily operational and clinical processes that supported pro-active quality control and assurance with the aim of developing the trust towards a learning organisation, improving accountability, performance and outcomes. The aim was to move the organisation away from day-to-day crisis management and align and connect staff through the trust values and behaviours aligned with the strategic vision. The external provider had recently been appointed so this work was at an early stage and was not embedded.

Effective systems were in place to identify and learn from unanticipated deaths.

There were systems in place to support innovation and improvement. The trust took part in clinical research and showed how research has improved patient outcome and experience at the trust. For example, patients who have Robot Assisted Radical Prostatectomy were found to have better treatment when compared with patients undergoing Open Radical Prostatectomy and that the cost of treatment was less. The Lister Hospital is a training hub for consultants to develop their robotic surgery skills.

The new electronic incident reporting system ‘ENHance’ was being formatted to support real time oversight of duty of candour application during all incident management. This supported local ‘unit’ level compliance as well as specialty level, divisional and trust level oversight.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

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	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community	Good	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023

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
Lister Hospital	Requires Improvement ↑ Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023
Mount Vernon Cancer Centre	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Queen Elizabeth II Hospital	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Hertford County Hospital	Good Apr 2016	Not rated	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall trust	Requires Improvement →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023

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 Lister Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Nov 2023	Requires Improvement ↓ Nov 2023	Good → ← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023
Services for children & young people	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019
Critical care	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019
End of life care	Good Dec 2019	Requires improvement Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Surgery	Requires Improvement ↑ Nov 2023	Good → ← Nov 2023	Good → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023
Urgent and emergency services	Requires Improvement ↓ Nov 2023	Good → ← Nov 2023	Good → ← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement ↓ Nov 2023
Maternity	Requires Improvement ↑ Nov 2023	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires Improvement ↑ Nov 2023	Requires Improvement ↑ Nov 2023
Outpatients	Good Dec 2019	Not rated	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019
Overall	Requires Improvement ↑ Nov 2023	Requires Improvement ↓ Nov 2023	Good → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023	Requires Improvement → ← Nov 2023

Rating for Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Chemotherapy	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Requires improvement Apr 2016	Requires improvement Apr 2016	Requires improvement Apr 2016
End of life care	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Inadequate Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Radiotherapy	Good Dec 2019	Good Apr 2016	Good Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019
Medical care (including older people's care)	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Outpatients	Not rated	Not rated	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Overall	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019

Rating for Queen Elizabeth II Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Overall	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019

Rating for Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Apr 2016	Not rated	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall	Good Apr 2016	Not rated	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall	Good	Good	Outstanding	Good	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.

Lister Hospital

Coreys Mill Lane
Stevenage
SG1 4AB
Tel: 01438314333
www.enherts-tr.nhs.uk

Description of this hospital

Lister Hospital is a 566-bed district general hospital situated in Stevenage, Hertfordshire. The hospital provides a wide range of acute inpatient, outpatient, and minor treatment services, including an emergency department and maternity care, as well as regional and sub-regional services in renal medicine, urology, and plastic surgery. General wards are supported by critical care (intensive care and high dependency) and coronary care units, as well as pathology, radiology, and other diagnostic services.

Since October 2014, Lister hospital has been the trust's main hospital for specialist inpatient and emergency care. It provides care 365 days a year, seven days a week.

Urgent and emergency services

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, including the highest level of life support training to all staff, but not everyone completed it.

Nursing and support staff received and kept up-to-date with their mandatory training. Records showed that 82% were up-to-date with essential training with 76% having completed recent life support training appropriate for their role. Practice development staff explained that there had been initial problems with a new on-line training system which had reduced their ability to arrange resuscitation training. Work was taking place to resolve this.

We could not be certain that medical staff received and kept up-to-date with their mandatory training. Senior staff told us that accurate training records were not available. Junior doctors rotated through the department every six months but the trust-wide electronic system did not remove their names from the department's training log when they left. Therefore, it appeared that a large number of doctors had not received recent training. This problem had been discussed at a governance meeting in May 2023 and had been escalated for action.

Records showed that nine doctors (confirmed as currently working in the department) had not completed recent resuscitation training. At our last inspection we had told the trust they should ensure that medical staff's mandatory training complies with the trust target. This had not happened.

The mandatory training was comprehensive and met the needs of patients and staff. The practice development team had ensured that the training was tailored to meet the needs of patients in the emergency department.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Additional training had been added so that nursing and support staff gained specific skills to meet the needs of patients with acute mental health problems.

Managers monitored mandatory training and alerted staff when they needed to update their training. A new on-line training system had recently been introduced and automatically reminded staff when training needed to be updated.

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, some of the doctors in the adult emergency department (ED) had not completed children's safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. Of the nursing staff, 89% had completed level 2 children's safeguarding training and 85% had completed level 3. All nurses in the children's ED had completed level 3, in accordance with the Intercollegiate guidelines for children in emergency care settings. Of the nursing staff, 92% of nurses had completed level 2 adults safeguarding training.

Medical staff received training specific for their role on how to recognise and report abuse. All doctors in the children's ED had received level 3 children's safeguarding training but only 58% in the adult ED. Of the medical staff, 72% had been trained to level 2 adult safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff were able to describe safeguarding referrals they had made when patients were at risk of harm. They gained support from the trust's safeguarding team and followed up referrals to make sure that action had been taken.

Staff followed safe procedures for children visiting the department. Children and adolescents were treated in a separate department with effective security controls. Staff had access to an online child protection register to check if children were at risk of abuse.

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. However, cleaning chemicals were not stored securely.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Regular cleaning audits showed compliance with cleaning schedules.

Staff followed infection control principles, including the use of personal protective equipment (PPE). We observed emergency department staff complying with good hand hygiene practices and using correct PPE. However, the hand hygiene audit for May 2023 showed only 66% compliance with correct techniques (the expected standard was 95%). This improved to 85% in June 2023. A senior nurse explained that some of the staff included in the audit were from visiting teams and it was not always possible to influence them. We saw evidence of this one morning when two doctors from visiting teams were wearing wrist watches. This prevents thorough cleaning of hands and wrists.

Staff were familiar with, and adhered to, up-to-date processes for COVID-19 prevention.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, we found that the room containing cleaning chemicals was unlocked, as was the cupboard in which they were kept. This was contrary to regulations for the Control of Substances Hazardous to Health (COSHH).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff employed by the trust were trained to use equipment and facilities and managed clinical waste well.

The design of the environment followed national guidance. The department was modern and well-designed with good circulation space. However, the ambulance entrance was not covered by a canopy and so patients were sometimes

exposed to bad weather when they were transferred from the ambulance to the ED. Patients in the resuscitation area and major treatment areas were treated in individual rooms with doors that closed for privacy and to aid infection control. However, more patients were being treated than was planned and so staff had had to adapt facilities to allow this.

For example, eight armchairs had been placed in the circulation space of the second major treatment area ("Majors2") for patients who did not need to be treated on a trolley (also known as "Fit-to-sit"). Space was limited and so the chairs did not have three feet between them as required for infection prevention. Many of the patients had relatives with them who were also given a chair which meant that there was often no space at all between chairs. The whole area was very crowded and most of the patients had limited mobility. It would have been difficult to evacuate them in the event of a fire. Staff told us that a fire risk assessment had been carried out. We were later sent a risk assessment carried out on behalf of the trust but it had not addressed the issue of crowding in the Majors 2 area. A separate health and safety risk assessment of the area did show a fire risk. Although actions to reduce the risk were described, it was not always possible to implement them. For example, moving patients with poor mobility on to a bed in a treatment room.

There was an adjacent children's emergency department which was separately staffed but shared the same entrance as the main department. It was spacious and modern and was designed to meet the needs of infants and children up to the age of eighteen years.

At one end of the department there was an eight-bedded clinical decision unit for patients who needed to stay overnight for the results of investigations.

An "overflow" major treatment area had been created in space that used to be offices. This was in response to increasing delays experienced by ambulance crews when trying to handover patients to the hospital. It was isolated from the rest of the department and there were not always enough nurses to staff it. Therefore, patients were sometimes cared for by ambulance crews. However, ambulance staff were not familiar with hospital equipment and procedures in the ED and may not have been able to respond effectively to a deteriorating patient. Patients were not cared for in this area during the inspection.

The service had suitable facilities to meet the needs of patients' families. There was a light, spacious and comfortable room for relatives of critically ill patients. It had tea and coffee making facilities and information about support services.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. We found that all equipment had been regularly maintained and had been checked to ensure that it was ready to use.

Staff disposed of clinical waste safely. Boxes for the disposal of sharp instruments were well constructed and filled to a safe level. Other clinical waste was disposed of in colour coded bins which were emptied frequently.

Assessing and responding to patient risk

Staff completed risk assessments for most patients swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, some children were not assessed on arrival and mental health patients often waited many hours for specialist assessment by a psychiatrist.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. National Early warning scores (NEWS2) were used for adults and paediatric early warning scores (PEWS) for children. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. We found that all scores were calculated accurately and regularly.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patients arriving by ambulance were rapidly assessed by an experienced nurse. This assessment was required to determine the seriousness of the patient's condition and to make immediate plans for their on-going care. This is often known as triage. Standards set by the Royal College of Emergency Medicine states that this should take place within 15 minutes.

During our inspection we observed the triage of 5 ambulance patients. All were triaged immediately. We reviewed the records of a further five ambulance patients who had attended in the previous fortnight. All had been triaged within 11 minutes.

Data from NHS England showed that the median (average) time to initial assessment for ambulance patients at the Lister Hospital was 6 minutes. (Data from March 2022 to February 2023). This was better than the national average of ten minutes for the same period of time.

If the department was completely full, there would sometimes be delays before ambulance patients could be brought into the assessment area. When this happened, we were told that triage would be carried out inside the ambulance.

Patients who walked into the department, or who were brought by families or friends, reported to the reception desk. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be triaged by a nurse. We observed the triage of two patients (with their consent) and found the assessments to be thorough and effective. They were based on the Manchester Triage Tool. Nurses told us they had completed specific training in triage and had been assessed as competent before undertaking the role.

If there were delays for triage a second, and sometimes a third, nurse were deployed to the assessment area. Despite this, in the past, some patients had waited longer than 15 minutes to be triaged. To reduce the risk to patients a new role had been created, known as the navigator nurse. This was an experienced nurse who stood beside the reception desk. If a patient appeared very unwell when they arrived, the navigator nurse would prioritise their triage or take them straight to a treatment area. The navigator nurse could hear the details being given to the receptionist. If these indicated a serious condition, their triage would also be prioritised. In this way, even if there were delays for triage, an initial risk assessment had taken place.

Children were triaged by specialist children's nurses. During our inspection this took place within 15 minutes. However, when we reviewed five sets of records for children who had attended recently, only two had been triaged within the recommended time. The other three had waited between 21 and 40 minutes. We asked the trust for recent triage times for all children but have not received that information.

Staff knew about and dealt with any specific risk issues. We looked at the risk assessments for sepsis, allergies, falls and pressure ulcers in eighteen patients records. All but one (sepsis) had been completed in a timely fashion. Sepsis

screening assessments were being transitioned on to the electronic system and we were told that the new assessments were not always being fully completed by staff. We looked at records for two patients who were being treated for sepsis and found the electronic screening tool had been completed for one and not the other. It was not clear whether a paper record had been completed for the second patient.

The service had 24-hour access to mental health liaison and specialist mental health support. However, response times from specialist mental health doctors (employed by a separate NHS trust) was slow. On the second day of our inspection, we observed two patients who had been detained under Section 136 of the Mental Health Act. One had waited for 11 hours to be assessed by a psychiatrist and the other by 19 hours, thus delaying specialist assessment and treatment. Staff told us that this happened frequently.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Triage nurses used a specific mental health assessment devised in conjunction with local psychiatrists.

Shift changes and handovers included all necessary key information to keep patients safe. In addition to regular staff handovers, the nurses and doctor in charge of each shift carried out regular safety huddles and recorded key information from them. They reviewed the electronic records of patients in treatment areas and highlighted new information. They checked that all patients with a high NEWS score (patients who were at risk of deteriorating) had been examined by a doctor and treatment started. If there were long waits for other patients to be seen by a doctor, they tried to re-organise staffing to improve the situation. The safety huddles normally took place every four hours but, if patients were experiencing long delays, this was increased to two-hourly.

Nurse staffing

The service had 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 staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Nurses that we spoke with told that there were usually enough staff and we observed good staffing levels during our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior nurses had previously used staffing calculations specific to emergency departments devised by the Royal College of Nursing. However, this was not well understood by the rest of the hospital and so they now used a staffing tool produced by the Shelford Group (a group of the 10 largest teaching hospitals in the UK). This is not a nationally recognised tool but is used in other parts of the hospital. A study of patient demand in the department had shown that the maximum number of nursing staff was required between 2pm and 2am. Two “twilight” shifts had been introduced so that there were 23 registered nurses on duty until 2am.

The service had low sickness rates. The average rate in 2022 was 6% for registered nurses and 8% for support workers. This was lower than the rest of the trust.

The service had low rates of bank and agency nurses. The duty rota for the last month showed that agency nurses were rarely used and bank nurses worked regularly in the department and were familiar with it. We noted a willingness and commitment by nursing staff to alter their shift pattern at short notice in order to cover for unexpected sickness. Managers made sure all bank and agency staff had a full induction and understood the service.

Urgent and emergency services

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. We looked at the rota for the last two months and found that there were sufficient doctors and a good skill mix.

Sickness rates for medical staff were low at 4%.

Managers made sure locums had a full induction to the service before they started work. Standard induction information was given to locums before they started. They were always supervised by more senior doctors. There was only one locum doctor on the current rota.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Three additional consultants had recently been recruited. The rota was being reviewed to ensure that there was a consultant present in the department for 16 hours a day, seven days a week. This had improved since our last inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. There was a mixture of paper and electronic records. We reviewed 18 patients' records and found them to be clear and detailed.

When patients transferred to a new team, there were no delays in staff accessing their records. Electronic records could be accessed throughout the hospital. Copies of patient records were sent with them when they were admitted to a ward.

Records were stored securely. They were kept in robust containers at the staff base and at reception, and were supervised at all times.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed on paper charts. We looked at medicine charts and found that allergies were always documented to ensure medicines were prescribed safely.

Prescribers and nursing staff had access to resources to ensure medicines were prescribed at the correct dose. However, nursing staff reported that psychiatrists were reluctant to use the ED medicine charts and so gave verbal instructions for ED doctors to prescribe specialist medicines. There was a risk that the wrong dose could be prescribed in these circumstances.

Staff stored and managed all medicines and prescribing documents safely. Medicines including controlled drugs (medicines requiring additional control due to the potential of misuse) were stored securely. However, we found one expired medicine on the clinical decision unit, we highlighted this to staff and the medicine was removed immediately.

Room and fridge temperatures where medicines were stored were monitored and staff we spoke to on the inpatient units understood when to escalate. The pharmacy team reviewed these temperatures weekly to ensure that any issues identified could be actioned quickly.

Resus trolleys were checked daily to ensure they were ready to use when required.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff had access to and sought consent from patients when viewing summary care records to check medicines taken prior to admission.

Staff learned from safety alerts and incidents to improve practice. There were clear processes to report and investigate incidents when they took place. Staff we spoke to understood duty of candour.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They were confident about the process and received feedback if required.

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. Investigation reports that we looked at demonstrated this.

Staff received feedback from investigation of incidents, both internal and external to the service. Outcomes of incident investigations, both within ED and throughout the hospital, were posted on the noticeboard in the staff room.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at ED governance meetings and changes made when necessary. For example, urine testing equipment had been re-organised to prevent confusion about results.

There was evidence that changes had been made as a result of feedback. As well as patient safety incidents, there were also frequent reports of violence and aggression towards staff. These were discussed at ED staff meetings and also at divisional meetings. As a result, there had been an increase in security staff in the department to improve staff safety.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The investigation report that we viewed was detailed and methodical.

Managers debriefed and supported staff after any serious incident. Senior staff understood the impact that serious incidents had on staff and provided timely support.

Urgent and emergency services

Is the service effective?

Good 

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

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. Emergency department staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust's quality and audit team sent monthly emails with new guidance from national organisations, such as the National Institute for Health and Care Excellence (NICE) and NHS England. ED leaders then updated their policies within one month and submitted then to divisional directors for approval.

The department had an audit programme that monitored the implementation of guidance from national clinical organisations. The programme included audits of NICE guidance, such as sepsis in adults and meningitis in children. The department also took part in national benchmarking clinical audits including those organised by the Royal College of Emergency Medicine (RCEM).

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. They regularly looked after patients subject to Section 2 and 136 of the Mental Health Act 1983 and were familiar with the Code of Practice. They ensured that the Psychiatric Liaison team undertook daily checks of patients while they waited for definitive psychiatric treatment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. They described these needs with insight and empathy.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed support staff carrying out regular refreshment rounds for patients and families. This included patients in the waiting room. Clinical staff regularly checked that patients had received enough to eat and drink.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. The records that we reviewed showed these had been accurately documented.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. However, pain scores were not always recorded.

Staff usually assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We looked at recent records of 10 patients who complained of pain. Three patients did not have a pains score

recorded, although all had been given pain relief. Seven patients had no record of their pain being re-assessed to make sure the pain relief had been effective. Senior staff had already identified this issue during an internal clinical audit. Further investigation had shown that pain was being assessed and treated but there was no consistent way of recording pain levels. Senior nurses were in the process of adjusting documentation to resolve the issue.

Patients received pain relief soon after it was identified they needed it or they requested it. We observed pain scores being recorded and timely pain relief being given throughout the inspection. There was positive feedback from patients regarding the speed of pain relief that was given.

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 participated in relevant national clinical audits such Royal College of Emergency Medicine audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. A sepsis audit that took place at the end of 2022 showed that sepsis documentation was not always completed. The documentation was changed and further training was provided by the trust's sepsis team. A repeated audit in March 2023 showed that documentation had improved.

Managers used information from the audits to improve care and treatment. For example, a recent audit of electrocardiogram (heart tracing) reporting showed variation in report detail. Updated guidance was about to be issued so that all staff knew which abnormalities to look for.

Managers shared and made sure staff understood information from the audits. Results were discussed at governance and staff meetings.

Competent staff

The service made sure staff were competent for their roles. The service held supervision meetings with staff to provide support and development. We were told managers appraised staff's work performance however, we were not provided with data on the compliance with yearly appraisals.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Rotas showed good range of skills and experience amongst medical and nursing staff.

Managers gave all new staff a full induction tailored to their role before they started work. Nurses new to the department received a one or two-week induction programme, depending on their previous experience. They then worked on a supernumerary basis for two weeks and worked closely with the department's practice development nurses. A similar programme was followed by support staff.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Group supervision sessions were held monthly. Themes for discussion were planned in advance but wide-ranging discussions were encouraged. All conversations were confidential so that staff felt more comfortable in raising concerns.

Urgent and emergency services

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. One of the consultants led the training of junior doctors and the professional development of senior doctors. All the consultants took part in the training programme. We spoke with junior doctors who were complimentary about their training programme. They told us that they received regular supervision from the emergency department consultants, as well as weekly teaching sessions.

The clinical educators supported the learning and development needs of staff. There was a large practice development team with five senior nurses and a band 4 clinical support worker. They had developed a comprehensive starter pack for newly qualified nurses and had established development targets for the first four months. After six months the development of nursing staff followed the Royal College of Nursing's National Curriculum and Competency Framework for Emergency Nursing.

They had recently introduced interactive scenarios training. A complex patient presentation (often based on a real patient) is described by the trainer and learners are asked to discuss potential responses or solutions. Staff told us that they enjoyed these sessions and found them very useful in converting theory into practice.

Managers supported staff to develop through yearly, constructive appraisals of their work. Nurses spoke positively about the appraisal process however, the trust was not able to tell us how many staff had been appraised in the last year.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Training needs were a key part of the appraisal process.

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, but not always effective, multidisciplinary meetings to discuss patients and improve their care. We were shown minutes of meetings with doctors from the neighbouring mental health trust and representatives of the Hertfordshire police force aimed at improving the care of patients detained in the ED under the Mental Health Act. However, the meetings had not yet reduced the number of patients spending prolonged periods of time in the department.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed ED staff regularly referring patients for mental health assessments. However, the response from on-call psychiatrists was often slow. On the second day of our inspection, two patients had been referred to a psychiatrist during the night. However, by 3pm neither had been assessed.

We observed ED staff working seamlessly with ambulance staff and with the hospital stroke team in order to improve the care of patients. There were well established links with the hospital frailty team, therapists and primary care practitioners.

Seven-day services

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

Urgent and emergency services

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. ED consultants provided cover 24 hours per day, 7 days per week, either directly within the department or on-call. Relevant diagnostic services were also available whenever needed.

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 took the opportunity, if it arose and was appropriate, to discuss topics such as smoking cessation and drug and alcohol misuse with patients. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff discussing patients' capacity to make decisions and using a standardised process to assess capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They asked for consent before invasive or intimate procedures and recorded consent in patient records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The staff we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

Clinical staff did not always receive or keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Minutes of the June 2023 mental health quality improvement meeting showed 90% of nurses had recently received this training but only 40% of doctors.

Staff understood the relevant 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. We observed staff discussing new patients with the on-call psychiatrist. There were monthly meetings with mental health professionals to discuss the care of patients detained under the Mental Health Act in the ED.

Is the service caring?

Good ➔➔

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

Urgent and emergency services

Compassionate care

Staff treated patients with compassion and kindness. However, it was not always possible to respect privacy and dignity or to take took account of individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. They were unfailingly courteous to patients and their families and took individual circumstances into account when deciding on treatment.

Patients said staff treated them well and with kindness. We spoke with three patients all of whom were complimentary about the kindness they had received. One said "You cannot fault the staff here. They have been marvellous." We also viewed recent written feedback from patients which praised the friendly and considerate way in which they had been treated.

It was not always possible for staff to follow policy to keep patient care and treatment confidential. There was a seated area for patients in the Majors 2 treatment area. Many of the patients in this area were waiting to be admitted to a ward. There were small clear plastic screens on the side of the patient chairs, but they provided very little privacy. Chairs were very close together and confidential conversations were easily overheard. Staff tried to transfer patients to a room if private conversations were needed but these were often full. In order to reduce delays for diagnosis or treatment conversations sometimes had to take place in this area. Nurses that we spoke with were frustrated with the situation but felt there was little practical alternative.

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. We observed staff discussing a patient with severe mental health problems. They displayed a good understanding of the patient's needs and the help that they and their family would require.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They took time to reassure patients emotionally, as well as treating their physical injuries. One patient told us how concerned they were on attending the department, but how staff patience and kindness helped them to feel better.

Communication with children was well thought out and effective. Staff took time to distract and comfort them during injections and blood tests.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Patients with mental health problems were nursed in single rooms often with one-to-one care.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed the great care, sensitivity and consideration that was employed when updating the relatives of a very sick patient.

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 member of staff discussing the results of investigations that were worse than expected. They spoke slowly and checked the patient's understanding before continuing their explanation.

Urgent and emergency services

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. We observed clinical staff introducing themselves and explaining what was about to happen before examining patients. All staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.

Parents were involved in the assessment and treatment of their children and clear explanations were given. We observed family members being included in discussions about on-going care.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff adjusted explanations of treatment depending on patients' level of understanding. They used pictures and computer images to aid communication.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Although negative feedback had been received about delays in the department, we read two recent messages from patients that complimented nursing and medical staff on their professionalism and kindness.

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 planned and tried to provide care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the needs of the local population. Studies had shown that peak patient activity in the emergency department (ED) was between 2pm and 2am. Additional nursing shifts had been introduced to increase the number of nurses available until 2am.

The new role of navigator nurse meant that patients could be referred to other parts of the hospital without waiting to see an ED doctor. For example, the early pregnancy unit or the same day emergency treatment centre.

Some patients came to the department with conditions that were neither an accident nor an emergency. Managers had arranged for a GP to work in the department every day until 8pm to ensure that suitable treatment was provided.

Facilities and premises were mostly appropriate for the services being delivered. The department had sufficient facilities to treat emergency patients. However, there were frequently many additional patients waiting for long periods to be admitted to an inpatient ward. There were 10 additional patients on the first morning of our inspection and 13 on the second. This meant that the department was often full and there were difficulties finding space for new emergencies.

Although there were six patient rooms in the resuscitation area, delays for admission meant that patients whose condition had improved could not be moved out. We observed a patient being treated in the middle of this area for over an hour because a newly arrived ambulance patient required immediate treatment in one of the rooms. Staff told us this was not unusual and they tried to make sure that the most stable patient was the one who was moved out of a room.

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 psychiatric liaison team were always available, although there were delays to see the on-call psychiatrist. The learning disabilities team were available from Monday to Friday but were on-call at weekends for urgent problems.

Meeting people's individual needs

The service was inclusive but could not always take account of patients' individual needs and preferences due to the demand on the service. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The seated area in the Majors 2 treatment area did not always meet patients' needs and preferences. The intention was for patients to spend two or three hours in a reclining chair before going home or being admitted. However, there were long delays to be admitted, or to see a visiting specialist. This meant that some patients spent up to 12 hours in a chair. On the first morning of our inspection there were three elderly patients and their relatives sitting in the middle of the treatment area. Staff confirmed they had been there all night. We spoke with one patient who said that they had not always been comfortable and had very little sleep. However, they had been offered breakfast and a shower.

The next day there were three more patients who had spent the night in the seated area. One had arrived in the department the previous afternoon. All were waiting to be admitted to a ward. A female patient was sitting in dressing gown and slippers next to male patients. This meant that privacy and dignity was reduced.

Staff that we spoke with were concerned about the service they were offering. However, they had been told that there were no available empty beds on a ward and the rest of the ED was full. They carried out two hourly patient safety rounds in the seated area to make sure that patients were safe and as comfortable as possible.

Staff tried to make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients with significant mental health problems often spent a long time in the department due to delays in on-going psychiatric treatment. Three rooms had been adapted to accommodate their needs. Risk assessments had been carried out to ensure they were safe for people at risk of suicide. Arrangements were made for specialist staff to provide care, often on a one-to-one basis.

However, due to a shortage of in-patient beds, some psychiatric patients had to spend several days in a room that was designed for a stay of only a few hours. During our inspection there were three patients who had spent between four days and eight days in the department. One of the patients found the confinement difficult to tolerate. They had been assessed as capable of making decisions about their care and so, when they decided to leave the department, staff were unable to stop them. The patient was later brought back to the department by the police. By that time, all rooms in the department were full and the patient had to wait in the waiting room under the care of police officers. These circumstances did not provide the therapeutic environment required by a patient with serious mental illness.

The ED risk register showed that there were risks for mental health patients spending extended periods of time in the department. Senior staff were aware of this and were working with mental health teams to improve the situation. However, no specific plan of action had been agreed.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were aware of 'This is me' documents but said that patients often did not bring them with them in an emergency. Staff had received training in responding to the needs of people living with dementia. They described the care needed in a knowledgeable and sympathetic fashion. They knew, for example, that patients with dementia should be cared for in a quiet part of the department in a low stimulus environment. We observed this taking place although staff told us it was not always possible when the department was full.

The service had information leaflets available in languages spoken by the patients and local community. Although the leaflets on display were in English, staff told us that they could print them out in different languages if necessary.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was a 24-hour telephone translation service available.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff in the Clinical Decision unit told us they would contact the hospital kitchen if someone had special dietary needs.

Access and flow

People could not always access the service when they needed it or receive 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 tried to make sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The major treatment area was often full which, in the past, had caused delays in diagnosing and treating patients who arrived by ambulance. To reduce these delays an ambulance assessment area had been created with a senior doctor and nurse present to commence medical assessment and treatment. This was known as the DART area (Direct Assessment and Rapid Treatment) and had helped to reduce delays in treatment for ambulance patients. In December 2022 50% of ambulance patients waited over an hour to be handed over to the care of emergency department (ED) staff. By March 2023 this had reduced to 30%. However, this was still worse than other hospitals in the East of England where 24% of patients waited longer than an hour to be handed over.

There were no handover delays during our inspection but the trust could not provide us with comprehensive data for April and May 2023.

There were considerable variations in the average (median) time to see an ED doctor. Data from the A&E quality indicators produced by NHS Digital showed an average of 120 minutes in May 2022 to 30 minutes in July 2022. The national standard is 60 minutes.

Managers monitored other waiting times during patients' progress through the department. For example, response times after a patient had been referred to on-call doctors. These showed that from January 2023 to June 2023 the longest delays were for Psychiatry (seven hours) and General Medicine (eight hours). We observed similar delays during our inspection.

After our inspection the trust told us there had been an error in their waiting time figures and that the average delay for general medical patients was not as long as eight hours. However, the amended data sent to us contained a number of inconsistencies and so it was still not possible to know the average delay for the response to these urgent referrals.

Urgent and emergency services

The Department of Health's standard for emergency departments is that 76% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. This standard was not met at the Lister Hospital. The percentage varied from 46.5% in March 2022 to 41.7% in March 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. The success of the DART area for ambulance patients had resulted in the introduction of a DART doctor for patients who had made their own way to the department. The doctor was based in a room adjacent to the waiting room and patients with a high triage priority were rapidly referred to them. Although this meant reduced delays for investigations and diagnosis it sometimes resulted in patients receiving treatment in the waiting room. We observed a patient with an intravenous infusion sitting in the waiting room on the first day of our inspection and another who required intravenous medication on the second. Staff explained that the treatment areas were full and so treatment in the waiting area was the only way to reduce delays. Although there was an experienced nurse in the waiting room to monitor patients it was not a suitable environment for patients who needed intravenous treatment.

We observed ED staff responding promptly to the results of investigations and referring patients for further treatment if required. However, there were often long delays for specialist treatment from on-call teams. While patients waited ED doctors were sometimes asked to arrange specialist investigations for them. Although they were willing to do this it meant they had less time to see newly arrived patients.

There appeared to be a reluctance by inpatient teams to admit patients from the ED at night. For example, a patient with severe heart and lung problems was referred for intensive care treatment (ITU) in the early hours of the morning. A doctor from ITU tried to start treatment in the resuscitation area of ED but this proved not to be possible. Although there was space available in ITU the patient stayed in the resuscitation room until an ITU consultant reviewed them the next day. The patient was eventually admitted to ITU after 10 hours. A senior ED doctor had spent several hours overnight with this patient and so was unavailable to treat emergency patients.

The pressure on doctors overnight meant that by 8am, some patients had waited up to 11 hours to see an ED doctor. They had all been triaged and a NEWS score had been calculated to assess their risk of deteriorating while they waited. All high-risk patients saw a doctor promptly. By 10am ED staff had reduced the delay to three and a half hours.

The trust held a bed management meeting three times a day aimed at reducing delays for admission and assessing whether the hospital as a whole was under high levels of pressure. The nationally recognised Operational Pressures Escalation Levels (OPEL) were used to assess pressure throughout the hospital. This includes the number of beds available in the hospital and the number of patients needing to be admitted. However, the trust did not appear to be using the levels correctly. At a 9am meeting that we attended it was reported that the hospital was at OPEL 2 which indicates that ED patients were being seen and admitted (or discharged) within four hours (the four-hour standard), although with difficulty. At the time, there were 10 patients who had waited all night to be admitted to a ward (including one who had been in the department for 17 hours), a patient who had been in the resuscitation room for nine hours and some patients who had waited up to 11 hours to be seen by an ED doctor (this did not include three psychiatric patients who had been waiting to be admitted to another hospital for more than four days). There was one patient, who had arrived by ambulance, who had spent two hours on a trolley opposite the staff base because all treatment rooms were full.

This situation is described at level four where 'the four-hour standard is not being delivered and patients were being cared for in overcrowded and congested department(s)'. Assessing a low level of escalation pressure means that lower levels of corrective action are taken and that patient delays will remain. It was unclear whether corrective action such as additional ward rounds or opening extra beds had been taken.

Following the meeting a senior nurse told us that there had been 19 specialist medical beds available during the night but that emergency patients could not be admitted to them. It was not clear who in the hospital had made that decision. We asked a senior member of trust staff if there was a hospital escalation plan that provided guidance to managers when there were long delays for emergency patients to be admitted. We were told that work on this had started but no dates had been agreed for completion or implementation.

The emergency department had drawn up a set of internal professional standards policy setting out expected response times from doctors for different situations and patient conditions. However, the trust had not agreed internal professional standards for other services within the hospital and so on-call teams did not know how quickly they were meant to respond to urgent referrals from the ED.

Several senior members of staff had told us the trust had tried to implement an admission process known as 'reverse boarding'. If there were long delays to admit emergency patients they could be admitted to a ward where an existing patient was due to go home. The patient who was ready to go home was moved from their bedspace to another area of the ward, thus providing treatment space for the new patient. There had been difficulties with this process because it was thought that an additional patient on a ward might cause problems with evacuation in the event of a fire. However, a risk assessment for the ED also showed this as a high risk associated with frequent crowding in the Majors 2 treatment area or the resuscitation room. It was not clear how the trust leaders assessed or balanced these two risks.

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.

Staff understood the policy on complaints and knew how to handle them. Staff told us that if a patient made a verbal complaint, they would try and resolve the concern at the time. However, they always gave patients the option of a formal written complaint.

Managers investigated complaints and identified themes. Senior ED staff sometimes phoned patients as soon as a complaint was received. This enabled them to give an early apology and to gain more details and understanding of the issues involved. Sometimes the ED was part of a wider complaint about the hospital. In such cases, a response would be sent to the patient advice and liaison service so that it could be included in a hospital-wide response. We found complaints were investigated methodically and a clear and courteous response was sent within three weeks.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, urine testing equipment had been re-arranged in so that confusion with results was less likely.

Is the service well-led?

Requires Improvement ↓

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

Urgent and emergency services

Leadership

Leaders had the skills and abilities to run the service. They understood and mostly managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The emergency department (ED) was part of the unplanned care directorate. The directorates of the trust had recently been re-organised and staff felt that the new structure would help them to address some of the problems that they faced. The leadership of the ED was shared by the matron, the clinical director and a general manager. Other senior staff took the lead in specialist aspects of emergency management such as mental health, governance, service delivery and GP liaison.

Leaders were visible in the clinical environment supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose. Those that we met demonstrated the skills, knowledge, integrity and experience needed for their roles. Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns.

We observed constant communication between the nurse in charge and consultant in charge of the department. They jointly looked at the case notes of patients being treated as well as those who were waiting to be seen in order to prioritise treatment. Both frequently consulted patient information on the ED computer system in order to maintain an overview of all the patients in the department. This helped to improve patient safety and flow within the department.

The trust had appointed a new chief executive, chief nurse and medical director in the last year. All had spent time in the ED when they first joined. This improved communication between front-line staff and those taking decisions at board level.

Vision and Strategy

The service had a vision for what it wanted to achieve and was working on a strategy to turn it into action. The vision and strategy were focused on sustainability of services and were aligned to local plans within the wider health economy.

The leadership team told us that their vision for the department was to deliver effective and timely care and treatment to urgent and emergency patients and their families. This vision was supported by staff that we spoke with. The vision had been shared with members of the trust board and work had started on the strategy to achieve it. A recent meeting of the Herts and West Essex Integrated Care System showed that the vision was shared by the wider health economy.

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 in the department were cheerful, friendly and energetic despite the sustained pressure under which they worked. They told us there were opportunities at all levels and that a supportive team of mentors encouraged career development. One of the staff nurses had recently been promoted to a Sister's role.

Staff that we spoke with told us they mostly enjoyed working in the ED. They said there was a strong sense of teamwork and a 'no blame' culture' that made it easier to admit any mistakes and to learn from them. Contact details for the trust's "Freedom to Speak Up" Guardian were described at recent staff meetings. The risk register showed that leaders were concerned about the well-being of all staff and took action to reduce threats to staff safety.

Urgent and emergency services

It was apparent that staff shared the same professional values. The main one being “the patient comes first”. Throughout the inspection we saw this value informing the actions taken by staff. However, there was also a shared frustration that capacity problems within the hospital resulted in long delays for patients in the ED. Staff worked hard to keep patients safe but were aware that individual needs such as comfort and privacy were not always met.

Governance

Leaders 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 governance lead co-ordinated clinical audits and policy development. Also, the introduction and monitoring of best practice. Two weekly governance meetings were held and were attended by senior nursing and medical staff. Issues discussed included new clinical guidelines, the results of incident investigations, complaints and updates to the risk register.

Mortality and morbidity reviews were well-established and were discussed monthly at a separate meeting. Lessons learned were clearly described and an action log was maintained to ensure that changes to practice were established.

There were joint governance arrangements with the pregnancy assessment unit and the same day emergency care unit to monitor the effectiveness of referrals by triage and navigator nurses.

Governance and performance issues were discussed at staff meetings and described in the minutes. To enable more detailed discussion, and to agree improvements, the ED matron had recently introduced governance meetings for nurses.

Staff told us they were clear about their roles and felt supported by their clinical leads and senior managers.

Liaison meetings with senior staff from the neighbouring mental health trust had been commenced in February 2023. This was aimed at joint working to improve the care and safety of patients with mental illness being treated in the ED. One of the results of this was that the mental health trust now funded psychiatric nurses to care for patients waiting in the ED for admission to a psychiatric ward. Difficulties in admitting patients with mental illness had been escalated to the trust board. The chief executive was meeting imminently with the chief executive of the mental health trust.

Management of risk, issues and performance

Leaders and teams used systems to manage some performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events however, there had been no recent training in responding to major incidents. It was unclear whether staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The departmental risk register was an active document and staff at all levels made contributions to it. The risk register had 40 risks described and the actions taken to reduce them were regularly reviewed. The five highest risks had a risk score of 20 out of 25. All reflected the concerns described to us by staff during the inspection. These included risks to patients and staff due to an increase in mental health attendances and admissions, risks to the physical and mental health of staff subject to violence and aggression and risk to patient safety and staff well-being due to overcrowding in the ED including waiting room care.

When risks were outside the influence of ED staff, they were escalated to divisional directors and sometimes to board level. For example, the chief executive was now involved with addressing the issues associated with patients with mental illness in the ED. However, the high risk associated with a crowded department appears not to have been addressed at divisional level.

We asked to see minutes from the last two ED performance meetings but were sent reports from the last two trust finance and performance meetings and the last divisional performance meeting. Most of the information was at trust level and information about urgent and emergency care was often combined with the urgent care centre at the neighbouring hospital in Welwyn Garden City.

There were no ED staff present at the divisional or trust performance meetings and performance data specific to the Lister ED was limited. Although a reduction in delays for ambulance handovers was noted, the percentage of patients spending less than four hours in urgent and emergency care or longer than 12 hours, appeared to be combined with figures from the urgent care centre. Therefore, we could not be certain that senior ED staff reviewed their own performance data or were active in managing performance. There appeared to be limited oversite of some of the difficulties experienced by the service. For example, some leaders were unaware of the low levels of recent resuscitation and safeguarding training amongst doctors, or that some children were waiting more than 15 minutes for an initial clinical assessment.

The role of navigator nurse, that had been introduced for patient safety reasons, was unfunded. Senior staff were not certain that the staffing budget would be increased accordingly and were concerned that financial pressures would compromise quality of care.

The trust had a plan for the response to major incidents such as a bus crash or major explosion. However, the trust was not able to tell us when the major incident exercise had taken place or whether any changes had been made as a result.

Information Management

The service collected data and analysed it. Staff could find the data they needed, but not always in easily accessible formats. This was needed to understand performance, make decisions and improvements. The information systems were integrated and secure.

Information from electronic patient records was easily available and reliable. However, performance data seemed to be collected at trust level and we could not be sure that specific ED data was used to understand performance. Staff reported that training data was unreliable**.**

There were effective information governance processes and safeguards. Staff received information governance training and understood their responsibility to safeguard confidential data.

IT equipment, including access to electronic patient records, was protected by individual smartcards and passwords.

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.

There were posters in the waiting room encouraging people to give feedback and describing how to do so. The hospital's website also encouraged on-line reviews. Staff in the department were working with the local branch a mental health charity to improve support for patients with mental health problems. Trained volunteers came to the department between 7pm and 1am to spend time with patients while they waited for treatment.

There were regular staff meetings to ensure that nursing and support staff were well informed and to raise their concerns. Some junior staff had felt self-conscious about speaking up at meetings so they had recently been re-organised with dedicated meetings for different groups of staff.

Discussions with staff had resulted in the creation of quiet rooms in both the adult and children's ED so that staff could take "time out" after stressful incidents. For example, a death in the department or violence and aggression.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Research from the Royal College of Emergency Medicine was discussed at governance and quality improvement meetings. It was used to inform new policies and to improve local services.

Posters in the staff room displaying learning from serious incidents now contained QR codes. Staff could use these to quickly download the learning in greater detail.

The pilot project to introduce local volunteers from a mental health charity to support mental health patients in crisis had been carefully evaluated. It had been so successful that the mental health charity now had plans to roll out the programme nationally.

Medical care (including older people's care)

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 mandatory training in some key skills to all staff. However, not all staff were up to date with mandatory training.

Nursing and clinical support staff received and mostly kept up to date with their mandatory training. However, this was raised as an issue in the previous inspection and training rates consistently fell below targets. The mandatory training rate for all nurses across the medical division as of June 2023 was 86%. Not all clinical support staff were up to date with mandatory training. For example, on Barley ward and ward 8A, only 58% and 45% of clinical support staff respectively were up to date with mandatory training. The training rate for clinical support staff across the medical division was 81%. Although this was an improvement from the last inspection, this still fell below the trust mandatory training target of 90%.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. However, this was not reflected in practice as not all staff were up to date with mandatory training.

The mandatory training provided was comprehensive and met the needs of patients. It included but was not limited to, safeguarding adults, safeguarding children, infection prevention and control (IPC), health and safety and moving and handling.

Staff told us they mostly completed mandatory training in their own time and were able to claim time back.

We requested information about mandatory training levels for medical staff from the trust but this was not provided. We could not be assured that medical staff received and kept up to date with their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse and they knew how to apply it. However, we were not assured that all staff received training and kept up to date with it.

Staff we spoke to were able to describe signs of abuse in vulnerable patients and who they would raise the issues with. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff described examples of referrals they had made including referring a patient to the safeguarding team who had been admitted to the ward from a care home with pressure ulcers.

The service had a safeguarding team which provided drop-in sessions for regular staff and induction sessions for new staff. We saw that safeguarding children and adults training compliance for staff on medical wards was 87% and 89% respectively in April 2023. However, this was below the trust 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 ward manager was the safeguarding lead on each ward. All safeguarding referrals were reported via the trust incident reporting system to the safeguarding team. There was also information posted in the main ward area displaying contact details for the safeguarding team.

The service had raised 6 safeguarding referrals in the month prior to inspection. The safeguarding team had introduced initiatives to help reduce vulnerable patients' length of stays on the ward and reduce instances of neglect as a result of concerns raised by staff. This included initiatives such as a 'fundamentals of care' plan and a 'deconditioning plan' where staff were encouraged to help patients move about to improve independence and reduce risks associated with long stays in bed. Information for this was displayed on care of the elderly wards.

The safeguarding team liaised with social care workers and charities when supporting patients who were at risk of abuse. For example, they supported patients who were at risk of domestic abuse and required additional support once leaving the hospital.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Cleanliness, infection control and hygiene

The service generally 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.

All clinical areas we observed were visibly clean. We saw housekeeping staff clean on the wards throughout the day. Ward areas had suitable furnishings which were clean and well-maintained. There were hand sinks and hand sanitiser available throughout the wards.

The service generally performed well for cleanliness. The service scored 95.71% in the PLACE score 2022 against a national average of 98%. However, the trust had reported 72 instances of Clostridium difficile (C.Difficile) and 1 instance of methicillin resistant staphylococcus aureus (MRSA) from April 2022 to April 2023 which exceeded the threshold of 59 and 0 respectively. However, 29 of C.Difficile cases had originated outside the hospital which affected the data.

Most staff followed infection control principles well such as washing hands when appropriate, wearing the appropriate PPE and being bare below the elbows. We saw one clinical support worker with acrylic nails which was an infection control risk. This was escalated to the nurse in charge.

We reviewed cleaning records and saw they were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Patients who had potentially infectious illnesses, were isolated in single rooms which were clearly signposted to staff and other patients.

Environment and equipment

The design, use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we could not be assured that the facilities, premises and equipment were being properly maintained.

Call bells were available and in reach of patients besides and in the bathrooms. Patients we spoke to told us that staff came when called. We saw staff responding quickly to call bells on the day of inspection.

The design of the environment followed national guidance. All wards we visited had separate male and female bays, with separate toilet and washing facilities allocated to each bay. Entry into and out of the ward was secure with swipe access to maintain a secure environment. Wards had facilities to isolate patients and staff closed doors to treat patients who were at risk of infection.

However, the wards did always have suitable facilities to meet the needs of patients' families. Wards did not have rooms dedicated for families to use when visiting. Staff told us that they did not have a dedicated safe space that could be used to have difficult conversations with families.

Staff carried out daily safety checks of specialist equipment and had enough suitable equipment to help them to safely care for patients on the wards we visited. We saw electrical equipment such as defibrillators on wards were suitably checked and resuscitation trolleys were stocked well and the equipment we saw was in date. We saw completed records of the resuscitation trolley being completed daily. However, we requested to review equipment and maintenance logs for all medical wards, but these were not provided by the trust. A backlog of equipment and environment maintenance was highlighted at the last inspection and so we cannot be assured that all equipment and the environment were being appropriately maintained.

Staff disposed of clinical waste safely. We saw bins with colour coding for general waste and clinical waste.

We reviewed logbooks of requests to the facilities team. We checked 3 previously requested issues and saw that issues had been resolved. However, staff did not log if or when all requests had been actioned, so it was unclear to visiting staff if issues has been resolved or not.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used the National Early Warning System 2 (NEWS2) tool to identify deteriorating patients. The tool is based on a scoring system relating to the change in physiological measurements including breathing rate, oxygen saturations and blood pressure. Staff used a portable handheld device to record observations. The observations were automatically scored to reduce human error. This information was monitored by the critical care outreach team so any indication of patient deterioration could be responded to quickly. We observed a student nurse escalate concerns of a patient's oxygen level to the nurse in charge and the doctor on shift. However, the service did not have an up-to-date trust wide policy for managing deteriorating patients. This meant there was not a single point source that staff could refer to in the case of an emergency.

Staff knew about and dealt with any specific risk issues. Staff received training on sepsis and were able to describe what the symptoms were and who to escalate to if required. Sepsis is a potentially life-threatening illness that occurs when the body's response to infection damages its own tissues and organs. Each ward displayed sepsis information and also had a sepsis folder describing the pathways of treatment for patients.

We saw 'bay nurses' present in ward areas during the inspection who monitored patients who had been identified as needing additional support. However, on the day prior to inspection a vulnerable patient with dementia who was under monitoring from a bay nurse left the hospital unsupervised when the bay nurse had left to assist another staff member. We were told by ward leaders that staff had been reminded to ensure that the 'bay nurse' was present at all times.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 14 patient records across the medical wards and saw that staff completed risk assessments for falls, pressure ulcers and nutritional requirements. We saw evidence of these mostly being re-assessed when required. Risk assessments for falls, pressure ulcers and nutritional requirements were re-assessed weekly or when there was a significant change in the patient's condition. Each ward had a screen displaying anonymised patient details which allowed staff to easily monitor patient status including when next observations or risk assessments were due. However, staff did not always action when patients were due risk assessments. On ward 8b, we saw 2 patients were overdue for venous thromboembolism (VTE) assessments. This was raised to the nurse in charge who actioned these assessments.

We saw completed care plans for patients once they had been risk assessed. For example, we saw patients who were at risk of pressure ulcers have specialist mattresses ordered.

The service had 24-hour access to mental health liaison and specialist mental health support, but it was not always available. The service had a team who could support staff on the ward of patients who required 1-to-1 or 2-to-1 care. We saw this team support a ward at night with a patient who was at risk of absconding. However, they were unable to support them for the following day. We spoke to a team member who told us this was due to prioritisation of patients who needed support as they had a limited workforce. Ward leaders told us that they could flex staffing requirements as the patients would be managed with the ward staff if there were not enough specialist support staff.

Shift changes and handovers included all necessary key information to keep patients safe. We observed safety huddles where we saw staff discuss patients' needs such as those who required non-invasive ventilation, those on deprivation of liberty standards, infection control, nutrition and those who were at risk of pressure ulcers. We saw stickers and other visual clues placed behind patients' beds who required enhanced care. We observed nurse handovers where they discussed patients' individual needs such as physical needs, medical needs, and emotional needs. Staff also discussed which patients were fit for discharge and where they would be discharged to.

We reviewed risk assessments on three wards and saw that they were comprehensive and addressed risks on the ward such as violence and aggression to staff.

Nurse staffing

The service mostly had 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.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. The service held ward staffing level meetings 3 times daily where they redeployed nursing and clinical support staff to other wards depending on staffing levels and patient complexity.

The service generally had enough nursing and support staff to keep patients safe. The number of nurses and clinical support workers matched the planned numbers on the day of inspection. On the wards we visited there was enough

nursing staff and clinical support workers to safely care for patients. For example, on Ashwell ward there were 4 registered nurses and 4 clinical support workers on shift that was in line with the required establishment for that ward. We reviewed staffing levels of wards 8A, 8B, 9B, 10B and Ashwell for the last 3 months and saw the actual staffing matched the planned staffing numbers at night for registered and unregistered staff. However actual staffing numbers during the day did not always match the planned staffing numbers. For example, on ward 10B, there were 1420 hours of actual nursing care hours versus 1583 hours of planned nursing care hours in March 2023.

Vacancy rates for nursing staff varied across medical wards. Ward 8A and Ashwell ward had more staff than they were budgeted for. However, Ward 11 and Barley ward had vacancy rates of 10% and 11% respectively against a target of 5%. We asked to review sickness and turnover rates for nurses on medical wards but this information was not provided.

The service had low rates of agency nurses used on the wards. Managers limited their use of agency staff and requested staff familiar with the service. We saw limited use of agency staff on the wards we visited and staffing rotas from the previous 3 months confirmed this. When the service did use agency staff, they requested staff that were familiar with the service.

Matrons told us they held weekly vacancy meetings in the division where they highlighted wards of concern for other leaders.

The service had a high vacancy, sickness and turnover rate of clinical support staff across the medical wards. There was a vacancy rate of 26% against a target of 5%. On ward 11 there was a vacancy rate of 66%. The trust had a turnover rate of clinical support staff of 19.7% against a target of 11% across the medical wards. The Barley ward had a turnover rate of 68.6%. The sickness rate was 5.7% across all wards against a target of 3.8%. Ward 11b and the acute cardiac unit had the highest sickness rates of 11.9% and 26.5% respectively.

The trust managed the high rates of vacancy and sickness with use of bank staff to cover gaps. However, staff told us that they felt pressure in the wards even when the establishment was met due to the varying complexity of patients. The service was currently recruiting and informed us that they had 48 clinical support workers roles being filled.

Managers made sure all bank and agency staff had a full induction and understood the service. We reviewed 2 inductions for agency staff and saw that they were detailed and complete.

We spoke to physiotherapists and occupational therapists on the medical wards who told us whilst they contributed to patient care and discussions on the ward, they felt they were not enough of them to meet the needs of all the patients. For example, one physiotherapist told us they covered 6 medical wards. They felt they did not have enough time to see all patients. We requested information of staffing of physiotherapists and occupational therapists on the wards we visited, but this information was not clear in the data provided.

Medical staffing

We could not be assured 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. However, 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 on the day of the inspection. We visited 6 wards and saw that the number of medical staff matched the planned number. Doctors we spoke with also told us they felt there was

enough medical staff to safely care for patients. On the wards we visited there were 2 consultants who were able to cover each other in case of sickness or emergency. Further support was available from the medical rostering team who could re-deploy staff to areas that required it. We were told by staff that the team was very responsive and were able to cover most shifts.

However, on ward 9B there were 3 vacancies for care of the elderly consultants. The ward relied on regular locum doctors and cover from consultants from elsewhere in the hospital. We requested further information from the trust about medical staffing, vacancies, sickness, turnover and training but this information was not provided. We could not be assured that that service had enough appropriately trained medical staff to safely care for patients.

We spoke with junior doctors who told us that consultants were supportive of learning and available if they required assistance.

The trust employed physician assistants who supported consultants with clinical tasks including documentation, routine prescribing and ordering tests. We saw trainee physician assistants being supported by doctors on the wards.

Managers made sure locums had a full induction to the service before they started work. They used regular locums who were familiar with the wards and the service where possible. Managers could access locums when they needed additional medical staff.

The service had consultants on site on Monday to Friday during the day and always had a consultant on call during evenings and weekends. A rota was shared between consultants and junior doctors to be on the ward during weekends. If a junior doctor was on shift during these hours, a consultant was on call to support if required.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and most were easily available to staff providing care.

We reviewed 14 sets of patient notes and saw they were comprehensive and all staff could access them easily on the electronic records.

When patients transferred to a new team, there were generally no delays in staff accessing their records. However, staff on the wards did not have easy access to social care records from social care workers and they told us this impacted patients being discharged in a timely manner.

Paper records were stored securely in locked trolleys at the nurse's station. Electronic records could only be accessed by staff on computers with individual security cards and log in details. Computer screens were locked when unattended.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed on an electronic prescribing and medicines administration system (EPMA). We looked at 9 medicine charts and found that allergies were always documented to ensure medicines were prescribed safely.

However, we saw one patient who had allergies listed on her wristband did not match what was documented on EPMA. We observed a staff nurse prepare a medicine which the patient had an allergy to as stated on the wrist band, but not on the EPMA system. We highlighted this to the staff nurse immediately before it was administered, who then checked the allergy with the patient. This demonstrated that allergy wrist bands were not always checked prior to administration.

Prescribers and nursing staff had access to resources to ensure medicines were prescribed at the correct dose.

Venous thromboembolism (VTE) assessments were mostly completed in a timely manner as per trust policy. Each ward had a display screen, which indicated which patients were overdue to be assessed. In 2 out of 9 records, the VTE assessment had not been completed on admission. However, we saw that all patients had been prescribed prophylactic treatment as appropriate. Monthly audits were undertaken to monitor VTE risk assessment completion. Data recorded in May 2023 had shown improvements in completion of risk assessments compared to previous months.

For patients who were prescribed antimicrobials, there was a clear indication and rationale documented on EPMA. The duration of the intended antimicrobial was clear and there was evidence of regular review.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were reviewed regularly on ward rounds. Clinical pharmacists regularly visited the wards and attended ward rounds. Staff understood how to seek advice on prescribing and administration from pharmacy teams. For patients who were prescribed antimicrobials, there was a clear indication and rationale documented on the medicine's charts and in the clinical notes. Antimicrobials were reviewed at 48-72 hours as per trust policy.

Staff stored and managed all medicines and prescribing documents safely. Medicines including controlled drugs (medicines requiring additional control due to the potential of misuse) were stored securely.

Room and fridge temperatures where medicines were stored were monitored and staff we spoke to on the inpatient units understood when to escalate if the temperatures were out of range. The pharmacy team reviewed temperatures weekly to ensure that any issues identified could be actioned quickly.

Medication safety audits were undertaken every two months. Data showed good compliance with most areas of medicines storage, with some improvements in compliance required for monitoring of temperatures where medicines were stored.

Resuscitation trolleys were checked daily to ensure they were ready to use when required.

The electronic prescribing and administration systems were secured when not in use.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation (the process of accurately listing a patients medicines they were taking at home and comparing it to what was prescribed whilst they were in hospital) was completed in a timely manner. Staff had access to and sought consent from patients when viewing summary care records to check medicines taken prior to admission. Recent audit data from March 2023, showed that 91% of patients had their medicines reconciled within 24 hours, meeting trust targets.

There were clear processes in place to communicate with the general practitioner (GP) and community pharmacy when patients were discharged from the hospital.

Patients were counselled on their medicines when they were discharged by the pharmacy team when changes were made to ensure they understood how to take them.

Staff we spoke to understood duty of candour.

Incidents

The service did not always manage patient safety incidents well. Managers investigated incidents but did not share lessons learned with the whole team and the wider service. It was unclear how managers ensured that actions from patient safety alerts were implemented and monitored. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Staff recognised and reported incidents and near misses.

All staff knew what incidents to report and how to report them in line with trust policy. Staff could describe how to report serious incidents clearly. We reviewed an incident that was reported the day before our inspection and we saw it was escalated appropriately. Staff on shift were aware of the incident and we were told that it was discussed at the daily huddle, but this was not recorded.

Managers did not share learning with their staff about incidents that happened elsewhere. Ward leaders were unclear as to how learning was shared across wards and services. We spoke to nursing and clinical support staff on various medical wards, and they were unable to recall any recent learning that had occurred as a result of incidents from other wards or specialties.

Staff met to discuss the feedback and look at improvements to patient care at ward level. Each ward had daily safety huddles that discussed updates such as staffing, alerts and local learning but these were not always recorded. For example, we reviewed the safety huddle handover sheet for ward 9B and could see no information recorded for incidents in the previous week to the inspection even though we could see incidents had occurred.

The service used medicines error matrix when investigating medicine errors. This matrix was used to identify the severity of the incident, record themes and promote learning. We were told these were completed on paper and uploaded onto the incidents system when they occurred. However, we did not see completed versions updated on the incident system and we were not assured that learning from them was shared to service leaders or other staff members.

Staff sometimes received feedback from investigation of incidents. Staff told us that feedback from incidents would be shared to senior ward staff via email and then shared at the daily team meetings to other staff at the monthly team meetings. They did not always receive feedback for incidents they logged. However, they told us they received support after serious incidents when they occurred.

Managers did not always investigate incidents thoroughly or in a timely manner. We reviewed the incident log on the day of inspection for ward 9B and saw that there were 24 open incidents from March 2023 to June 2023. We saw incidents that did not have any recorded actions or local learning identified. Ward leaders described to us that regularly reviewed the incidents and shared any local learning with the teams, however this was not always documented in the incident reporting system.

We reviewed the incidents log for all medical wards and saw that there had been 1792 reported incidents since the start of 2023 with varying degrees of severity of harm to patients. Of these reported incidents, 770 were still open for

investigation and 282 of them were from February and March 2023. This was not in line with trust policy that no harm and low harm incidents were investigated and closed within 25 days. It was unclear if local learning had been established from these incidents or if any actions had been taken. It was also unclear if themes had been identified from these incidents.

Ward leaders told us that safety and patient alerts were cascaded to staff through daily communication briefings. We asked to see evidence of the alerts being actioned and implemented but this information was not provided.

We reviewed the trust's policy for reporting and investigating incidents and saw that it was version controlled, in date and reflected national and best practice. However, it had not been updated to reflect changes to the incident reporting system.

We spoke with ward leaders and service leaders who were able to articulate the themes and/or trends of incidents on their wards. Across the wards we visited, pressure ulcers, falls and aggression towards staff were 3 of the biggest risks on the medical wards. We saw the service had action plans in place to address these issues.

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. We observed staff give a patient and family an explanation and apology for an incident that had occurred.

Staff we spoke to relied on a team social messenger group that was used to share non-sensitive information such as incidents on the wards or general information. However, not all staff used the social messenger group application. There was a risk that staff who did not use the social messenger group application would not receive updates about the trust.

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. However not all policies were up to date.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a sample of hospital policies such as safeguarding policy, VTE assessment policy and fall prevention policy which were all in date and referenced national guidance and best practice by associations such as the national institute for health and care excellence (NICE) and the royal college of nursing (RCN). However, not all trust wide policies were in date. Information provided post inspection, showed that the 72% of all policies in the trust were not up-to-date.

Policies and guidance could be accessed by staff via the trusts intranet.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We heard nurses discuss patients current emotional state and likes and dislikes when handing over care.

Medical care (including older people's care)

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.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw staff support patients at mealtimes and encouraging patients to eat. Patients told us they were given enough to eat and drink. We saw red topped water jugs that easily identified vulnerable patients who should be encouraged to drink.

The service made adjustments for patients religious, cultural and other needs. They offered vegetarian, vegan, kosher, halal, allergen free and Caribbean meals.

Staff fully and accurately completed patients' fluid and nutrition charts in records we sampled. Staff used the malnutrition universal screening tool (MUST) to monitor patients at risk of malnutrition which was completed on admission and updated when required. The service had recently made improvements as a result of a quality improvement programme which aimed to increase the correct recording of food and fluid charts and regular assessment of nutritional needs.

Specialist support from staff such as dietitians was available for patients who needed it. There was a system to highlight which patients needed support with clear visual cues above patient's beds.

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 reviewed 14 patient records and saw staff assessed patients' pain using a recognised tool, including a tool for those who were unable to verbalise pain and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately.

We spoke to 7 patients across various medical wards, and they told us they received pain relief soon after requesting it.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a limited programme of audits. We asked ward leaders on inspection to show us local audits completed on the ward and actions that had been developed but they were unable to show us these audits. We also asked the trust to provide results and actions of local audits on the medical wards such as infection prevention control (IPC), call bell audits and mental capacity assessment audits. However, these were not provided. It was unclear how they monitored improvement over time as staff could not demonstrate on the audit system how to compare audit scores or easily track actions that had been put in place. We could not be assured that the audits were being used to improve care or the services provided.

The matrons completed a monthly audit for their wards they oversaw that spot checked areas such as cleaning compliance, completion of records and completion of observations. The results were variable from 58% to 92% from the

previous 3 months across medical wards. The target for these audits was 85%. The results of these audits were shared via email which highlighted areas of improvement and what went well. However, the auditing system the service used did not allow ward staff to compare audit results or create or review actions. There was risk that trust leaders could not easily access audit results and so did not have full oversight of the performance of the ward.

We reviewed audits of patient risk assessments that were available electronically and saw that the service performed generally well for VTE risk assessments, falls assessments and pressure ulcer risk assessments. The service had created actions for increasing the completion of assessments following an increase in incidents and improvements were reflected in the audit scores.

The service participated in relevant national clinical audits such as sentinel stroke national audit and the national diabetes audit. The Lister hospital had achieved a grade D in the latest sentinel stroke national audit in December 2022 which was the second lowest score possible. The service provided us with action points and recommendations that they had developed. However, the overall score had not improved from April 2022 to April 2023.

From January 2021 to December 2021, patients had a lower-than-expected risk of readmission for elective admissions when compared to the England average. Risk of readmission for elective and non-elective patients by specialty was about the same or lower than expected compared to the England average.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the trust showed that 84% of staff were up to date with appraisals against a target of 90%. Staff that had not received an appraisal were due to be appraised by the end of August 2023. Staff told us that their appraisals were helpful for their training and progression and gave them an opportunity to discuss their training needs. The service used a concept called grow together. This was used to create a timeline of progression for staff, so they could work towards achievable targets. There was an established career pathway available for clinical support staff to progress to qualified nurses over a 4-year apprenticeship.

We saw managers gave all new staff a full induction tailored to their role before they started work. We spoke with trainee staff who told us they were well supported by their peers and managers. They had a period of induction, shadowing and further support during their training period including preceptorship programmes, clinical induction programme and a new joiner handbook.

International recruited nursing staff received an induction to support them in passing objective structured clinical examinations which would allow them to be registered with the national nursing body, the nursing and midwifery council (NMC).

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The clinical educators supported the learning and development needs of staff. Staff told us that they were offered and attended additional training course such as tissue viability training courses. We saw staff had completed leadership courses and would assist ward leaders in managing appraisals to help them get experience for progressing within the service.

Medical care (including older people's care)

Managers made sure staff received any specialist training for their role. Staff on the care of the elderly ward received additional training in supporting patients with dementia.

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

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They mostly supported each other to provide good care. However, social care professionals did not give timely input into patient care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We attended board meetings led by consultants which was well attended by doctors, nurses, physiotherapists and support staff. We saw good input in the discussion from all professions.

Staff could refer patients to a dietician if patients were identified as needing extra support. This service was available Monday to Friday 9am to 5pm with on call support available at evenings and weekends.

We saw evidence in patient records of input form the wider multidisciplinary team such as physiotherapists, occupational therapists, nurses and consultants. However, we did not see input or planning from social care workers until patients were ready for discharge. All staff we spoke to highlighted this was an issue for discharging patients in a timely manner.

Patients had their care pathway reviewed by relevant consultants. If a patient had been admitted to a ward that was not specific to their needs, consultants from the speciality were supported in reviewing these patients on these other wards. The service held regular meetings to move patients to the required speciality once there was availability to do so.

Seven-day services

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

Daily ward rounds were led by appropriately trained doctors on all wards, including weekends. Patients were reviewed by relevant consultants depending on their care needs.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 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 wards. We saw leaflets on display for managing grief, incontinence, reducing infections and information on take home medications.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw physiotherapists assess patients with reduced mobility on the stroke ward on admission and contributed to the care planning of the patient to help them improve their condition.

Medical care (including older people's care)

Consent, Mental Capacity Act 2005 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, they did always use measures that limit patients liberty appropriately.

Staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Of staff, 91% were up to date with the training.

Staff mostly understood how and when to assess whether a patient had the capacity to make decisions about their care. The safeguarding team for the service monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. They had oversight of the patients with applied Deprivation of Liberty Safeguards and ensured that that they were regularly reviewed. They monitored how well the service followed the Mental Capacity Act 2005 and made changes to practice when necessary. However, some assessments were not decision specific. The records did not demonstrate specifically how they were unable to consent with regards to being able to retain information, weigh up information or communicate. We also reviewed one patients record who had delirium and saw that there was no review date even though they potentially could regain capacity. There was a risk that the patient would be unnecessarily deprived of their liberties. This was raised to the nurse in charge for the patient to be reviewed.

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and the Mental Capacity Act 2005 and they knew who to contact for advice. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We saw staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

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.

Medical care (including older people's care)

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. During the inspection, in all the areas we visited, we witnessed staff interacting positively with patients and answering patients' questions.

Patients said staff treated them well and with kindness. We spoke to patients and family members on all the wards we visited and we were told that the staff were 'very caring' and that they were 'excellent, including the housekeepers'. We saw one patient being discharged thank each staff member by name for the care that they had received. We saw letters from patients of medical wards thank staff for the "brilliant" and "first class" nursing care they had received.

Staff generally followed policy to keep patient care and treatment confidential. Staff made use of curtains around beds to ensure patient privacy when needed. However, on nurse handovers, nurses discussed individual patients needs in the ward bays at a volume that could be heard by other patients. We saw a patient make a comment about another patients age during one of the nurse handovers as a result of this.

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. We saw nurses respond to patients with dementia who were in distress in a kind and caring manner on the care of the elderly wards.

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 supported patients who became distressed on the ward, and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We saw evidence of sensitive discussions taking place between staff and patents and their family members. Family members told us that staff were caring and sensitive when delivering bad news.

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. This was reflected in the multidisciplinary team meetings where staff discussed all needs of the patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw examples of staff contact the chaplaincy service on behalf of a patient who visited the patient on the ward. Staff also organised for a bible to be delivered to the patient who was religious.

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. We reviewed patient records and saw that there was evidence of discussion of care with families.

Staff talked with patients, families and carers in a way they could understand. Patients told us that the communication from staff was good and they were kept informed of updates in their care. We saw completed do no attempt resuscitations (DNARs) that had been discussed with the family.

Medical care (including older people's care)

The service had translation services available. They could be booked to attend onsite when having difficult conversations. The service was made up of staff from a variety of backgrounds and ward leaders told us that they used staff fluent in the required language to discuss care if possible.

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

Staff supported patients to make informed decisions about their care. The service displayed a variety of leaflets relevant to the speciality of the ward. For example, we saw leaflets for carers caring with relatives with dementia on the care of the elderly ward.

We saw some patients gave positive feedback about the service. Matrons led a monthly audit that included asking patients if they were happy with the care they were receiving. The medical wards scored well in these audits scoring 97.4% in the latest audit. However, we asked the trust service leaders for the latest results of the friends and family test. This is an NHS patient feedback tool used to gather feedback about the care patients received. We were not provided with the latest results.

The service had received 66 compliments in the period of April 2023 to June 2023.

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.

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

Facilities and premises were mostly appropriate for the services being delivered. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We saw single gender bays in use on the wards and single cubicle toilets and showers that could be either allocated to male or female patients to meet the needs of the ward. Side rooms were available on some wards for patients who required minimal supervision requirements or who were isolating to prevent passing on infectious disease. However, medical wards we visited did not have family rooms that allowed a place for patients and visitors to relax.

The service had a diabetic outreach team that could be contacted for advice or support. When patients' diabetic physiological measures were out of range on the electronic system, the diabetic team would be notified to review them. The electronic system also allowed the team to search for other parameters that were out of range to help identify patients who needed support.

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 service had a mental health liaison team which could support with, but was not limited to, crisis intervention, psychological support and medicine management.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. We saw physiotherapists review patients with reduced mobility as soon as they were admitted to the stroke ward and had 'specialling' teams who were available to assist in the care of mental health patients. However, staff told us that these were not always available due to limited numbers of staff offering the service.

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had a learning disability team that reviewed patients with learning disabilities. The team was notified via the electronic record system. Patients with learning disabilities had dedicated purple folders which detailed their condition and needs.

We saw staff meeting the needs of patients with dementia. However, only some wards had dementia passports in use. On Ashwell ward we saw completed patient comfort booklets that were used to help staff support patients who needed enhanced care. This was a pilot project that was developed jointly with a local university. These booklets guided staff on patients' preferences and enhanced needs to allow them to safely care for them. Other care of the elderly wards had access to 'this is me' booklets but did not use them. Although we saw and heard from family members that the regular staff were meeting the needs of patients with enhanced needs, there was a risk that these patients would not receive the enhanced care they needed if the regular staff were to be absent. We spoke with a dementia link clinical support worker who had supported dementia patients in stimulating patients on the ward including 'imagination dancing' and singing for them.

The service had access to a specialist dementia nurse who was available Monday to Friday 9am to 5pm. We were told by staff they would sometimes visit the wards and provide help and advice for staff and support patients with stimulating activities such as going for walks or completing puzzles. The dementia nurse had organised live music from a harpist on some care of the elderly wards. This was well received by patients and staff but we were told this was not a regular visit.

Wards were designed to meet the needs of patients living with dementia. However, there had been no day room available for elderly patients on ward 9B for the previous 2 months due to refurbishment. We saw the refurbished areas and observed that they had the facilities to meet the needs of the patients staying on the ward. For example, the new day room was dementia friendly and was designed to feel more like a patients home than a hospital. The refurbished areas were due to be open the following day after inspection. The hospital scored 63.02% and 63.54% for dementia and disability respectively in the 2022 PLACE audit which focused on the suitability of the environment to meet the needs of these patients. The national average scores for PLACE 2022 was 79.2% for the dementia domain and 81.1% for the disability domain in similar site types. Therefore, the service was below the national average.

We saw completed enhanced care plans that highlighted when patients required additional support. We saw staff support a patient who was at high risk of falls but liked moving about as noted in their plan.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They accessed communication aids to help patients become partners in their care and treatment.

The service had access to information leaflets available in languages spoken by the patients and local population.

We saw stickers and signs on patients board from dieticians highlighting if they had additional nutritional requirements. For example, if a patient was nil by mouth, needed support with eating or had difficulty swallowing and needed to avoid solid foods.

The service organised pet therapy for patients on various wards. This was organised every Tuesday and would visit a different ward each week. We observed patients interacting positively with the dogs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed.

Access and flow

People could not always access the service when they needed it and receive 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 but patients could not always access services when needed and received treatment within agreed timeframes and national targets. The service had a high waiting time for access to gastroenterology services. However, this was improving with the number of patients on the waiting list for over 52 weeks which had decreased from 1,270 in September 2022 to 622 in March 2023.

The trust had a high number of patients waiting to receive treatment. Since December 2022, the percentage of patients on the waiting list that had been waiting 18 weeks or less had increased from 55.3% to 60.5% in March 2023. This was against a target of 92%. The most common affected area in medicine was gastroenterology.

The trust had 1272 delayed discharges in the past 6 months. We were told by the trust that 80% of these delays were caused by external factors such as waiting on packages of care for patients at their usual place of residence or they were awaiting equipment to be ordered. However, we saw on the wards that planning for patient's discharge was not started with their social care workers until they were medically fit to leave. This meant that they were waiting on the ward for care to be organised at their place of residence even though they were well enough to leave. We spoke with staff on the wards who told us that if planning was started earlier with social care workers, patients could be discharged quicker to their home.

The trust had a discharge programme group which aimed to improve safety and timeliness of patient discharges. We reviewed the action log from the group and saw actions were not clear, no actions had target dates for completion, and none had been completed yet. We saw no actions or meetings had been updated since February 2023. Service leaders told us that they had plans to reintroduce the programme with an updated terms of reference in June 2023. We were told of other actions that the trust was using to improve discharge such as having 10 discharges before 10am and standardising start time of ward rounds. Although we did not see evidence of any progress that had been made as part of these actions, we saw the service had made some recent improvements in patients accessing their "Hospital at Home" initiative (an initiative to treat and monitor patients in their own home to help improve safety and timeliness of discharges) from April 2023 to September 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service held regular meetings to discuss patients who had been in the hospital for over 7 days. We attended one of these meetings and saw that patients were discussed but there were no clear take away actions from the leaders.

Managers and staff did not start planning each patient's discharge as early as possible. On all wards we visited, we saw patients who were medically fit for discharge but had discharge delayed due to social care planning occurring only after

they were ready to leave. Patients could benefit from social care being organised for them before they were medically optimised to leave so that they did not stay in hospital any longer than they had to. This was reflected in the data from February 2021 to January 2022. For medical non-elective patients, the average length of stay was 7.0 days, which is higher than England average of 6.0 days. Managers monitored the number of patients whose discharge was delayed and knew which wards had the highest number.

The service moved patients only when there was a clear medical reason or in their best interest. Managers monitored that patient moves between wards/services were kept to a minimum. Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

We saw that there were different systems for community nurses in the emergency department that physiotherapy and occupational therapy staff told us they did not have access to. They told us this meant there were difficulties in the continuity of care when patients moved between the areas.

A checklist was completed for patients when they were being transferred to the discharge lounge. This included but was not limited to information such as medicines, discharge location, mobility, dietary requirements and whether transport had been arranged. This information helped staff in the discharge lounge organise any additional requirements for the patient. We saw patients being discharged from the discharge lounge in a timely manner.

The discharge lounge had a dedicated transport coordinator to help facilitate travel for patients leaving the hospital. However, they were only available Monday to Friday and there was no other coordinator to take charge for absences or sickness. The discharge lounge was open 7.45am until 8pm seven days a week.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. However, referrals from the emergency department to specialties were not always prompt. Response times to referrals from the various specialities were inconsistent month on month. For example, the average cardiology referral time in April 2023 was 19 minutes but was 236 minutes in May 2023. There was no internal professional standards policy which would determine how quickly emergency referrals should be responded to. There was a risk that patients were not being seen promptly to address their emergency physical needs.

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. Recent complaints that had been raised on Ashwell ward were film on the windows that meant patients were not able to look outside and enjoy the view, the quality of the food and noise of the wards at nights.

The service clearly displayed information about how to raise a concern in patient areas and staff understood the policy on complaints and knew how to handle them.

Leaders investigated complaints and identified themes. The service had 208 complaints in the period of April to June 2023. The common themes for the complaints were complaints about medical care, nursing care and communication. We saw complaints were discussed at quality and safety meetings. We reviewed the complaints for the medical division

and saw they treated concerns and complaints seriously and saw replies from the services to patients who complained acknowledging the complaint and highlighting changes that had been made. For example, safety huddles had been introduced as part of a quality improvement project as a result of an incident which had led to patient suffering from a stroke.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. However, not all complaints were responded to in timeframes set out in policy. We saw that there were 31 complaints overdue for a response to patients in June 2023.

Managers told us they shared feedback from complaints with staff at team meetings. However, staff we spoke to could not give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. 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. Not all leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical wards were led by an acute speciality medicine leadership team under the unplanned directorate which included a head of nursing, a divisional director of operations and clinical director. They had relevant experience and skills to run the service. They were supported in each speciality by matrons, ward managers, service managers and clinical leads.

Leaders of the service were able to describe the challenges that the service faced.

Staff told us that ward managers and matrons were visible on the ward, supporting staff when required. Staff told us that other senior leaders in the trust were less visible. However, the service had introduced a new initiative in 2023 called positive leader walk rounds where leaders visited different areas of the hospital each week to support staff. Discussions with staff were then discussed at the trust's quality and safety committee.

All staff told us that ward leaders and matrons were visible and approachable for them. However, some staff also told us that they rarely saw or spoke to divisional leaders.

The service used a scheme called 'grow together' which aimed at supporting staff develop their skills. We saw examples of staff attending leadership courses.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. 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.

Medical care (including older people's care)

The service displayed their values around the hospital. These values were include, respect and improve.

The trust had a clear vision set out with a mission to provide high quality compassionate care for the communities it served over the next 2 years. Objectives were achievable and relevant. We saw regular discussions around performance of trust objectives in senior leader meetings.

Staff were involved in the development of the service vision and strategy. Staff we spoke to were aware of the trust's values and objectives.

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.

The service monitored staffing levels of workforce disability equality standards and workforce racial equality standards. However, 11.6% of staff answered that they had experienced discrimination in the workplace in the 2022-2023 NHS staff survey. This was above the national average which was 8.7%.

Staff told us they were able to raise concerns without fear. They had access to freedom to speak up guardians.

We saw that behaviours and performance inconsistent with the trust vision and values were dealt with effectively.

The medical division, which formed part of the unplanned care division, scored the worst in the trust for staff engagement and morale in the latest NHS staff survey. They also scored second worse for feeling compassionate and included, being recognised and rewarded and being safe and healthy. Also, 46% of staff said they had felt unwell in the past 12 months as a result of work-related stress. However, staff we spoke on the day of inspection told us this had improved, and ward leaders were supportive and made them feel valued. For example, we saw a ‘survivor kit’ in the staff room of ward 10B which contained snacks bought by the ward manager in recognition of stressful days.

Staff attitudes towards learning and appraisals had improved from the previous year's staff survey with positive results in the survey increasing to 56% from 51% in the previous year and negative results reducing from 18% to 16%.

Governance

Leaders operated governance processes, throughout the service and with partner organisations but they were not always effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet and discuss the performance of the service.

Staff were clear about their roles and accountabilities.

The trust had clear governance structures in place for the dissemination, sharing and learning of incidents. However, upon talking to front line staff we were not assured that processes for sharing and learning were robust or that information was filtered down to this staff group effectively. We reviewed meeting minutes for ward managers and matrons and saw no set agenda for items of discussion. We could be not assured that all relevant areas of information were passed down to frontline staff. Attendance for the meetings was varied with some reporting good attendance and some not reporting on the attendance at all. However, managers told us that staff would be emailed minutes of meetings if they could not attend. The service also sent staff a message of the week. The topics of the message varied week on week.

Medical care (including older people's care)

We saw the service had monthly meetings of safety and quality that discussed governance and performance of the service. However, we did not see regular discussion of audit results and using them to drive improvement.

Medical speciality meetings took place throughout the service, for example, the renal and gastroenterology specialities held quarterly clinical governance meetings that were well attended by relevant clinical staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance but it was not always effective. We could not be assured they always identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had a divisional risk register and we requested to review this, but this was not provided by the trust. We could not be assured of the quality of the risk register in that risks were scored, assigned, actioned and progress monitored. However, we saw from divisional meeting minutes that risks and performance were discussed.

We also requested information from the trust post inspection including information on staffing of doctors and local audit performance. We were not provided with this information and could not be assured that risks and issues were identified and then escalated. However, when performance issues were identified, they were escalated to the board through the relevant committees.

Ward leaders we spoke to were able to describe local risks such as staffing, pressure ulcers and falls.

The service had identified that deconditioning patients were a risk due to the increased length of stays. This means patients were becoming less independent and increasingly reliant on hospital care. These patients would be more difficult to discharge since they were underprepared to leave the hospital and be cared for in the community. We reviewed the risk reduction action plan for this risk and saw that while they contained recommendations and actions, it was not clear if actions had been met and what the progress had been made as a result of the action plan.

Information Management

The service did not collect reliable data and analyse it. Staff could not 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.

Staff, ward leaders and matrons conducted audits of the wards they were responsible for. However, we could not see how the audits were analysed effectively and improvements measured using the audit systems the service used. We reviewed audits conducted on wards 9B and saw that the system did not easily allow staff to compare audit results to measure improvement or measure actions. The matrons audit results were shared via email. It was unclear how the actions and improvements of these audits were measured by staff and senior leaders.

Staff followed arrangements to ensure patient identifiable information and records were kept confidential.

Information was submitted to external organisations for submitting data for national audits.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.

Staff told us they were well supported on the ward-by-ward managers and matrons. They could attend staff networks such as the Black, Asian and Minority Ethnic (BAME) for additional support.

The service leaders had held an unplanned staff survey in September 2022. It asked what mattered most to teams and what changes they would like to see. We could see next steps had been developed by ward leaders, but we could not see any evidence of the actions being revisited to check if they had been completed or had any impact. However, it was unclear if these actions had led to improvements to the service.

Staff were able to raise issues directly with the chief executive officer with regular drop-in sessions.

The service displayed posters to encourage patients to give feedback and described how to do so. The service held regular twice monthly student forums that were used for learning and feedback. We saw these were well attended.

In the 2022-2023 staff survey only 48.9% of staff said they were involved in changes being introduced into their department and only 54% said they were able to make improvements happen in their area of work.

Learning, continuous improvement and innovation

All staff were committed to learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The medical division had initiatives for increasing patient safety in the medicine wards. We reviewed a quality improvement programme for reducing controlled drug (CD) errors in the acute medical unit 1 led by the nurse team leader. Implemented ideas included video training, twice daily checks, weekly spot checks, adding a reminder on handover sheets and implementing a new CD checklist. There was a reduction in controlled drug errors from 19 in the period of January 2022 – August 2022 to 5 in the period of August 2022 to February 2023.

However, we reviewed other quality improvement programmes on other wards where it was not clear what improvement had been achieved. For example, we reviewed a medication error quality improvement project for ward 6A that began in March 2022. It was not regularly updated, nor did it contain any next steps or learning to date.

Surgery

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, however, the service did not make sure everyone completed it.

Staff received mandatory training but did not keep up to date with this. Mandatory training included training such as falls prevention, learning disability awareness and essentials of patient safety.

We reviewed evidence of mandatory training records provided by the service. We found all staff groups were below the trust mandatory training target of 90% compliance. We saw mandatory training completion scores range from 34% completion to 79%.

Staff told us they completed training for female genital mutilation (FGM), autism awareness and the Mental Capacity Act 2005. We saw evidence that this training had been completed by staff. For example, we saw 84% of staff completed dementia awareness training.

Mandatory training was a mix of face to face and online training. Staff were clear on how to access their training through e-learning modules and face to face training.

New staff had an induction and staff were required to complete competencies according to their role.

The service used an electronic system to record and monitor mandatory training compliance. The system automatically sent alerts to staff and their managers when training was due to be completed. However, this was not reflected in the information provided by the service as mandatory training did not meet the 90% completion rate for the trust.

Safeguarding

Staff understood how to protect patients from abuse. Staff did not always complete their training on how to recognise and report abuse, however they knew how to apply it.

All staff (including bank staff) received training specific for their role on how to recognise and report abuse. Most staff were up to date with safeguarding training at the time of our inspection. Training records for safeguarding showed 90% of staff had adults safeguarding level 1 training and 87% of staff had safeguarding adults level 2 training. The service's target compliance percentage for safeguarding training was 90%.

Safeguarding children level 1 compliance rate was 91% and safeguarding children level 2 compliance rate was 90%. However safeguarding children level 3 compliance rate was 48%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff explained how the pre-assessment process captured all relevant risk factors. Staff understood how to support patients from abuse.

We saw the safeguarding children policy which was version controlled and in date. The policy was being updated at the time of our inspection and the new draft was going through the internal governance processes for sign off.

Staff discussed safeguarding risks during patient handovers and staff huddles.

We saw posters on display indicating who to contact in the trust's safeguarding team should there be any safeguarding concerns.

The trust had an adult safeguarding policy which was in date and version controlled. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice. They used online forms to refer safeguarding notifications or queries to the local authority. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

In the 12 months prior to our inspection, 12 safeguarding referrals had been made by staff within the service.

Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the service. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

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 clean and had suitable furnishings which were visibly clean and well-maintained. We inspected communal patient and staff areas and found them to be visibly clean. Hand hygiene points were visible at the entrances of each ward. Hand sanitising gel was available throughout the service, and we saw staff use this.

All surgical areas including theatres, recovery and the anaesthetic rooms were visibly clean and tidy.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Checklists had been completed according to the service's policy.

We saw staff take trays and instruments downstairs for decontamination after each surgery. These were cleaned and checked by two theatre nurses. The trays were prepared for the next surgery. Staff completed the tray set up request and amendment form which was scanned onto the electronic system for audit purposes.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff adhered to the infection control policy and all staff were bare below the elbows and wearing the correct uniform.

The service adopted the trust wide infection prevention and control policy which was version controlled and in date. The policy set out the principles and framework for the management of infection prevention and control within the trust. During our inspection we saw staff adhere to national guidance whilst observing in theatres.

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

Surgery

Staff worked effectively to prevent, identify and treat surgical site infections. We observed a theatre list and noted the theatre was cleaned down effectively post procedures. All staff were compliant with infection prevention control (IPC) precautions and always wearing PPE.

Following the inspection, we requested any audits completed by the service including any monthly IPC audits, PPE, hand hygiene and environment related audits for the last six months. The service did not provide this information.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We observed staff promptly responding to call bells.

The design of the environment followed national guidance. Access to operating theatres was restricted, and staff access was by swipe card. Staff passing into this area were required to sign in and out of a logbook.

All equipment was situated on suitable trays provided. The theatres were cleaned after each patient contact, and equipment stocked daily. Documentation was completed daily.

Single use sterile instruments were stored appropriately and were within their expiry date.

The resuscitation trolleys were easily accessible and available on the inpatient wards and in the operating theatres. They were sealed with security tags to ensure people could not tamper with the equipment within them. Trolleys were clean and dust free. The automated defibrillator, and suction equipment was in working order. However, staff did not always complete daily safety checks of specialist equipment, including the resuscitation equipment. We found daily checks of the paediatric airway trolley for June 2023 had missed 5 days. Daily checks for the adult cardiac arrest trolley also had days which had not been completed. We found in April 2023 three days had been missed. In March 2023, May 2023 and June 2023 one day had been missed in each month.

We found out of date single use consumables within the paediatric airway trolley and the adult cardiac arrest trolley in the day surgery unit. For example, we found stabiliser rods, aintree intubation catheters, adult-paediatric CO2 sampling line and airway adapters, paediatric masks, tracheal tubes and blades which were out of date. We highlighted this to the service, and they immediately removed all of the out-of-date single use consumables. We completed a random check of 4 resuscitation trolleys on the second day of inspection. We found all single use consumables were in date.

Following our inspection, we requested information about any incidents involving single use consumables. The service told us they had not reported any incidents involving single use consumables in the last 12 months. The service told us they have not received any incidents involving intubating LMA's on the emergency airway trolley in theatre.

The service had suitable facilities to meet the needs of patients. Each clinical area of the service was secured by locked doors which could be accessed by staff swipe card only. Patients and members of the public could buzz to speak to the staff on the ward to gain access.

The service had enough suitable equipment to help them to safely care for patients, including bariatric patients. The equipment for bariatric patients was kept on site with the estates team.

Surgery

We looked at 10 pieces of medical equipment on a range of wards and in operating theatres and we saw portable appliance testing stickers on all the electrical equipment. The electrical equipment had been tested and was safe to use.

Storerooms were tidy and well organised. However, on the first day of our inspection we found 4 unlocked cupboards which had controlled substances which were hazardous to health. There was a risk that these substances could be accessed by visitors and patients on the wards. This was raised with ward leaders who took action to ensure the cupboards were locked. On the second day of inspection, we checked 2 cupboards with controlled substances which were locked.

Fire extinguishers were accessible and in date. We also saw that fire exits were checked and clear. Staff we spoke with were aware of the service' fire procedures.

Staff disposed of clinical waste safely. Appropriate facilities were in place for the storage and disposal of clinical waste. Appropriate segregation of clinical waste took place within secure areas on the ward. Sharps disposal bins were available in all relevant areas. They were dated and the temporary closure mechanism was in use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

We saw pre-operative assessments had been completed by staff and included relevant risk assessments in accordance with national guidance.

Following our inspection, we requested a copy of the service's deteriorating patient policy. However, the service did not have an up-to-date trust wide policy for managing deteriorating patients. This meant there was not a single point source that staff could refer to in the case of an emergency. The policy included comments and suggestions for amendments however the majority of the content was in date.

Staff knew about and dealt with any specific risk issues and completed risk assessments for sepsis, venous thromboembolism risks, falls and pressure ulcers. Patients were assessed and monitored on admission to the ward.

We reviewed patient records and saw comprehensive risk assessments were completed at pre-assessment consultations with each patient, and these were regularly reviewed and updated as and when required. The electronic system provided a complete audit trail for each patient throughout their period of care and treatment at the service.

The service used a scoring system called National Early Warning Score (NEWS2) to indicate early signs of deterioration in a patient's condition. NEWS2 scores were documented in the patient records and included actions to escalate for review. If a patient's score increased, staff were alerted and a response would be prompted. The response varied from increasing the frequency of the patient's observations, to urgent review by the patient's consultant. From the patient records we saw, patients were escalated appropriately.

Theatre staff carried out the World Health Organisation (WHO) 'five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. Staff regularly audited the use and completion of the WHO surgical checklist.

Surgery

Following our inspection, we were provided with the trust-wide policy for the monitoring and recording of physiological observations which was version controlled and dated. The policy provided guidance to healthcare professionals to maintain safe levels of monitoring for adults' patients admitted to acute inpatient wards. Staff we spoke with were aware of this policy and could describe how to monitor and record observations.

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared key information to keep patients safe when handing over their care to others. We observed a handover which included information about patients NEWS scores, their mobility and the overall plan of care for each patient that day. Daily safety huddles, which were recorded, took place on each shift, where all essential information was cascaded appropriately.

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. During our inspection we saw some wards did not meet the required number of nursing staff required. We saw 2 wards had 4 registered nurses on shift and 1 student, however, the actual number of nurses required was 5 nurses. We revisited 1 of the wards with short staffing and found a staff member had been redeployed from another ward onto that ward to support staff. Other wards we visited during our inspection met the required number of nursing staff required.

Staffing had continued to be a challenge across the service. However, senior nursing leads could adjust staffing levels daily according to the needs of patients. Staff told us that staffing levels were regularly reviewed and increased where needed to keep patient care safe by using regular bank and agency staff to fill gaps.

Managers calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance. The service used a safer staffing tool to monitor staffing levels and ensured that staff were delegated appropriately across the service. The service had daily meetings that reviewed staffing levels across the division and ensured that all areas had sufficient staffing levels.

Daily staffing meetings took place to review staffing on a daily basis and clinical areas rated their environment using the red, amber green (RAG) system. At the time of our inspection, the service had 8.43 WTE band 5 and 8.5 band 2/3 WTE vacancies. We were told the service were recruiting to fill these positions.

The service provided data for staff sickness in percentages but did not inform us for which timeframe these were for. The trust target for both long term and short-term sickness was 5%.

We requested data for bank and agency usage for nursing staff. The service presented data for May 2023 as percentages for bank usage full-time equivalent (FTE), agency usage full-time equivalent and the total number as a percentage. For example, the main theatres had a 9.1% bank usage FTE and a 1.4% agency usage FTE. Ward 5B had 9.7% bank usage FTE and 0.5% agency usage FTE with a total of 23% for agency and bank staffing usage.

Managers made sure all staff including bank and agency had a full induction and understood the service. All bank candidates were screened by NHS Professionals to ensure staff had completed their mandatory training. Staff were required to achieve the full mandatory training requirements.

Surgery

Medical staffing

We requested to speak with doctors on the day of inspection. However, they were too busy to speak with us. On the day of inspection, we could see there were doctors around on the wards and surgeons within theatres. We asked for information about doctors vacancy rates and sickness absence but this information was not provided. However, following the inspection, the service told us surgical specialities were not usually ward based and there were usually multiple specialities on the ward. For example, gynaecology and urology shared general surgery. Each specialty had its own team of doctors who were training in the specialty and ward cover was part of their day-to-day work. We could therefore not be assured that the service had enough medical staff to keep patients safe.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and authorised staff could access them easily. The service used both an electronic and paper-based system for patient records. Staff spoke of the plan to move completely to electronic records.

Records were stored securely. All computers were left locked when not in use. Paper patient records were also stored securely and could only be accessed by staff authorised to access them.

We reviewed 8 sets of patient records and saw they contained information needed to deliver safe care and treatment such as care plans and risk assessments. This information was available and easily accessible to relevant staff.

All patients received appropriate pre-operative assessments prior to admission for surgery. The pre-operative assessment paperwork was fully completed and formed part of the paper record.

In each patient record we saw there was an appropriate care pathway in place dependent upon the procedure patients were undergoing. There was evidence to show discharges were planned.

Documentation in patient records were fully completed by staff. All patient records we reviewed had seen a doctor within 12 hours of admission. Their diagnosis and management plans were documented. Patient observations were recorded and completed at correct intervals and NEWS scores were calculated correctly and escalated where appropriate.

Patient records we saw had evidence of input from the multi-disciplinary team.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed on an electronic prescribing and medicines administration system (EPMA). We looked at 10 medicine charts and found that allergies were always documented to ensure medicines were prescribed safely.

Prescribers and nursing staff had access to resources to ensure medicines were prescribed correctly.

Venous thromboembolism (VTE) assessments were mostly completed in a timely manner as per trust policy. Each ward had a display screen, which indicated which patients were overdue to be assessed. In 5 out of 10 patients we looked at,

the VTE assessment had not been completed on admission. However, we saw that all patients had been prescribed prophylactic treatment as appropriate. Monthly audits were undertaken to monitor VTE risk assessment completion. Data recorded in May 2023 showed that improvement was required in 3 of the 7 surgical wards to meet trust compliance targets.

We looked at 2 patients who were prescribed medicated patches. There were no records of where the patch had been applied to ensure that the site was being rotated as per manufacturers guidance. This meant there was a risk of increased skin irritation and exposure to medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were reviewed regularly on ward rounds to ensure they were safe and effective for patients.

Clinical pharmacists regularly visited the wards and attended ward rounds. A prioritisation tool had been developed so that patients with complex medicine needs could be prioritised. Staff understood how to seek advice on prescribing and administration from pharmacy teams. For patients who were prescribed antimicrobials, there was a clear indication and rationale documented on the medicine's charts and in the clinical notes. Antimicrobials were reviewed at 48-72 hours as per trust policy.

Staff stored and managed all medicines and prescribing documents safely. Staff completed medicines records accurately and kept them up to date. Medicines including controlled drugs (medicines requiring additional control due to the potential of misuse) were stored securely.

Room and fridge temperatures where medicines were stored were monitored and staff we spoke to on the inpatient units understood when to escalate. The pharmacy team reviewed these temperatures weekly to ensure that any issues identified could be actioned quickly.

Medication safety audits were undertaken every month. Data showed good compliance with most areas of medicines storage, with some improvements in compliance required for monitoring of room temperatures where medicines were stored.

The electronic prescribing and administration systems were secured when not in use.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation (the process of accurately listing a patient medicines they were taking at home and comparing it to what is prescribed whilst they are in hospital) was completed in a timely manner. We saw 91% completed within 24 hours above their 90% trust target for medicines reconciliation. Staff had access to and sought consent from patients when viewing summary care records to check medicines taken prior to admission.

There were clear processes in place to communicate with the GP and community pharmacy when patients were discharged from the hospital.

Patients were counselled on their medicines when they were discharged by the pharmacy team when changes were made to ensure they understood how to take them.

Staff were not always aware of incidents to improve practice. There were clear processes to report medication errors and investigate incidents when they took place. Staff we spoke to understood duty of candour. However, some staff we

spoke to were not aware of any recent medicine's incidents. We looked at the documentation for the daily ward checklists on ward 7B, which had a standing agenda item for learning from incidents. We did not see any documentation of discussions of incidents, despite senior staff telling us of recent medicine related incidents, therefore we were not assured that learning was shared to improve practice.

Senior staff told us that learning from incidents were cascaded through 'message of the week' however they did not receive information about incidents occurring in other divisions of the trust. However, the message of the week varied and did not routinely contain information on incidents. Therefore, we were not assured that information was communicated to staff when needed.

Incidents

The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff we spoke with were able to clearly describe how to report incidents and shared examples of this with us.

The policy for accident/incident reporting was version controlled and had a date for review. The policy described how the service intended to ensure all incidents were reported by staff in a timely manner and described how incidents would be identified, managed, and investigated. The policy described how lessons would be learnt and how they would be promoted to enable future best practice.

The service used an electronic system for reporting incidents. All staff could access the incident reporting system. Staff told us they were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents.

Staff reported serious incidents clearly and in line with trust policy. The policy gave clear guidance for staff involved in investigating serious incidents to ensure there were learnings from serious incidents and appropriate actions were taken to improve patient safety. The never events policy 2018 was last updated in February 2021. The policy was version controlled and dated. The policy included information about wrong site surgery, overdose, mental health and falls.

The service reported 2 never events between April 2022 and February 2023. The service did not provide any further information about how these never events were investigated, or the lessons learnt.

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. Following the inspection, we saw evidence of a verbal discussion was held with a patient and a patient safety manager. A formal apology was given, and a duty of candour letter was sent by the chief nurse.

In the past 12 months, the service reported 575 incidents of which 156 were related to trauma and orthopaedics and 115 were related to general surgery.

From February 2023 to June 2023 the service had 62 incidents involving medication, 55 incidents involving falls and 48 incidents involving communication.

Surgery

Staff did not meet to discuss the feedback and look at improvements to patient care. Lessons learnt from incidents were not always communicated through team meetings however, all incidents were reported using an electronic database. We requested information about any learning or improvements that had been implemented following incidents. The service provided three examples of incidents and the actions required thereafter. We saw appropriate lessons had been identified and effective action plans were in place to support improvements.

Managers investigated incidents thoroughly. We saw the divisional board quality reports for January 2023, March 2023, April 2023, May 2023 and June 2023. These meetings discussed the total number of open incidents.

Is the service effective?

Good 

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

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies.

Policies based on best practice and clinical guidelines were developed trust wide and cascaded to the services for implementation. Staff demonstrated awareness of the policies and knew how to access them.

Staff could access policy documents on the service's intranet.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The individual needs of patients were discussed at handover meetings. Patient records demonstrated that patients' psychological and emotional needs were recorded.

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. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal.

Patients waiting to have surgery were not left nil by mouth for long periods. We spoke with 3 patients who told us that they had a good supply of food and drinks.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. These were entered into the electronic notes, and staff completed nutritional assessments for all patients using nationally recognised tools.

Specialist support from staff such as dietitians were available for patients who needed it. Patients requiring this extra support were regularly reviewed. When modified diets were needed, assessments of patient's requirements were detailed above their beds.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a nationally recognised tool and gave pain relief in line with individual needs and best practice. Patients had access to a variety of pain relief appropriate for their surgery. We saw 8 patient records. Staff completed regular assessments to make sure that patients' pain was controlled.

Patients received pain relief soon after requesting it. We saw staff completing and updating the patient records.

We reviewed patient records and found staff prescribed, administered and recorded pain relief accurately. We observed staff discussing patient pain at handover.

The service scored well in pain audits. We reviewed results from the past 12 months and saw compliance ranging from 97% to 100% across the surgical wards.

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 participated in relevant national clinical audits. Examples included, the ophthalmology database audit, the elective surgery (National PROMS Programme) audit and falls and fragility audit programme. The service had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment.

The trust's clinical audit forward plan was agreed annually and rolled out to the divisions who were required to participate in all relevant mandatory audits. For example, from the directory of national clinical audit and patient outcomes programme (NCAPOP) comprising of national clinical audits and national confidential enquiries.

Common themes or issues arising from mortality, patient claims, complaints, incidents, risks and infection prevention and control over the course of the current financial year were reviewed by the trust. The collated themes were cross-referenced against any potential national, clinical outcome review programme or local clinical audit projects that could be of the same theme. The final clinical audit topic themes were shared, discussed, and provisionally agreed as priority projects with the medical director for clinical effectiveness. The provisionally agreed plan of prioritised local clinical audit projects were shared with the clinical effectiveness committee membership in advanced of the last meeting of the current financial year, for discussion and approval.

Performance in national outcome audits were variable. However, appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required.

Surgery

The service had clinical audit and effectiveness quality review meetings which provided an opportunity for a speciality clinical audit and effectiveness programme to be reviewed and areas of improvement identified and shared.

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff were subject to pre-employment checks to make sure their professional qualification was active and with no restrictions in place.

Managers gave all new staff a full induction tailored to their role before they started work. There was a corporate induction programme for new staff and staff could attend a welcome day. There was also a local induction programme facilitated by their line manager. Staff received an induction handbook.

Staff we spoke with confirmed that induction was relevant, useful, and met their needs in the new workplace. New staff were required to complete e-learning and face-to-face training.

Staff received the appropriate training to meet their learning needs to cover the scope of their work and were given protected time for training.

Managers supported staff to progress through regular development meetings and yearly appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. However, some members of staff we spoke told us the appraisals were too focused on the trust's objectives.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Line and ward managers completed annual appraisals including any learning and development opportunities with their staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw a copy of team meeting minutes. The minutes did not list who attended the meetings, however, staff we spoke with told us they always had access to minutes of the meeting. We saw discussion topics varied between the wards but was relevant. Topics of discussion included bank staff, discharges, skin inspections and fluid balance charts.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us study days were available to complete their training. If staff complete training from home, this time was given back to staff.

Individual staff competencies were completed depending on the staff members role and grade. Competencies were worked through with each staff member and recorded centrally on the electronic system.

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 team meetings to discuss patients and improve their care. Each morning, a team huddle with all senior and department leaders was held to discuss any staffing issues, any concerns and the activity for the day.

Surgery

We could see from the handover sheets and records we looked at that there was detailed communication between staff of different grades and roles. Nursing staff said they had good communication between theatre and ward staff.

Staff of all grades and all disciplines worked together as a team to benefit patients. Doctors, nurses, healthcare professionals and administration staff supported each other to provide care to patients.

There were many examples of multidisciplinary team working including the daily huddles, handovers and ward rounds which included input from doctors, pharmacists, and physiotherapists.

The service could access mental health liaison and specialist mental health support for patients when needed. The mental health matron role was established to provide advice to nursing and medical teams and facilitated the implementation of the mental health management plan.

Seven-day services

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

The service was open seven days a week 24-hours a day to care for patients after surgery.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Consultants were available out of hours, during weekends and on call 24-hours a day for patients in their care.

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 patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. There were leaflets available on a variety of topics.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Leaflets were available for the procedures that were performed. These leaflets included information to support patients to recover well including advice about wound care, returning to work and the importance of a healthy balanced diet. The leaflets also included information about who to contact if patients had any concerns or became unwell.

The service limited the number of patient information leaflets on the wards due to the continued risk of COVID-19. However, leaflets were available by scanning a QR code.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service had a consent to examination or treatment policy which was version controlled and in date. The policy included information about different types of consent, withdrawal of consent and the process of recording consent. Staff told us they supported patients to make their own decisions wherever possible.

Surgery

Patients were risk assessed on an individual basis and adjustments put in place to deliver safe care to the patient if needed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients old us staff fully explained their treatment and additional information could be provided if required. Consent forms we saw in patients' records were fully completed and detailed the procedure planned and the risks and benefits of the procedure. Patient records showed consent was reviewed on the day of surgery as part of their pre-operative checklist.

Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We spoke with patients who said that they were asked for their consent.

We saw the trust wide policy guide to managing mental health patients. This was version controlled and in date. The guide provided information to staff to protect the rights of patients subject to the Mental Health Act 1983. Information within the guide included completing the equality impact assessments and information about referrals to the trust's mental health team.

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. We saw several positive, caring interventions by staff, who always took their time to ensure patients' needs were understood and met. Staff were very proud of the care they gave. From our observations, all staff were very pleasant and polite to patients, other colleagues and to all visitors.

All patients told us staff treated them well and with kindness. Feedback from patients was positive about all staff. Visitors were very complimentary about the service provided.

We saw positive feedback from three patients. Patients told us "I have experienced nothing but the highest level of care" and "the professionalism, caring, and overall attitude has been exemplary."

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered. Staff always knocked on the door before entering a room.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff provided a person-centred approach to the care they delivered.

Surgery

Patients felt confident in the quality of care provided by consultants and nursing staff.

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. Staff working in the service showed sensitivity and support to patients and those close to them. Staff understood the emotional impact having surgery has on patients and their families. They understood the need to give patients appropriate and timely support and information to cope emotionally with their care, treatment, or condition. Theatre staff told us they would give additional reassurance to a patient if they were anxious about their surgery.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff provided care to those patients that were in communal areas, such as the reception area, in line with their assessed needs and care planning. We saw staff demonstrated empathy with all patients.

Staff told us an online training session was planned for 24 September 2023. The training session planned to include communication skills, understanding compassion and kindness, and included practicing the skills in difficult conversations.

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. Staff used a holistic, person-centred approach to each individual patient, and took time to get to know them and their needs and wishes.

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. Patients told us they felt involved in the planning of their care. They told us they had received detailed information about their diagnosis and treatment and the care and support which would be offered following the procedure. Patients we spoke with confirmed they knew who to call in case they needed more information.

Staff talked with patients, families, and carers in a way they could understand. Staff were very kind and friendly to all patients and any visitors.

Staff supported patients to make informed decisions about their care. We were told pre-operative patients received general and specific pre-operative information in relation to their care. We saw leaflets were available patients to help them understand their care and treatment. For example, we saw information leaflets on preparing for anaesthetic, caring for wounds at home and a guide to medical terminology.

Patients provided positive feedback. For example, patients told us that they were "guided through every step of the process with clarity and compassion".

Surgery

Is the service responsive?

Requires Improvement 

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

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. The division used trust data to plan demand and capacity for surgery. For example, they used a health inequalities application which compared the number of patients waiting over 52 weeks by characteristic to the number of patients overall.

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 service had systems to help care for patients in need of additional support or specialist intervention. Patients completed a pre-admission medical questionnaire to identify patients with certain medical conditions, patients who may need further assessment or patients requiring further specialist support. Patients arrived at different times to enable staff to manage admissions and to reduce the patients' waiting times for patients.

Managers monitored and took action to minimise missed appointments. Appointments were arranged and booked in order from the tracking list which prioritised patients by clinical urgency. Short notice appointments were communicated via telephone, if accepted these were followed up with a letter and text reminder. Reasonable notice was sent via letter and a reminder was sent via text message.

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Support was available for patients with physical and learning disabilities. Staff made reasonable adjustments to meet their individual needs such as patients with a learning disability or who were living with dementia and their family members.

All surgical patients attended a pre assessment appointment so staff could assess patient needs prior to admission. Staff used this information in planning the care and treatment of patients and mitigate any possible risk to the patients.

The service had a mental health liaison team that conducted a daily review of patients with mental health conditions. This included crisis intervention, psychological support, psychiatric consultation, medication management, referral and follow up. They also provided one to one support for patients detained under the Mental Health Act (1983).

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. However, the wards did not always have suitable facilities to meet the needs of patients' families. Wards did not have rooms dedicated for families to use when visiting.

Staff supported patients living with dementia and learning disabilities. Staff told us they had completed dementia awareness training.

Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and provided patients with relevant information leaflets.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

The service had access to an interpreting service for patients whose first language was not English and sign language interpreters if needed. This was available by both telephone and face to face.

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. 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. However, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. The overall waiting list for surgery had increased over the 12 months prior to inspection. We saw the number of patients waiting for surgery in different areas had increased.

We saw for ear, nose and throat the number of patients waiting for surgery in May 2022 increased from 61 patients to 142 in May 2023. There was an increase in patients waiting for surgery in ophthalmology in May 2022 increased from 56 patients to 347 in May 2023.

Managers monitored delayed theatre lists. We were told between June 2022 and May 2023; 3,958 scheduled theatres had started later than planned. Some of the reasons for the delays included delayed team briefings, consultant/surgeon still assessing patient and staff not present or available.

We saw ophthalmology waiting lists had increased from 6,651 in June 2022 to 7,745 in June 2023. We were informed there were unfilled staffing vacancies leading to reduced capacity and the junior doctor strikes impacted on the service.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service offered either day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay. However, day-case patients were told to bring an overnight bag with them in case they were required to stay overnight. For example, if a patient became unwell following their procedure. Inpatient surgery required the patient to remain overnight or longer after the surgery was completed, for care or observation.

We reviewed surgical outliers relating to surgical patients being placed on medical wards. The evidence provided showed that this had not happened in the last 12 months.

Surgery

We saw the protocol for the management of day surgery patients which was version controlled and dated. The protocol stated the document should be reviewed within three years of issuing the protocol or sooner. The protocol was issued in August 2015 and was set to be reviewed in March 2023. The review of this protocol should have taken place in 2018 or sooner. Therefore, the policy was out of date.

Managers worked to keep the number of cancelled appointments and operations to a minimum. Patients could contact the helpline for a short notice slot if one was available at the time. Staff told us the service was working towards launching a patient electronic portal which would offer patients more ways to communicate with the service.

Patients were discharged back into the care of their referrer if they missed their appointment. The service worked to reschedule appointments that were not suitable for the patient.

When patients had their operations cancelled at the last minute, we were not assured that when patients had their operations cancelled at the last minute that managers rearranged them as soon as possible and within national targets and guidance. The service did not provide up to date information. The service told us in November 2022, there were nine operations that had been cancelled and had not been treated within 28 days. We asked to review data from 2023 but this was not provided.

Between 1 June 2022 and 31 May 2023, we saw 1,284 elective on the day surgeries had been cancelled. The reasons for these cancellations included the patient being acutely unwell, unfit for procedure and the operation was no longer necessary.

The service had daily meetings such as huddles and bed meetings where access and flow were discussed at a ward level.

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 but did not always share lessons learnt with all staff.

Patients, relatives, and carers knew how to complain or raise concerns. Patients could make complaints in various ways including the chief executive's office, through the patient advice liaison service (PALS), emailing the complaints team or direct contact with the division.

The service clearly displayed information about how to raise a concern in patient areas. We saw information on how to raise a complaint around the service and ward area.

Staff understood the formal complaints standard operating procedure (SOP) and knew how to handle them. The SOP provided a step-by-step process from when the formal complaint was received until the learning had been implemented as per the action plan. Staff told us they felt confident in handling patient's complaints and the reporting process.

Complaints were forwarded to the complaint's inbox for the complaints team to manage. Any letters that were being sent to the complainant was reviewed by the divisional team Any actions were formulated into an action plan by the divisional leads. Any complaint themes or trends were analysed, and actions put in place to stop them occurring again.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We were provided with documentary evidence of recent complaint investigations and correspondence to the complainant of the outcome, and we saw duty of candour had been applied.

Surgery

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff said learning from complaints and concerns would be communicated to them mainly at handovers, daily huddles, and team meetings. However, some staff members we spoke with had not received any information about recent incidents and learning from those investigations.

We were given examples of action that had been taken following a complaint. For example, a reminder for staff to clear equipment away after using it.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. 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. 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.

The service had a clear management structure in place with defined lines of responsibility and accountability. The services' leadership team comprised of a divisional lead, divisional operations director, divisional medical director and a divisional nursing and quality director.

Leaders at all levels had the knowledge and experience to run the service and told us they felt well supported to do so. Managers were keen to retain staff and focused on how they could develop staff to progress internally.

All leaders we spoke with demonstrated a good understanding of the service and a passionate and committed approach towards the future of the service. The leadership team understood the current challenges and pressures impacting upon service delivery and patient care. The leadership team could identify the actions needed to address these challenges and pressures. For example, the leadership team were consistently recruiting to fill staff vacancies.

Leaders told us the focus remained on the overall transformation of services; training needs, developmental opportunities, service efficiencies, culture and new ways of working were being explored and implemented. The division was receiving additional support through the corporate nursing team looking at roster efficiencies, safer staffing metrics and key performance indicators (KPI) information/performance.

The clinical leadership team were visible and approachable. Staff told us they had confidence in leaders' abilities to understand issues and work together to improve them.

Staff told us there were opportunities to develop their skills by applying for secondment opportunities which would enable them to later develop into the role. There were also leadership development courses including leadership and management for clinicians, coaching skills and compassionate inclusive leadership.

Surgery

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. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders wanted to achieve in surgery and this was in line with the trust vision to be trusted to provide consistently outstanding care and exemplary service. The mission was to "provide high-quality compassionate care for our communities." The vision had four guided themes which were quality, thriving people, seamless services and continuous improvement. The service promoted training, and staff we spoke with were aware of the vision for surgery.

The service had a planned care board which was a monthly forum for facilitating the development of a coherent strategy for the planned care division and all its component departments.

Staff were involved in discussions to shape the vision and strategy for the service. During our inspection, staff we spoke with could tell us about the vision for surgery. They told us these had been incorporated into their yearly appraisals and these objectives were discussed in full at their appraisals. Appraisal discussions required staff to rate their objectives using the red, amber and greed (RAG) system and evidence their rating for each objective. Staff were required to evidence how they had met each objective.

Staff felt positive and proud to work in the organisation. Staff told us they provided patients with person-centred care and that working well in a team was key to achieving their vision and strategy.

The management team shared they were dedicated to workforce retention and prioritising wellbeing and development across staff groups.

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 were positive and caring towards patients and their relatives who used the service. In addition, we also noted caring and respectful interactions between staff of all grades and disciplines.

Staff at all grades, were friendly, and welcoming and open and honest about the care they provided. Staff from all disciplines felt valued in their roles and part of the team. Staff expressed pride and commitment in their work.

Career development was discussed as part a concept called grow together. This was used to create a timeline of progression for staff, so they could work towards achievable targets. There was an established career pathway available for clinical support staff to progress to qualified nurses over a 4 year apprenticeship.

The service offered staff a range of online courses and workshops to attend to develop their careers.

The service told us there was a career pathway for attaining qualified nursing positions for unqualified staff. Staff had the opportunity to follow pathways to become qualified nurses.

Surgery

We were told the trust had over 300 staff members on apprenticeship programmes and offered a wide range of leadership courses. Nursing staff also had access to the Florence nightingale foundation leadership programme and the royal college of nursing clinical leaders' programme.

There were monthly mental health training sessions available to staff. We were told there was a mental health course available to staff from the university of Hertfordshire which was a bespoke four-day course focusing on mental health awareness and skills in meeting the needs of patients who presented in their care.

All the patients we spoke with told us they felt confident to raise concerns without fear. All the patients and families we spoke with were positive about the care they received.

The service promoted equality, diversity, and inclusion. The service utilised divisional and local meetings to promote trust plans for events such as pride and black history month. The service had staff networks for black, Asian and minority ethnic staff as well as the disabled members staff network.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

The service had divisional service line performance reviews. The standard agenda items which included new serious incidents, overdue/due reports, new risks and overdue risks and datix.

The planned care board oversaw and ensured that risks, governance, and performance of all its component departments were appropriately monitored and escalated. The planned care board was comprised of divisional directors, business partners and heads of departments.

Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system. However, some of the policies we saw were not the final version and had comments within it. We saw 2 policies out of 10 had not been reviewed within the timeframe stated in the policy.

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. We saw the senior leadership team met face to face every week informally to discuss urgent issues and/or concerns. However, staff told us learning from incidents was not always filtered down effectively. We reviewed meeting minutes for ward managers and matrons and saw no set agenda for items of discussion. We were therefore not assured that all relevant areas of information were passed down to staff.

Weekly divisional leadership team meetings included Band 8a staff and above. The senior triumvirate updated staff on issues, concerns, trust plans, meetings for the week ahead and priorities. This was an interactive session online and staff had the opportunity to ask questions and discuss relevant issues.

We were told each service had a divisional performance review which was chaired by at least one of the divisional senior leadership team members. The performance review was based on the balance score card in which quality, finance, people and operation were reviewed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues but did not identify actions to reduce their impact. They had plans to cope with unexpected events.

There were clear and effective processes for identifying, recording, managing and mitigating risks. Risks were managed at divisional level. All new risks were reviewed and approved at divisional quality and safety meetings. Risks with a score above 16 were reviewed and approved at divisional board. All risks were approved by the service and there were trust set key performance indicators (KPI's), which were monitored through the divisional board and the trust risk management group.

The risk register for surgery was managed by the clinical service managers. We looked at the risk register which had a red, amber, and green (RAG) rating system. From the spreadsheet provided by the service we could see they had appropriately identified the risk but there was no information about how this impacted the service and the measures that were in place to reduce the risk. The risk register provided did not provide a date of when the risks had last been reviewed or who was responsible for the risk.

The service had plans to cope with unexpected events. Following our inspection, we saw the service business continuity plan which was version controlled and dated. The policy was implemented on 19 May 2022 and the date of review was set to annually. Therefore, the policy had not been reviewed on time and was out of date. The purpose of the plan was to provide clear guidance to staff delivering the service when dealing with an unexpected event or incident that affected part or all of the day-to-day operations.

The trust wide business continuity plan was version controlled and in date. The plan included information about the trust arrangements for trust priorities, risk register and records management.

The trust wide policy for major incident planning was version controlled and in date. The plan provided information about declaring a major incident, command and control and training, exercising and lessons learnt.

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. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. Staff and leaders collected and analysed data on staffing, quality and safety. This included monitoring of compliance with surgical safety checklist, hand hygiene, use of personal protective equipment and medicines management.

The information systems were integrated and secure. Electronic information was kept on computers that were secured with usernames and passwords for each member of staff preventing unauthorised access. Staff logged out of computers when not in use.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams.

Staff told us they used IT systems to access the e-learning modules required for mandatory training.

The service was using a new theatre management system. This integrated multiple patient systems and clinical processes. There was real-time recording of data including times using the mobile application. Staff told us information was displayed clearly and was easily accessible.

The service's data protection policy outlined the measures in place to ensure the service was processing data in accordance with the data protection laws and to promote confidence that the service was handling patient and staff information in a confidential manner.

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 clinical leadership team engaged with staff and aimed to ensure all their voices were heard and acted to shape services and the culture. The service gathered feedback from staff through a variety of forums and methods including staff surveys. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and leaders.

All leaders across the division were asked to review results for the 2022 staff survey. Leaders were asked to hold team talk sessions with their services from April 2023 to June 2023 and present back to the wider team sharing key findings and feedback. The final divisional team talk feedback and action plan was to be approved at divisional board in August 2023. We saw evidence of the team talk for theatres and the action plan dated May 2023. Key themes included not enough staff to cover breaks, overbooked lists, improper skill mix and staff retention.

Since the previous survey in 2021 some improvements had been made following staff feedback. This included creating the trust's new values, new appointment into the speak up guardian role and more development opportunities through the trust academy.

All staff we met on inspection told us they had good support from management.

Learning, continuous improvement and innovation

The service had some initiatives such as rezum which was launched in urology. The surgical option available to patients was transurethral resection of the prostate (TURP) which was a 90-minute procedure with at least a two-night length of stay. Rezum takes approximately 20 minutes, under either local or general anaesthetic and patients could be discharged the same day. The service told us they performed 21 cases between October 2022 and June 2023. We were told the procedure was quick and easily achievable as a day case and 57% of patients were discharged after the first follow up appointment.

However, we could not see the progress of these initiatives or how this impacted the service.

Maternity

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff had completed it.

The service had effective systems in place to ensure staff were appropriately trained to provide safe and evidence-based care for women and babies, however staff did not always keep up to date with their mandatory and maternity specific training.

The trust provided statutory mandatory training, this included but was not limited to conflict resolution, adult basic life support, new born basic life support, mental capacity act and deprivation of liberty safeguards, and infection prevention and control. The service also provided evidence of learning disability awareness and dementia awareness as part of mandatory training. This was confirmed by the staff we spoke to. The compliance rate for midwives was 92% which exceeded the trust target of 90% and 87% compliance rates for medical staff which did not meet the trust target.

Nursing and midwifery staff did not always receive and keep up to date with maternity specific training. Maternity specific training included, but was not limited to, practical obstetric multidisciplinary training (PROMPT), cardiotocography (CTG) training, pool evacuation and adult basic life support (ABLS). Compliance for PROMPT was 91%, compliance for CTG training was 91%, compliance for Grow Gap training was 92% and compliance for pool evacuation was 91%. These figures exceeded the trust target of 90%, however, compliance for the midwifery senior management team consistently did not meet the trust target rate of 90% in all areas. The overall compliance for the midwifery senior management team was 71%.

Medical staff did not always receive and keep up to date with their maternity specific training. Compliance for PROMPT was 95%, compliance for CTG training was 99%, compliance for pool evacuation was 95% which met the trust target of 90%, however, compliance for Grow/ Gap training was only 71.5% which did not meet the trust target.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training team monitored training compliance and worked closely with midwifery matrons to ensure staff received training in a timely manner. Compliance had improved since our last inspection and the trust had an action plan in place to meet compliance for all staff.

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 most staff had completed it however, this did not meet the trust target.

Maternity

The trust provided adult and children's level 3 safeguarding training to midwives, support workers and medical staff. Compliance with level 3 safeguarding training was 85% for midwifery staff and 88% for medical staff. These figures almost met the trust target of 90% and was an improvement from our last inspection.

Staff reported there had been instability within the safeguarding team due to sickness. At the time of our inspection, the safeguarding team consisted of a temporary team lead who was also the children's safeguarding lead, a band 7 team member and a band 6 midwife. Staff we spoke with told us the team were visible, and they felt comfortable approaching them. The safeguarding team told us they had a good relationship with other agencies such as social services, the police, and other services such as independent domestic violence advocates. The safeguarding team also worked closely with the specialist perinatal mental health team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us there was guidance available on who to contact out of hours if the safeguarding team was not on site. Staff also knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Safeguarding details were identified during handover and on the maternity wards handover sheets. Full details on safeguarding concerns were available on an electronic system which all necessary staff had access to. The system was password protected and staff were also able to add details if incidents were to occur during their shifts.

On the day of our inspection, we observed individual safeguarding cases being managed correctly and being discussed at midwifery handovers and during the management safety huddle.

Staff were able to give examples of how to protect women from harassment and discrimination. Staff followed the baby abduction policy and undertook baby abduction drills. The latest baby abduction skills drill was carried out on 7 February 2023.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. This was an improvement from our last inspection. We found evidence that staff completed cleaning and room preparation checks. There were cleaning schedules for each room including toilets and bathrooms across the maternity unit which was filled daily with occasional gaps on the consultant led unit which was due to the room being occupied. Staff on the maternity unit were clear which rooms had been cleaned and were ready for use.

The service generally performed well for cleanliness. The service completed multiple infection prevention control (IPC) audits such as cleaning and hand hygiene audits.

The cleaning audits were completed using the National Standards of Healthcare Cleanliness 2021. A breakdown of the cleaning audit data for the consultant led unit, midwife led unit and the maternity wards for April to June 2023 showed the consultant led unit scored an average of 97% for cleanliness and the midwife led unit scored an average of 98% for cleanliness. These figures were against an average target of 98% for those areas, the consultant led unit failed to meet this target. The maternity wards scored an average of 97% for cleanliness between April and June 2023, which exceeded the average score target of 95% for this area.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff bare below the elbow, wearing appropriate PPE when handling specimens, using hand sanitiser when entering clinical areas and washing their hands in between patient contact. We requested hand hygiene audits for the last 3 months. The results of the hand hygiene audit for the maternity wards showed 89% compliance overall in April 2023. The results for one of the maternity wards in May 2023 showed 86% compliance and lastly the audit for the consultant led unit and the midwife led unit in June 2023 showed 90% compliance. The service target of 80% was exceeded in the areas audited.

Hand sanitising gel dispensers were available at all entrances, exits and throughout the clinical areas for staff, women, and visitors to use.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning record sheets were available across the unit to demonstrate which rooms and areas had been cleaned. This was completed by domestic staff and maternity support workers; each staff group were aware of their responsibility regarding cleaning. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed the use of green 'I am clean' stickers, which is used to indicate what equipment had been cleaned and when on all equipment we observed.

Women who were booked for elective caesarean section were screened for methicillin- resistant staphylococcus aureus (MRSA) during their pre-operative assessment appointment. This was evident in records reviewed.

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 maternity unit was open 24 hours a day. The premises were secure, access to all areas was by swipe card only. All doors were closed, and we observed staff asking for identification before admission into areas. The corridors in all areas were brightly lit and clutter free.

The design of the environment supported the volume of women who arrived and had suitable facilities to meet the needs of women and their loved ones. This included a 9 bedded consultant led unit with 1 birthing pool available, a private bereavement room and 2 operating theatres. One theatre was used for planned surgical cases and the other was used for emergencies with a 4 bedded recovery area which was staffed by a recovery nurse. There was a 7 bedded midwife led unit with 4 birthing pools available, an antenatal ward for women who were pregnant and a postnatal ward for women following their delivery. The service also provided a separate triage area for women presenting with immediate concerns, which included a waiting area and separate rooms for assessment along with a four bedded day assessment unit (DAU) for semi planned care.

The service carried out an environmental audit for maternity which involved but was not limited to observing the cleanliness of the environment, whether equipment was clean and labelled and the condition of furniture however, the audit was not performed consistently. The most recent audit of the wards took place in May 2023 and prior to that was March 2023. The average compliance in May 2023 for the maternity wards were 89% which exceeded the trust target of 80%.

The service had enough suitable equipment to help them safely care for women and babies. This included cardiotocography (CTG) machine, handheld dopplers and observation machines. Staff reported that this is an improvement since the last inspection.

All equipment we observed such as CTG's, observation machines, dopplers were maintained in line with safety standards, however, staff did not always carry out daily safety checks of specialist equipment. We reviewed 8 daily safety checks of neonatal resuscitaires, adult resuscitation trolleys and emergency trolleys across the unit and found 2 gaps in June 2023. The midwife led unit had an emergency trolley with individual trolleys for post-partum haemorrhage, eclampsia, hypoglycaemia, and latex allergies. Although we found 4 gaps in the daily checks in the last 3 months, this was an improvement from the last inspection. This was consistent across all the daily safety checks we reviewed.

The midwife led and consultant led units had daily equipment and room checklists on the back of each delivery room door. The checks included, ensuring the room had the correct equipment and that the equipment was in working order. We found 5 gaps across two rooms on the consultant led unit and 4 gaps across two rooms on the midwife led unit in the month of June 2023. We discussed this with the midwife in charge who explained the gaps were due to the room being occupied by the same woman the day prior and a repeated check not being necessary.

Matrons and ward managers had oversight of the compliance of safety checks and carried out compliance audits. This was conducted weekly by ward managers and monthly by matrons for each area.

Across the unit we found equipment such as blood pressure machines, CTG machines, suction units, weighing scales had been serviced and/or portable appliance tested.

Women could reach call bells and we observed staff responding quickly when called. All toilets on the post-natal ward had call bells that worked and were ligature free.

Staff disposed of clinical waste safely. Colour coded clinical waste bins and sharps bins were available in all areas. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

We reviewed 8 maternity care records, and the lead clinician was identified in all of them, risk factors such as BMI and comorbidities were highlighted, and risk assessments took place at every contact with evidence of appropriate referral.

Staff used a nationally recognised tool, Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration and escalated them appropriately. This was completed on a paper chart and stored in each woman's notes. We reviewed 7 MEOWS charts and found staff had completed, scored and escalated correctly. The service carried out an audit of MEOWS charts completed between June and November 2022. The compliance rate for the use of MEOWS charts was 80% and 85% for staff taking action when the scores triggered. The trust had plans in place to increase the compliance rated which included disseminating learning points to staff.

We also requested new-born early warning trigger and track (NEWTT) audit from the service, but they were unable to send data as the NEWTT audit was under review and they planned to restart the monthly audit in July 2023.

Staff knew about and dealt with any specific risk issues such as sepsis and venous thromboembolism (VTE). We observed VTE assessments being completed in the notes we reviewed to determine whether women were at risk of developing blood clots. Preventative medication was prescribed and administered as appropriate.

Maternity

We observed fresh eyes being performed in all the notes with CTG traces. Fresh eyes is an in person review of the CTG trace by another clinician which is then documented in the women's notes. The service carried out an audit of fresh eyes, where the completion of fresh eyes was reviewed hourly, the correct classification being identified, and an appropriate plan being put in place. The audit from February 2023 showed 76% compliance with the sticker being used hourly, 93% compliance with the correct classification being identified and 93% compliance with the appropriate plan being put in place. The audit from June 2023 showed 100% compliance across all three criteria however, the audit for June had not been fully completed at the time of data submission.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly. The service had implemented the Birmingham Symptom- Specific Obstetric Triage System (BSOTS) in March 2023. BSOTS is a system to assess women presenting with pregnancy related concerns to be seen or prioritised based on their clinical need. Prioritisation was undertaken using a red, amber, green (RAG) rating, recorded on a paper documentation sheet. We observed staff using this tool and saw evidence of it being completed in the women's t notes we reviewed. Staff reported that due to low staffing BSOTS had not been fully embedded on the night shift. BSOTS requires 2 midwives in order to work as intended; however, there was only 1 midwife to triage on the night shift.

Triage had a dedicated telephone line that was staffed by a designated midwife on the day shift from 10am to 6pm. The designated midwife completed a telephone triage assessment card for each woman that called which would include the woman's details, medical history, current concern and the advice given by the midwife. Staff we spoke with reported that having a dedicated midwife to answer the telephone worked well but as there was no one dedicated overnight it became difficult to manage along with women walking into triage. The senior leadership team reported that they are aware of the staffing issues in triage and they had future plans for recruitment drives in place. Staff informed us that the trust offered twilight bank shifts from 7:15pm to 1:30am to midwives as a mitigation.

The service carried out an audit on 119 notes for women that attended triage from March to May 2023. Finding showed that 100% of women were RAG rated appropriately and seen in appropriate time frames according to the RAG rating. However, 7% of women attending with reduced fetal movements did not have a CTG started within 60 minutes of arrival in line with BSOTS guidance. The trust reports that this was discussed with staff at monthly ward meetings to increase compliance.

Obstetric cover for triage was provided during the day however, at night triage was covered by the team covering the consultant led unit. Staff told us that due to there not being a designated doctor at night there had been delays with women being reviewed. Data from the audit showed that 2% of women were not reviewed by the doctor within the time frame according to the RAG rating.

Theatre staff completed the World Health Organisation (WHO) checklist prior to starting surgical procedures. The WHO checklist is a set of priority checks to ensure patient safety before, during and after a surgical procedure. The service carried out an observational audit of the completion of WHO checklists. Data provided showed 100% compliance in March 2023, 93.33% compliance in April 2023 and 95.24% compliance in May 2023.

Staff knew about and dealt with specific risk issues. In all records we reviewed, staff had completed venous thromboembolism risk (VTE) and the standard questions for identifying abuse.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

We observed the consultant led unit handover and ward round. Shift changes and handovers were organised and included all necessary key information to keep women and babies safe. Staff used a structured communication tool known as Situation, Background, Assessment, Recommendation (SBAR) for communication during handover and between team members. The Obstetric team used a ward round book to be signed morning and evening to confirm attendance of handover and the completion of consultant led unit ward round.

The service carried out an audit on the use of the SBAR tool, findings showed 68% compliance in May 2023 and 81% compliance in June 2023 across all wards. The trust had an action plan in place to increase compliance which included, monthly updates of SBAR audit result to staff for discussion and learning. The service also reported that they included a record keeping teaching in the midwives mandatory study day.

Safety huddles, also known as the situational awareness report, took place on the consultant led unit. We observed a safety huddle, this was attended by the manager on call, maternity and neonatal matrons, the obstetric consultant on shift and specialist midwives. The safety huddle was comprehensive, well organised and included representatives from all relevant areas of the service. The manager on call led the safety huddle and followed a spreadsheet with all the required topics to be discussed. The topics included, but were not limited, to staffing, acuity, safety checks, safeguarding, mental health, and any induction of labour or elective caesarean delays on the unit.

At our previous inspection we raised concerns about ligature points across the unit. At this inspection we saw the service had carried out a ligature risk assessment across the unit. We observed ligature free emergency call bells in bathrooms across the unit.

At our last inspection, we identified the service did not have a policy for using the birthing pool in labour, particularly for those with complex pregnancies or medical conditions. At this inspection, we noted the service had a departmental water birth guideline in place that included ensuring women with complex pregnancies were managed safely.

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training, and experience to keep women safe from avoidable harm and to provide the right care and treatment.

The service did not have enough nursing and midwifery staff to keep women and babies safe. The trust used Birthrate Plus to monitor acuity and calculate midwifery staffing levels on the consultant led and midwife led units, while it used another acuity tool called safe care on the maternity wards. The acuity tool was updated 4 times a day, and staffing shortages were escalated to the manager on call, matrons and the ward managers and were also discussed at the daily safety huddle.

The trust provided us with red flag event data from April to June 2023. A midwifery red flag event is a warning that there may be an issue with staffing. Red flag events are situations such as missed or delayed care, delay between admission for induction and beginning of process and the coordinator being unable to remain supernumerary. Once a red flag event is highlighted, the midwife in charge should be alerted and if staffing is identified as the cause, action should be taken. Between April and May 2023 there were 16 maternity red flags, the most prevalent red flag event was the coordinator being unable to maintain supernumerary status (not providing 1:1 care). This accounted for 31% of the red flag events. Between May and June 2023 there were 34 red flags, the most prevalent red flag event was delayed or cancelled time critical activity. This accounted for 62% of the red flag events. On the day of our inspection, we observed evidence of this, as 4 women undergoing induction of labour (IOL) on the ward were waiting to be transferred to the consultant led unit to continue the process but were unable due to lack of available staff.

Maternity

The number of midwives, maternity support workers and nurses did not always match the planned numbers. On the day of our inspection, we found that the midwifery rota was short staffed on the consultant led unit. There were 19 registered members of staff (nurses and midwives) instead of the planned number of 23 registered members of staff on the day shift and 14 registered members of staff instead of 19 on the night shift. Staff we spoke with reported that this was a common occurrence.

At the last inspection it was highlighted that midwives were scrubbing in the obstetric theatres without scrub training and competencies. We saw evidence from training schedules and staff reported that all midwives are now given full scrub training prior to being allocated to scrub in obstetric theatres. However, the practice of midwives scrubbing in obstetric theatres is still not in line with best practice guidance around national staffing of obstetric guidance consensus statement (May 2009).

Staff told us the midwife led unit was no longer frequently closed due to staffing shortages. This was an improvement since our last inspection. Data provided by the trust showed an increase in deliveries on the midwife led unit from 4.7% in October 2022 to 14.1% in May 2023 which supports this.

The service had a high vacancy rate for midwives. As of May 2023, the vacancy rate for midwives was 28.16 WTE which was a 13.7% vacancy rate and 0.32 WTE for maternity support workers which was an 0.8% vacancy rate. The practice development team reported that they had recruited 15 preceptorship midwives with 3 due to start in July 2023 and 4 international midwives with 8 currently in the pipeline to start by December 2023. Senior staff told us that they used bank staff who were familiar with the service regularly to fill gaps in the rota. The overall sickness rate for maternity staff in July 2023 was 6.9% which was similar to the figures at the last inspection.

Managers made sure all bank and agency staff had a full induction and understood the service before they start work.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Not all staff had their annual appraisal. As of 21 June 2023, 13% of maternity staff band 4 and below, 57% of midwives and 33% of nurses had completed their annual appraisal. The service had a deadline for all appraisals to be completed by August 2023.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. However, the service had enough anaesthetists to keep women safe from harm and provided locum doctors with a full induction.

The service did not always have enough medical staff to keep women and babies safe. As of June 2023, the service employed 18 whole time equivalent (WTE) obstetric consultants,16 WTE middle grade doctors (registrars) and 14 junior grade doctors.

The service provided the trust board with an update on staffing every 6 months in line with the maternity incentive scheme requirements. Data from the maternity board safety paper in January 2023 showed that 14% of consultants were on long term sick leave. There were 16 WTE middle grade doctors which left an 18% vacancy rate for middle grade obstetric doctors and 16 WTE junior grade obstetric workforce which left a 7% vacancy rate.

As of June 2023, the only difference in medical staffing was a reduction in the number of junior grade doctors. The number of junior doctors had dropped from 16 WTE to 14 WTE. The medical staffing risk had been highlighted by the service on their risk register. According to the risk register the service reports this is being managed and they are awaiting the maternity improvement report.

Maternity

Staff told us that consultants carried out daily ward rounds twice a day. There was a consultant on the labour ward 125 hours per week which met the goal set out on the national maternity dashboard. There was a resident consultant on call at night from 8pm to 8:30am, Monday to Thursday and an on-call consultant Friday to Sunday and bank holidays. The elective caesarean section lists were undertaken by a separate consultant obstetrician that does not have any consultant led unit responsibilities during the day.

The trust used locum doctors to fill gaps in rotas. The maternity board safety paper from January 2023 highlighted high locum costs to cover the unit. Locum doctors were given a full induction. The service also provided evidence of an orientation booklet for locum doctors in maternity to ensure they were aware of trust processes and procedures.

Anaesthetist cover of the consultant led unit and obstetric emergency theatre were staffed by a consultant and a duty anaesthetist. The duty anaesthetist mainly covered labour ward but was also responsible for all inpatients, and they also attended the obstetric ward rounds. The consultant anaesthetist was available Monday to Friday from 8am to 6pm and on call. They were also on call between 6pm on Friday and 8am on Monday. There was also a dedicated consultant anaesthetist for the elective caesarean list. Staff reported good anaesthetist cover for the unit.

The trust met the clinical negligence scheme for trusts and the maternity incentive scheme requirement for anaesthetist medical staffing of the anaesthesia clinical services accreditation.

Consultants and career doctors which are doctors who specialise in obstetrics, had yearly appraisals of their work. Data submitted by the service showed that consultants and career grade doctors had an overall compliance rate of 98% as of June 2023.

Records

Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, they were not always up-to-date.

Women's notes were comprehensive, and all staff could access them easily. The unit used both paper and electronic patient records. Staff reported were able to easily access patient records.

We reviewed 8 maternity records for women at different stages of the maternity pathway and found the records to be comprehensive. Risk assessments and clinical assessments such as venous thromboembolism (VTE), fetal movement, high or low risk pregnancy, safeguarding questions, fluid balance charts and modified early obstetric warning score (MEOWS) were all recorded and documented correctly.

The service carried out a documentation audit which included record keeping in midwifery notes, medicine administration, patient identification, and assessment tools such as urinary catheter care, fluid balance and intravascular devices. The findings showed 96% compliance in April 2023, 85% compliance in May 2023 and 78% compliance in June 2023. This meant we were not assured that records were always up to date.

Records were stored securely in a locked notes trolley.

Medicines

The service used systems and processes to safely administer and record medication. However, the service did not always prescribe and store medicines safely.

Maternity

Staff mostly followed systems and processes to prescribe and administer medicines safely; however, these were not always safe. Medicines were prescribed on paper charts. We looked at 10 medicine charts and found that allergies and weights were always documented to ensure medicines were prescribed safely. However, we saw that medicine charts were not always fully completed. For example, we saw one prescribed medicine missing the prescriber's signature and the medication was abbreviated. We also saw that 'as when required' (PRN) medication prescribed without the administration frequency or the maximum dose being identified on the chart which meant that staff could potentially administer the medication too soon or administer too much of the medication.

Prescribers and nursing staff had access to resources to ensure medicines were prescribed correctly.

All women had anticoagulant therapy prescribed correctly according to their weight, and there was additional guidance printed on the prescription charts to guide prescribers.

When medicines were administered through midwife exemptions (midwives can administer or supply medication to patients under their care without need for prescription), this was recorded on the prescription chart as a once only medicine. However, discussions were due to take place to discuss the recording of these administrations so they could be monitored.

Staff reviewed each woman's medicines regularly and provided advice to women and their carers about their medicines. Medicines were reviewed regularly on ward rounds. There was no dedicated pharmacist for the maternity wards, however the service told us that they had a pharmacist aligned to women's health and staff understood how to contact them if they required advice.

Staff mostly stored and managed medicines and prescribing documents safely. Medicines including controlled drugs (medicines requiring additional control due to the potential of misuse) were stored securely. However, on the delivery suite, we observed an isolated case of 2 medicines used during labour that would have a reduced expiry date if stored at room temperature without the date of opening written on. This meant the service could not be assured that they continued to be safe to use. We highlighted this to staff, who removed it immediately.

Room, fridge and freezer temperatures where medicines were stored were monitored and staff we spoke with understood when to escalate. The pharmacy team reviewed these temperatures weekly to ensure that any issues identified could be actioned quickly. However, on the consultant led unit and midwife led unit we saw there were some gaps in recording of fridge temperatures.

Blank prescriptions were stored securely to reduce the risk of misuse.

Discharges from Gloucester and Dacre wards were mostly carried out from the ward, with use of prepack medicines to facilitate rapid discharge. There was a discharge checklist in place, which included counselling women on how to administer their anticoagulant injections as appropriate.

Medicines management training was mandatory. Following the inspection, the trust submitted training figures, medical staff had 92% compliance, midwifery 94% and nursing staff 100% which exceeded the trust target of 90%.

Staff learned from safety alerts and incidents to improve practice.

There were clear processes to report and investigate incidents when they took place. Staff we spoke to understood duty of candour.

Maternity

Incidents

Staff recognised and reported 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 women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, the service did not always manage safety incidents in a timely manner.

Staff knew what incidents to report and how to report them and the service used an electronic incident reporting system to report incidents. Staff raised concerns and reported incident and near misses in line with trust policy. The governance team reported that incidents were reviewed daily by the clinical governance midwife to assess the level of harm; incidents were then allocated to the appropriate lead to investigate.

We reviewed incidents from November 2022 to January 2023, and data showed 490 incidents had been reported, that were appropriately graded. We did not have access to more recent data which meant we could not be assured that all incidents were being reviewed and graded appropriately.

Incidents were not always managed in a timely manner; we noted a backlog of incidents to be reviewed and graded. The service currently had 32 overdue open maternity incidents awaiting or being reviewed as of July 2023. This is an improvement from the last inspection; however, it is unclear how long these incidents had been opened as it was not specified in the data the trust provided.

The service had no never events between June 2022 and May 2023 and the service reported 5 serious incidents (SI's). Three of the SI's were declared and accepted by the healthcare safety branch (HSIB). One maternal death was reported by the trust in the last 12 months between June 2022 and June 2023, which was appropriately reported for incident investigation. We saw evidence of incidents being discussed at serious incident review meetings. Minutes from meetings in June 2023 showed that 2 incidents had been discussed and identified as serious incidents with a date being set for it to be investigated by.

The service carried out a thematic review of maternity serious incidents and HSIB cases between January and December 2022. The thematic review showed that 12 cases were referred to HSIB and 6 were accepted for investigation. The service investigated four internal serious incidents which were investigated by the patient safety team. The key areas of learning highlighted in the cases that occurred in 2022 were the management of operative vaginal births, women requesting to birth outside of guidance and women with deteriorating mental health. In response to this the service had updated guidelines, developed new guidelines, added risks to the risk register, updated training packages and presented learning via different platforms such as clinical governance reports and rolling half day which is a learning forum open to all clinical staff. This assured us that changes had been made in response to incidents and feedback.

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

Staff received feedback from investigations of incidents, both internal and external to the service. Staff were updated about learning from incidents through various channels, including but not limited to, clinical governance newsletters, LMNS message of the month, rolling half day, maternity alerts and during team meetings. The maternity governance team worked closely with the practice development midwives to ensure that local learning was used in training.

Staff we spoke with reported that managers debriefed and supported staff after any serious incident. Women and their families were involved in these investigations.

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All stillbirths, maternal deaths and neonatal deaths were investigated and reported to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). They were discussed at monthly perinatal mortality review meetings using the perinatal mortality review tool kit which was produced by MBRRACE-UK.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. 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. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.

The maternity services sat within the division of Women's and Childrens Services. This division covered obstetrics, gynaecology and neonates and was overseen by the divisional triumvirate. The divisional triumvirate was currently made up of the director of midwifery and the medical director of women's and children, with a deputy director of operations to join in September 2023. The triumvirate was supported by the quadrumvirate which was made up of the head of midwifery, general manager, clinical director of obstetrics and the clinical director of neonates. They were also supported by two maternity board safety champions, one of which was the chief nurse.

Leaders understood the challenges and issues within the service. The senior leadership team had oversight of the issues maternity faced and held monthly women and children's speciality meetings. These meetings were multidisciplinary team (MDT) and the team highlighted issues and discussed actions required. The trust had developed action plans in response to our previous inspection of maternity services, and the senior leadership team had oversight of this.

The service had enrolled senior staff in a perinatal culture and leadership course to develop the leadership and improve the culture within the service. There were also opportunities given to midwives to take on developmental senior roles.

Staff were able to give feedback on leaders, which included matrons and ward managers and the visibility of the senior leadership team was positive. Staff reported that the director of midwifery and head of midwifery were visible and reported that they felt they were accessible as they held weekly drop-in sessions by teams for all staff to attend if they wish.

The maternity board safety champion and director of midwifery attended board meetings. This, alongside our previous inspection, had raised the profile of maternity services and supported the board in understanding the challenges the maternity service faced. We saw evidence that maternity services had been discussed at board meetings.

Vision and Strategy

The service had a vision for what it wanted to achieve and strategy to turn it into action.

Maternity

The maternity service did not have a maternity specific vision but followed the trust wide vision "to be trusted to provide consistently outstanding care and exemplary service". The service produced maternity specific objectives to achieve this. Staff we spoke with were aware of the trust vision and trust values which were "Include, Respect and Improve".

The service had a 2022-2025 digital maternity strategy. This included end to end electronic patient records, creating an appetite and ambition to further exploit digital technology to benefit women and staff, and funding to invest further in digital developments. This would be achieved through collaboration with stakeholders within the trust, local maternity network system (LMNS) region and the digital midwife network. The service had liaised with staff and the maternity voice partnership (MVP) in developing the strategy.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of women receiving care. The service provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

We spoke with staff across most grades and disciplines, who told us they were proud to work for the trust. We observed staff working together as a team to provide high quality care and positively impact patient care and experience. Staff we spoke with had mixed reactions as to whether culture in the service had improved, some staff felt it had whilst others felt it had remained the same. This was largely related to staffing shortages.

The results from the NHS survey showed that maternity scored lower than the rest of the hospital on all 8 people promises/ themes. The people promise included, we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we are safe and healthy, we are always learning, we work flexibly, we are a team and morale.

The service had developed an action plan to improve culture as some staff had experienced poor culture and there had been friction among specialists. The service had an external review and had put measures in place to improve the culture in the service. This included a listening event with the senior leadership team, monthly MDT culture forums for all staff, perinatal leadership, and culture courses for senior leadership team (SLT). This was facilitated by the associate director of culture, inclusion, leadership, and engagement.

Staff told us they felt comfortable raising concerns without the fear of victimisation. The trust had a freedom to speak up guardian who staff were aware of, and we saw posters around the unit encouraging staff to contact them if they needed.

The service provided opportunities for career development. Two band 6 midwives were currently given the opportunity to develop in a band 7 ward manager programme, they reported being supported by the senior leadership team.

Women, relatives, and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in women's and visitors' areas and had staff responsible for asking women to complete the Friends and Family Test (FFT). The FFT was created to help service providers understand whether their women were happy with the service provided, or where improvements were needed.

Complaints were investigated by matrons and the head of midwifery and themes were identified. Matrons told us they shared feedback from complaints with staff and learning was used to improve the service. We saw evidence that learning from complaints were communicated through message of the week which was shared with all staff.

The service had received 12 formal complaints between April 2023 and June 2023. The head of midwifery and matrons had oversight of these complaints, how long they had been open and had actions in place. As of June 2023, 2 of these complaints had been closed with the remaining 10 either awaiting a reply from the division or awaiting a response to be drafted. These complaints were mainly related to quality of care and staff attitude.

Governance

Leaders 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.

There was a governance structure in place with lines of reporting within the maternity service. The structure was intended to allow for escalation upwards and information to flow down the divisional structure. The governance team included a Clinical Governance Midwife and a Quality and Safety Manager, they were also supported by the Clinical director of Obstetrics.

Staff were clear about their roles and accountabilities and reported that channels for escalation had opened since our last inspection, which had raised the profile of maternity. Staff reported that there were clearly defined reporting avenues. Incidents, risks, performance, guidelines, audits and user experience were discussed at monthly governance meetings. These fed into divisional meetings which were then communicated trust wide through different channels and meetings.

The maternity service sought assurance through various meetings such as governance meetings, divisional meeting, and trust board meetings. This included divisional meetings, speciality meetings, quality and governance meetings, perinatal mortality risk meetings. We reviewed the minutes of perinatal mortality risk meetings, risk management meetings and speciality meetings from April to June 2023 which took place monthly. The service also provided the minutes from the serious incidents review meetings for June 2023. The meeting minutes showed that the meetings were multidisciplinary, they were well attended and that actions were highlighted and reviewed at each meeting. Outcomes of governance meetings were shared with staff through monthly clinical governance newsletters. This was shared with staff by email and displayed on display boards across the wards.

The Governance team were aware of the risks on the risk register and were involved in reviewing it. The governance team also worked closely with the practice development team to ensure appropriate medicine and safety alerts were shared with staff by newsletters and during rolling half day which is a learning forum open to all clinical staff.

Minutes from the service showed that the divisional triumvirate had a meeting in May 2023 and 2 meetings held in June 2023 however, prior to this the last documented meeting was October 2022. The divisional triumvirate reported that they now planned to meet every 2 weeks which was reflected in the minutes provided for the month of June 2023. Minutes from the divisional triumvirate meeting showed that they discussed operational matters, workforce, culture, people, updates from trust management and risks.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues however, they did not always manage the risks effectively.

The maternity service had a risk register to identify and manage risk to the service. The risk register currently had 41 risks that included insufficient neonatal doctors, the risk to women their babies and staff in relation to staffing levels that fall below establishment, the risk of not having maternity electronic patient record system and concerns raised by

the care quality commission at the last inspection. The document included a risk ID, title, description of each risk, control measures in place, owner, next review date, current rating, and the progress of each risk. However, the progress of the risks had not been updated since January 2023 therefore, we were not assured that the risks on the risk register were being managed effectively.

The service participated in the MBRACCE: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK perinatal mortality surveillance 2021 audit. The result showed the stabilised and adjusted perinatal mortality rate at the trust was more than 5% higher than the comparator group average for all births and for births excluding congenital anomalies.

We received minutes from the Perinatal Mortality Review Tool (PMRT) meetings for April to June 2023. The trust also provided a perinatal mortality review summary report which was generated following mortality carried out using the national PMRT. This showed 1 review had been completed and 3 reviews were in progress for the period of January to June 2023. The minutes from the PMRT meetings showed that the cases were reviewed with midwifery and obstetric input. There was also representation from neonatology.

Data shared by the trust showed the service was compliant with the Ockenden Immediate and Essential Actions (IEA). We also saw the service's current position for compliance with Saving Babies' Lives Care Bundle and NHS resolution: maternity incentive schemes. As of May 2023, the service was working towards/ partially compliant for both schemes. The Quality and Safety Manager had oversight of this with input from the Clinical Director of Obstetrics.

The service displayed the maternity dashboard and performance in all clinical areas. The maternity dashboard helps to identify where the trust is performing better or worse than expected using a red, amber, green RAG rating. We reviewed the maternity dashboard from June 2022 to May 2023. The service was not meeting the target for induction of labour, births on the midwife led unit (however there had been an upwards trajectory from 4.7% in October 2022 to 14.10% in May 2023), births between 23+6 and 36+6 weeks and 3rd/ 4th degree tears. However, the dashboard showed that the service was meeting the target on vaginal births after previous caesarean section, post-partum haemorrhage, smoking at booking and delivery, term admissions to the neonatal unit and breastfeeding at discharge.

Information Management

The service collected 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.

The service had clear performance measures such as key performance indicators (KPI) and local/ national audits which were reported and monitored. These included the MBRRACE-UK audit, maternity dashboard and friends and family test (FFT) results. Performance results and clinical updates were displayed across the unit for staff and discussed at service, divisional and board level to improve care and patient outcomes.

Women, relatives, and carers knew how to complain and raise concerns. The service clearly displayed information on how to raise concerns on the maternity ward and reported having a good relationship with the trust Patient Advice and Liaisons Service (PALS).

The service used a combination of electronic and paper records, the trust had highlighted this as a risk as it meant that staff were unable to remotely access records or document management plans. The service was planning to go paper free by February 2023 but implementation of this is delayed until February 2024.

Maternity

Engagement

Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

Managers engaged with staff through newsletters, social media, display boards and during learning forums. The head of midwifery had a weekly open-door session that all staff could attend individually with the choice of meeting either in person, by teams, telephone, or text message. The director of midwifery also held a drop-in session by teams in which all staff could attend to receive updates around quality improvement and raise any concerns.

The service engaged well with stakeholders such as the Care Quality Commission (CQC), NHS England and Healthcare Safety Investigation Branch (HSIB). The service was also actively involved with the Local Maternity System group (LMS). The service had a LMNS project lead who actively worked as a link between the service and the LMNS.

The maternity service had an active and functioning Maternity Voices Partnership (MVP) team that met regularly and worked closely with the trust consultant midwife and LMNS project lead midwife. The MVP worked with maternity services to bridge the gap with women that could be harder to reach. They used social media platforms to connect with women, raise awareness, and act as their advocates.

The MVP had a 2023 activity plan in which we reviewed. The MVP service engaged with women via social media, feedback questionnaires, listening events and parent and baby fairs with a focus on gathering more insight from ethnic minorities women. They also 'walked the patch' which involved going into hospital and talking to women to gain their feedback first hand. They then fed this back to the matrons on the unit. The MVP were also involved in reviewing trust guidelines and sharing communication with women. Communication around the last CQC inspection was a priority for the MVP as the rating caused anxiety amongst women. The team shared communication around the actions the service were implementing in response to the report to ease the anxiety of women. They also launched a campaign called 'Buy Your Midwife a Cuppa' which involved women donating money to buy midwives a hot drink to show their appreciation. The response from staff was hugely positive and helped staff morale.

Both the MVP chair and consultant midwife demonstrated good understanding of the population served by the service and the issues they faced.

The maternity friends and family test (FFT) results for the period of January to April 2023 showed an overall satisfaction rate of 98.15% in January, 46.15% in February, 97.14% in March and 95.45% in April. This was set against the trust target of 93%.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, there was no evidence of research at the present time.

Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research, and innovation.

There was a commitment to safety, learning and improvement, which, required a firm commitment to supporting staff through induction, training, and processes of review. This created a culture of learning and improvement rather than defensiveness and blame.

Maternity

The trust reported research projects that were ongoing which included Feed 1 trial, HARMONIE study, SINEPOST study and others. Staff reported that the service had quality improvement projects underway, this included the cultural work being done in the service and the band 6 development programme. The governance team reported that it is now much easier to get approval for quality improvement projects and this will now be a focus.

The service had approved a continuity service for women who identify with autism regardless of if they have been officially diagnosed. This project is being overseen by the LMNS project lead midwife and will allow women with autism to get extra support.