Barnsley Hospital NHS Foundation Trust

Barnsley Hospital

Quality Report

Gawber Road
Barnsley, S75 2EP
Tel:01226 730000
Website: www.barnsleyhospital.nhs.uk

Date of inspection visit: 14 to 17 and 26 July 2015
Date of publication: 13/01/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Good
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Barnsley NHS Foundation Trust provides a range of acute hospital health services at Barnsley Hospital. The trust serves the Barnsley area which has an estimated population of 236,000. In total the trust had 359 beds. Barnsley is in the 20% most deprived areas in the country.

We inspected Barnsley NHS Foundation Trust as part of our comprehensive inspection programme. We carried out an announced inspection of hospital between 14 -17 and July 2015. In addition, an unannounced inspection was carried out on 26 July 2015. The purpose of the unannounced inspection was to look at the Emergency department and medical wards at the weekend.

Overall, we rated this trust as requires improvement and we noted some outstanding practice and innovation.

However, improvements were needed to ensure that services were safe and well-led.

Our key findings were as follows:

- Staffing levels were planned and monitored. There were some shortages; most notably there was a shortage of children's nurses at the trust.
- There had been no cases of hospital acquired MRSA since 2008. The rate of hospital acquired C.difficile was within the trust's trajectory.
- The adjusted mortality rates had reduced significantly in the trust over the past year. Analysis across a range of indicators showed there was no evidence of risk regarding mortality.
- The trust performed mostly above the 95% standard for percentage of patients waiting to be seen within four hours since May 2014, with the exception of December 2014 and May 2015.
- Assessments of patient's nutritional needs were recorded. Across the trust, we found patients were supported to eat and drink.
- Following transfer to a new IT appointment system, the trust had discovered a backlog of outpatients who potentially needed a follow-up appointment. Work was underway to clinically validate the list and ensure all relevant patients were offered a review appointment by 31 January 2016.
- Leadership at the trust had been subject to significant change over the last 20 months. Staff spoke positively about the trust leadership.

We saw several areas of outstanding practice including:

- The uro-gynaecology nurse specialist had introduced "percutaneous tibial nerve stimulation for overactive bladders" following a successful business case to the trust. This improved symptoms for patients and made cost savings for the trust. Audit data from 2014 demonstrated improved outcomes for women.
- The dermatology service described a tele-dermatology project they were providing in conjunction with the local Clinical Commissioning Group whereby some GP practices could send in pictures of patient problems and receive an electronic treatment plan within three days. The service had also recently been approved to provide private cosmetic procedures (such as Botox) and was seeking to use these as a revenue generator for the trust.
- We saw that staff in the breast clinic had developed a simple tool for patients to remind them to take their medication. The staff had developed a card, covered in a picture of brightly coloured tablets that could be hung from a door handle at their home such as a kitchen cupboard. This had been shared at an internal nursing conference and staff in other areas of the trust were using for their patients.
- A midwife had won the prestigious 2015 Royal College of Midwifery's (RCM) Philips AVENT National Award for Innovation in Midwifery. They created a secure staff social networking site called 'Ward-book' which was used by

midwifery staff at the hospital to communicate important messages across the department. Each week the Head of Midwifery wrote a departmental update which gave staff the opportunity to feedback in real-time and this was posted on the system. The Ward-book was used as a virtual notice board. It helped communication between managers and staff and helped improve the outcomes for patient care.
- Pharmacy robots had been introduced at the trust in July 2014. This has reduced errors and increased staff capacity.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- ensure all patients attending the emergency department, have an initial assessment undertaken by a suitably qualified healthcare professional in accordance with national guidance.
- ensure that children attending the hospital are cared for by nursing staff who have the qualifications, competence, skill and experience to do so safely.
- ensure oxygen is prescribed in line with national guidance.
- ensure that medicines reconciliation is completed in 24hrs and meets local and NICE guidance.
- ensure compliance with the five steps for safer surgery.
- ensure suitable patients are offered laparoscopic colorectal surgery in accordance with NICE guidance.
- address the backlog of outpatient follow-ups.

In addition the trust should:

- review processes to enable staff to receive mandatory training on a regular basis.
- confirm guidance to staff, based on best practice, as to the recording of verbal consent by patients in the clinical record.
- review sign language interpretation availability for patients whose main or only means of communication is British Sign Language (BSL).
- monitor the consistent use of the sepsis screening tool and timely completion of the interventions on the sepsis pathway.
- review the out of hours medical staffing provision within medicine.
- work with local services to reduce the number of medical outliers and medically fit patients in hospital to improve patient flow and reduce bed occupancy.
- work with medical consultants to implement a robust system of timely mortality review.
- work with ward staff to improve the understanding of the specific requirements associate with Duty of Candour.
- undertake regular infection prevention and control ward audits.
- improve the quality of medical record keeping and include this in the audit programme.
- monitor and reduce the number of out of hours bed moves.
- undertake a review of historic serious incidents and recommendations made to ensure learning is carried forward in to current areas of clinical practice
- provide appropriate access to IT systems for appropriate staff, including temporary staff.
- ensure medicines are stored at the correct temperature.
- review medical note taking including prescription documentation.
- review infection prevention and control practices within surgical areas including clinical stock rotation, environmental cleanliness and the changing rooms within main theatres environment
- ensure there are sufficient numbers of staff with suitable qualifications, competence, skill and experience to provide care to patients within trauma and orthopaedics.
- continue to take action to ensure the urology service meets patient need.
- improve compliance with national emergency laparotomy audit.
- undertake a full assessment of the area currently used for lucentis and its environmental and engineering suitability for service provision in the current facility.

Summary of findings

- consider the amount of sessions for ward rounds for surgeons.
- consider undertaking a review of waiting facilities within theatre reception area.
- store records in line with data protection requirements.
- meet the government targets for antenatal screening between 10 and 12 weeks gestation relating to foetal abnormality.
- consider monitoring of waiting times in the CAU.
- support incident reporting and ensure timely response to investigations and clear lines of communication to staff in order that lessons are learnt in a transparent manner.
- consider improving the environment in the POPD waiting area.
- review the safe storage of patient records in the children's outpatients department.
- take action so advanced care planning and preferred place of care are considered by the MDT in a timely way in order that patients wishes at end of life can be met.
- quality assure radiology reports generated by voice recognition.
- take action to improve cancellation and DNA rates.
- take action regarding the visibility of patient information on their electronic check in screens.
- review the seating arrangements in the phlebotomy department and main outpatients' areas to provide seating for patients with differing needs.
- review the facilities and waiting areas for inpatients to improve the maintenance of privacy and dignity.
- review processes for reporting of x-ray films and CT scans to ensure acceptable and consistent reporting times are achieved.
- include the quality of record keeping in medical records and the use of WHO checklists in its audit programme.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The emergency department operated a triage system to assess patients arriving by ambulance or 'majors'. However, they did not have a system for triage or initial assessment of patients who did not arrive by ambulance. There were insufficient numbers of children's nurses to have a children's nurse on each shift. The trust had not met the 90% target of all staff in the emergency department having received mandatory training, including safeguarding training, in the last year. There was a high usage of bank and agency staff. The management team had not identified the lack of initial clinical assessment or triage as a risk. Limited audits of nursing care were undertaken. There was a system of governance, risk management and quality measurement, aligned with a senior management leadership structure but this had not identified some key risks. There was limited evidence of engagement with the public. The nursing leadership in the emergency department and clinical decisions unit was in a period of change. Staff reported an open culture and there were regular meetings. We found that pain scores were not being recorded. There were discrepancies between staff as to whether verbal consent should be recorded in the medical record. Although there was a good system in place for the training of medical staff there was no evidence of regular clinical supervision for trained nursing staff that were not new to the department. The service followed best practice guidelines in the care and treatment of patients and took part in patient outcome audits and reviews. There was good evidence of multidisciplinary working and an effective seven day service. Patients were cared for in a compassionate and understanding manner and treated with respect. Ninety percent of the patients who completed the "friends and family" test between January and March 2015 recommended the emergency department. The majority of patients we spoke with told us that communication was good and that they were offered emotional support.

Summary of findings

The trust performed mostly above the 95% standard for percentage of patients waiting to be seen within four hours since May 2014, with the exception of December 2014 and May 2015. This was an improvement in the previous years. They were also better than other emergency departments with regard to ambulance handover times. The service met people's individual needs except in the case of the provision of professional sign language support for patients who were profoundly deaf who could not communicate in spoken English.

Medical care

Good

We rated this service as good.
We saw evidence of learning from incidents locally and across CBU's. Wards were clean and tidy and equipment was available for staff to use and checked regularly. People's care and treatment was planned and delivered in line with current evidence based guidance and there was participation in local and national audits.
Feedback from patients, those close to them and stakeholders was positive about the way staff treated people.
There was a clear statement of vision and values driven by quality and safety. Staff in all areas understood the vision and values. The levels of governance within the CBU functioned effectively and financial pressures were managed so that they did not compromise quality of care. The management team promoted staff empowerment and a culture where the benefit of raising concerns was valued. Improvement and innovation was supported.
Services were planned to meet the needs of local people. There was an openness and transparency in how complaints are dealt with. Informal complaints were logged and reported in the CBU. The bed occupancy was higher than the national average. There were a high number of medical outliers in July 2015 and the trust opened additional medical bed capacity during times of operational pressure.
We found evidence of incomplete action plans of serious incident investigations. We saw breaches in infection control practices during our inspection and there was concern about medicines

management. We found that some staff groups were unable to access patients' full clinical record. There was a clinical risk that patients were not fully assessed and treated for sepsis.
Some concerns had been raised prior to our inspection regarding the care of patients with complex needs.

Surgery **Requires improvement** 

Significant concerns were highlighted with the trust in relation to suitable patients with colorectal cancer not being offered laparoscopic colorectal surgery; the trust was the only trust in the country to report 0% in the data tables for offering laparoscopic surgery to suitable patients.
Non-compliance with national emergency laparotomy audit data was also noted and a lack in trained laparoscopic competent medical staff.
There was learning from incidents; however, this wasn't fully embedded in all investigations. There were concerns about clinical stock being out of date on one ward and drug fridge temperatures were inaccurately recorded on three ward areas. Interim measures were in place due to the condition of some drugs fridges within theatres which were awaiting replacement.
We found evidence of junior and locum medical staff sharing passwords for IT systems. Immediate action was taken to address this. Gaps were found in medical records.
Mandatory training rates were low for surgical medical staff. The World Health Organisation (WHO) five steps for safer surgery process was inconsistently used at Barnsley hospital. Nurse staffing levels in trauma and orthopaedics were lower than the established safe levels; however, staff were taking appropriate action to recruit to vacant posts.
Staffing on the escalation ward during the night raised concerns because of the mixed competence of staff from different areas in the trust.
During the inspection there was no clinical lead for surgery in post. Recommendations made in serious incident reports were reviewed in historic serious incidents these had not been consistently acted

Summary of findings

upon and the similar incidents had occurred since. The lack of offering laparoscopic colorectal surgery to patients at Barnsley hospital had not been addressed. Public engagement was limited. Departmental policies were based on nationally recognised best practice guidance. Enhanced recovery pathways for patients undergoing hip and knee replacement procedures were implemented to improve the patient experience and outcomes. Protected mealtimes and a duty "snack monitor" had been implemented to improve nutrition on wards and departments.

Throughout the inspection we saw positive, kind and caring interactions on the wards between patients and staff. Patients spoke positively about the standards of care they had received.

There was access to a specialised dementia nurse and learning disability nurse. We saw examples where lessons had been learned and actions taken following complaints.

There were effective systems in place to deep clean equipment regularly. The wards and departments had systems in place to safeguard vulnerable adults. Mortality rates within orthopaedics were below the national average.

Surgical elective and non-elective length of stay data was better in the trust than the England average. The number of patients not treated within 28 days was good and only one patient since 2011 had not been treated within 28 days from cancellation day. During the reporting period April 2013 to November 2014, the trust performed better than the standard and the England average for the 18 weeks from referral to treatment target. The percentage of patients (with all cancers) waiting less than 31 days and 62 days from urgent GP referral to first definitive treatment was better than the England averages. Breaches of national waiting time targets including the cancer waits were occurring in some specialties. Increases in non-elective surgical activity and medical admissions have led to an increasing number of medical and surgical outliers.

A clear vision and strategy for surgical services and clear governance structures within the business units was apparent. Nursing leadership at ward

Summary of findings

level was good, with positive interactions between staff, ward managers and matrons noted. Some good areas of innovation, improvement and sustainability were noted.

Critical care

Good

We rated the care delivered by the intensive therapy (ITU) and the surgical high dependency (SHDU) units as good.
Staff used the trust policies and procedures when reporting incidents. Details of incidents and the lessons learnt were shared among staff and action was taken to prevent or minimise the occurrence of similar incidents. There was a multidisciplinary team (MDT) approach to reviews of incidents, morbidity and mortality. Staff attended organisational inductions, mandatory training which included safeguarding and infection prevention and control.
The Safety Thermometer results between April and June 2015 showed the unit had performed better than the nationally expected targets. The units had sufficient supplies of equipment and cleaning products to maintain safety. Equipment was cleaned in line with the department of health infection control policy. Staff we spoke with were aware of the major incident policy and their role in managing it.
An outreach team made up of a consultant, a nurse, a physiotherapist and a healthcare assistant supported patients when they were transferred from ITU or SHDU to wards. They also assessed deteriorating patients within the hospital and decided whether patients would be appropriately cared for in either SHDU or ITU.An outreach team supported patients when they were transferred from ITU or SHDU to wards. They also assessed deteriorating patients within the hospital and decided whether patients would be appropriately cared for in either SHDU or ITU. A multidisciplinary team approach meant care was delivered in a more co-ordinated and consistent way which had a positive impact on patient progress and the length of time spent on the unit.
The computerised system used by nursing staff was seen as onerous, time consuming and unreliable. Access to information for bank and agency professionals was available after appropriate

training. Management told us that there was a system in place to provide agency nurses with their own unique access login. However to maintain safety this automatically expired after 30 days.There was good understanding of the Mental Capacity Act and its application.
Patients and relatives we spoke with told us that they would recommend this service to others. We observed examples of good compassionate care and treatment practices by staff. Staff had implemented the use of 'patient's diaries' on ITU. Relatives had access to a bereavement service and enquiries about organ donation were attended to by a specialist nurse.
The ITU and SHDU services worked collaboratively with the surrounding NHS providers to meet the needs of the local population. Patients discharged from ITU and SHDU had access to a follow-up clinic. Staff were proud to work at the Barnsley hospital and they understood the priorities.
There was a clear structure within the unit for doctors, nurses and the multidisciplinary staff. They demonstrated their roles and their specific responsibilities during our inspection so that patients received consistent care.
We found that 24 hour intensivist cover was not provided for ITU in accordance with Core Standards for Intensive Care Units guidance (2013), however plans were in place to address this. On six occasions over two weeks the lead nurse and the clinical educator were counted in the numbers to ensure safe staffing levels. The fill rate of shifts for registered nurses was 80-85% during days and 93 -97% at nights over the previous three months.

Maternity and gynaecology

Good

Staff were encouraged to report incidents and systems were in place following investigation to help rapidly disseminate learning. Both nursing and medical staffing levels were in line with national guidelines. The service was 90% compliant for mandatory training overall and this was in line with the trust target. We saw evidence of how they had recently addressed non- compliance in safeguarding supervision training, and although there were some areas which did not meet the trust target, they had identified further training days to address these shortfalls. We found an unlocked

cupboard of diaries which contained confidential information. This was brought to the attention of the trust who acted immediately and addressed the situation.
Women received care according to professional best practice clinical guidelines. The unit provided individualised care to people using the service and they were treated with privacy, dignity and respect. The trust had a specialist midwives in bereavement who provided support, compassion and care for women and their families in time of bereavement.
The trust dashboard showed they were not always meeting their key performance indicators (KPI's) for antenatal bookings for women to be seen before 10 and 12 weeks of pregnancy. The trust target was 90% and the information showed, between April 2014 and February 2015, the bookings for women to be seen before 10 weeks ranged between 53.3% and 81.2%. Women booking before 12 weeks ranged between 72.4% and 96.9%. Trust managers had identified that there were data extraction issues following implementation of the new maternity information system. A manual audit showed the target was met for the 12 week bookings, but not the 10 week antenatal bookings. An action plan had been written to address the issues which included a review and completion dates. A supervisor of midwives was available for all women using the service and feedback/debriefing was offered to patients who had not followed their choice of care pathway.
The service was managed by a cohesive team who understood the challenges of providing good, quality care. They were aware of their shortfalls and had taken steps to address them. Staff were encouraged to drive service improvement and used creative and innovative ways to try to ensure they met the needs of women who used the service and the organisation.

Services for children and young people

Requires improvement

Overall we rated the service as requires improvement. We rated safety and well-led as requiring improvement. We rated effectiveness, responsive and caring as good.
There were significant gaps in medical and nursing staffing which had led to high usage of locum staff and the regular movement of nursing staff across all

Summary of findings

the areas attended by children and young people to attempt to meet the service needs. In the POPD, the CCN team records were not stored in secure cupboards which presented an information governance risk.

The service had a system for reporting incidents; however, there did not appear to be a culture of reporting incidents and complaints. Data provided by the trust identified incidents which had passed the date by which they should have been investigated and reported on. Senior management staff we spoke with told us there had been challenges feeding back from incident reporting and were looking at improving feedback mechanisms.

There were outstanding follow up outpatient appointments following a change to record keeping. These records were being assessed for follow up appointments. Waiting times on the CAU were long for some children.

There was a board level Executive Director for Children's Services, as required by the National Service Framework for Children.

The service had processes in place to implement NICE guidelines and other best practice guidelines, and the service participated in national audits. The service implemented local audits and had developed a local safety thermometer tool for paediatric services. The service had care pathways in place, but some policies were out of date. There was evidence of multidisciplinary working across all the children's services; children and families were provided with timely and appropriate advice.

The children's services worked together to promote early discharge and reduce readmissions. The children's service had responded to feedback with a 'you said – we did' project which is displayed on the wards. The play team work across the trust providing support to children in any department of the hospital, the sensory equipment was mobile which enabled them to also meet the needs of children with special needs. There was a pathway to promote a safe transition to adult services for children.

Throughout our inspection we saw children and their families were treated with dignity, respect and compassion. We heard staff using language that

was appropriate to children's age and level of understanding. All the children and their families we spoke with were happy with the care and support provided by the staff. Parents felt confident when leaving their child on the wards that their child would be safe and well cared for.

End of life care

Good

We rated end of life care services at Barnsley hospital as good. There were some outstanding examples of compassionate care. There were areas where there was potential for improvement and these had been identified by the trust. We saw evidence that work was in progress to further improve the service.

The end of life service was led by committed leaders. There was good visibility of senior staff and end of life care was high on the agenda of the trust. The trust's end of life steering group, which was responsible for providing clinical leadership and implementation of the service, told us they provided assurance to the trust. Procedures had been developed to support a smooth transition of care from hospital to the community. There were strong links with community teams.

There had been 550 referrals to the specialist palliative care team from April 2014 to March 2015. This had increased from 480 referrals the year before. We saw 100% of the referrals made to the team from April to June 2015 were seen within 24 hours. Most of the referrals (85%) were for cancer related diagnosis and the palliative care team were aiming to address the imbalance by working with other services to reach end stage heart and respiratory failure patients. The AMBER care bundle had been implemented using a rolling programme across medical wards at Barnsley hospital since May 2013. There was a dedicated AMBER care pathway facilitator. The AMBER care bundle is an approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live.

We saw outstanding compassion for patients at the end of life and their families, particularly from the porters, mortuary staff and bereavement officers. Porters told us they looked after deceased patients as if they were their own parents and were committed to caring for them in a dignified manner.

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The mortuary team provided training to a wide range of staff from inside and outside the trust. There were comfortable, sensitively decorated areas for bereaved families; we found that a number of staff in a variety of roles supported them.
During our inspection we found that oxygen was rarely prescribed. The National Patient Safety Agency (NPSA) indicates oxygen should always be prescribed except in emergencies, as there is a potential for serious harm if it is not administered and managed appropriately. We pointed this out to senior managers at the time and immediate action was taken to address this.
We found that advance care planning was rare. If patients brought in a preferred place of care folder into hospital from the community, hospital staff thought it was not relevant, as it was a 'community document'. Senior nurses and doctors told us they did not understand the concept of advance care planning; they thought this could only be done in the community. Some staff told us it was often too late to have care planning discussion with patients by the time it was recognised they were dying. This was reflected when we found three patients on the respiratory ward had become too poorly to be transferred. We found that advance care planning would have prevented these situations and enabled patients to achieve their preferred place of care at the end of life.

Outpatients and diagnostic imaging

Good

Barnsley Hospital NHS Foundation Trust outpatients and imaging departments was judged as good overall. The safe, caring and well-led domains were rated as good with the responsiveness domain found to be requiring improvement. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.
Within the departments, patients received safe care and staff were aware of the actions they should take in case of a major incident. Incidents were reported, investigated appropriately and lessons learned were shared with all staff. The cleanliness and

hygiene in the departments was within acceptable standards, however, there were some areas in need of re-decoration and a lack of appropriate seating for patients with different needs in some areas.
Staff were aware of the various policies designed to protect vulnerable adults and children and we saw good examples of actions taken to address identified concerns.Patients were protected from receiving unsafe treatment as medical records were available 99% of the time and electronic records of diagnostic results, x-ray images and reports and correspondence were also available. The records we looked at were in good order and entries were legible; however, some areas of record keeping practice required improvement.
Workload within outpatients was predictable due to the scheduling of clinics and availability of clinic lists in advance and nurse staffing levels were based on the number of clinics and expected number of patients. There were some vacant radiologist and radiographer posts; however, there were mitigations in place to ensure gaps in service were covered.
Care and treatment in outpatients and diagnostic imaging was evidence-based and performance targets consistently met. The staff working in outpatients and diagnostic imaging departments were competent, received an annual appraisal and there was evidence of multidisciplinary working across teams and local networks. Nursing, imaging, and medical staff understood their roles and responsibility regarding consent and the application of the Mental Capacity Act.
Staff undertook regular audits in imaging and pathology departments regarding quality assurance to check practice against national standards and action plans were put in place to make improvements when necessary. We found that some imaging reports contained mistakes due to the voice recognition system that generated the reports. We were told that no formal audit was in place to monitor these errors, but that clinicians highlighted errors in reports within their discrepancy audits.Outpatient clinics ran every weekday, occasionally at weekends and on Thursday evenings. Imaging services for inpatients were available seven days a week.

Summary of findings

During the inspection, we saw and were told by patients that staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey. Patients told us they were given all of the information they needed, were given sufficient time and were encouraged to ask questions to ensure understanding. Patients were able to make informed decisions about the treatment they received and there were services in place to emotionally support patients and their families. Confidentiality was maintained in all of the areas we visited.

Areas of good practice included mechanisms to ensure that services were able to meet the individual needs of patients such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems in place to record concerns and complaints, review these and take action to improve patients' experience.

Staff were focussed on delivering the best possible experience for all of their patients.

Staff and managers had a vision for the future of the departments and were aware of the risks and challenges. Managers at all levels were active, available and approachable to staff. Staff felt supported and were able to develop to improve their practice. Regular meetings took place where all staff participated and were confident to talk about ideas and sharing of good news as well as anticipated problems. There was an open and supportive culture where lessons were learnt and practice changes resulting from incidents and complaints were discussed.

The department was supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments. Staff were centred on delivering a good patient experience, they said that they felt proud to work for the trust and that they provided a good service to patients.

After moving to the new electronic patient record system in October 2014, the trust had identified in June 2015 that 23,557 patients were being held on a review list and who may not have been provided with follow up appointments. Immediate validation of the list reduced this to 7,980 patients overdue an

appointment to end August 2015. Due to the change in processing the trust was carrying a backlog of about 2,000 outpatient outcomes per month; these were all reconciled by the end of each month. A further 9,613 patients appeared to have an open patient pathway, however these patients were discovered to have multiple pathways opened in error and the duplicates were removed from the system early into the validation process. Work was underway to ensure all relevant patients were offered a review appointment by 30th November with all patients seen by 31 January 2016; however, this was rated as a red risk by the trust, which indicated the potential patient safety risk associated with missed appointments. It was unknown at the time of inspection whether any harm had occurred to patients as a result of this situation, however, there was a risk that there may have been delayed treatment or diagnosis.
There were relatively high rates of cancelled clinic appointments and patients who did not attend their appointments.

Barnsley Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Barnsley Hospital

Barnsley Hospital is a district general hospital. The trust was authorised as a foundation trust by Monitor in 2005.

The hospital provided a full range of hospital services, including an emergency department, critical care, and general medicine, including elderly care, general surgery, paediatrics and maternity care. It had 359 beds including 13 critical care beds.

The trust served the Barnsley area which had an estimated population of 236,000. The population had a similar age group breakdown to the England average. There was a much lower proportion of black, Asian and minority ethnic (BAME) residents in Barnsley with 4% BAME residents compared to an England average of 14.6%.

Barnsley Local Authority lay in the bottom quintile in the index of multiple deprivation when compared to other local authorities. This signified that the area was in the 20% most deprived areas in the country. The health profile showed a number of indicators, such as life expectancy, smoking related deaths and levels of obesity were worse than the national average.

We inspected Barnsley NHS Foundation Trust as part of our comprehensive inspection programme. We carried out an announced inspection of hospital between 14 to17 July 2015. In addition, an unannounced inspection was carried out on 26 July 2015. We inspected urgent & emergency services, medical care (including older people's care), surgery, critical care, maternity and gynaecology, services for children and young people, end of life care and outpatients and diagnostic imaging.

Our inspection team

Our inspection team was led by:

Chair: Jan Ditheridge, Chief Executive, Shropshire Community Health NHS Trust.

Inspection Manager: Cathy Winn, Care Quality Commission

The team included CQC inspectors, including a pharmacist inspector, and a variety of specialists including consultant surgeons, medical consultant, a consultant paediatrician, consultant intensivist, a student nurse, two midwives, two executive directors, a safeguarding lead, senior nurses including a children's nurse. We were also supported by two experts by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before our inspection we reviewed a wide range of information about Barnsley Hospital and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team. We held a listening event in Barnsley on 13 July 2015 where members of the public shared their views and experiences of the trust. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection of Barnsley Hospital took place between 14 and 17 July 2015. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists and pharmacists. We also spoke with staff individually as requested. We talked with patients and staff from all the clinical areas including outpatient's services. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 26 July 2015 at Barnsley Hospital. The purpose of our unannounced inspection was to look at the Emergency department and medical wards at the weekend.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment delivered by the trust.

Facts and data about Barnsley Hospital

Data from March 2015 showed Barnsley Hospital had 359 beds including 33 maternity and 13 critical care beds. There were approximately 2556 whole time equivalent staff members including over 230 medical staff and 862 nursing staff.

The trust had total revenue of over £171 million in 2014/15. Its full costs were over £183 million and it had a deficit of over £11 million.

During 2014/15 there were 62,112 inpatient admissions, 268,149 outpatient attendances and the A&E department saw 79,055 patients.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The emergency department at Barnsley Hospital saw 79,052 patients between April 2014 and March 2015. This was an average of 217 patients a day. The percentage of patients aged under 16 was 21%.

Of the total number of patients attending between April and December 2014, 26% of these resulted in an admission to hospital, which was above the England average of 21.9%.

The department treated all emergencies except for major trauma. The emergency department was open 24 hours a day, seven days a week.

The department was divided into areas for the treatment of minor illness and injury, a majors' treatment area and a resuscitation room. There was also a children's area and a room for patients attending in a mental health crisis. In the minors' area there was one treatment room, although the trust told us this was to increase to three. There were five further cubicles for minors' stream patients. The majors' area consisted of 10 cubicles, one of which was a specialist eye cubicle. The resuscitation area had five bays, one of which was used for the treatment of children. The children's area had seven cubicles, one of which was for adolescents, and one which was a high dependency treatment area. There was a 10 bedded clinical decisions unit (CDU) adjacent to the ED and managed by the department. It was used for patients who were waiting for a decision as to whether to be admitted or discharged from hospital.

During our inspection, we spoke to approximately 40 patients and relatives, and 57 members of staff. We observed care and treatment being undertaken. We also reviewed clinical records, and policies and procedures.

Urgent and emergency services

Summary of findings

The emergency department operated a triage system to assess patients arriving by ambulance or 'majors'. However, they did not have a system for triage or initial assessment of patients who did not arrive by ambulance. There were insufficient numbers of children's nurses to have a children's nurse on each shift. The trust had not met the 90% target of all staff in the emergency department having received mandatory training, including safeguarding training, in the last year. There was a high usage of bank and agency staff.

The management team had not identified the lack of initial clinical assessment or triage as a risk. Limited audits of nursing care were undertaken. There was a system of governance, risk management and quality measurement, aligned with a senior management leadership structure but this had not identified some key risks. There was limited evidence of engagement with the public.

The nursing leadership in the emergency department and clinical decisions unit was in a period of change. Staff reported an open culture and there were regular meetings. We found that pain scores were not being recorded. There were discrepancies between staff as to whether verbal consent should be recorded in the medical record. Although there was a good system in place for the training of medical staff there was no evidence of regular clinical supervision for trained nursing staff that were not new to the department. The service followed best practice guidelines in the care and treatment of patients and took part in patient outcome audits and reviews. There was good evidence of multidisciplinary working and an effective seven day service.

Patients were cared for in a compassionate and understanding manner and treated with respect. Ninety percent of the patients who completed the "friends and family" test between January and March 2015 recommended the emergency department. The majority of patients we spoke with told us that communication was good and that they were offered emotional support.

The trust performed mostly above the 95% standard for percentage of patients waiting to be seen within four hours since May 2014, with the exception of December 2014 and May 2015. This was an improvement in the previous years. They were also better than other emergency departments with regard to ambulance handover times. The service met people's individual needs except in the case of the provision of professional sign language support for patients who were profoundly deaf who could not communicate in spoken English.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The emergency department operated a triage system to assess patients arriving by ambulance or 'majors'. However, they did not have a system for triage or initial assessment of patients who did not arrive by ambulance. This put patients at potential risk of harm.

The trust had not been able to staff the emergency paediatric service with the number of registered children's nurses they had decided was safe. There was a high usage of bank or agency staff.

Documentation on CDU nursing assessments did not cover areas such as nutrition, tissue viability, Waterlow scores or falls assessments.

The trust had not been able to ensure that at least 90% of all staff in the emergency department had received mandatory training, including safeguarding training, in the last year. This breached the trust's internal target, set at 90%.

There were a sufficient number of emergency department consultants.

There was an effective system for the management of incidents. The department was clean with a good presence of domestic cleaning staff. Equipment was clean and well maintained, whilst drugs were appropriately stored and effectively managed.

There was a major incident and chemical, biological and nuclear (CBRN) plan, with major incident and CBRN equipment readily available. The trust had held a number of large multi-agency exercises, which included ED staff.

Incidents

- Staff told us they were aware of the trust's incident reporting system, and told us they knew how to report incidents. They received feedback on the results of any investigations undertaken, and the learning from those investigations.
- We reviewed governance and team meeting minutes which showed that incidents were discussed at clinical governance and team meetings. The clinical governance meetings incorporated mortality and morbidity reviews.
- Between 1 June 2014 and 31 May 2015 the trust reported one unexpected death and two incidents of moderate harm as occurring in the emergency department (ED). There were 905 incidents

where "no harm" was caused; these were 98% of the total.

- The most frequently reported categories of incident were those involving patient care, and those involving infrastructure. Incidents that involved patient care were 59% of the total. The most common incident was patients arriving in ED with pressure sores. Those that involved infrastructure; which included staffing, facilities and the environment, were 16%.

Duty of Candour

- Staff we spoke with were aware of the trust's duty to openly investigate moderate and severe patient safety incidents, and keep patients and their relatives informed of the progress of their investigations, and the final results of those investigations.

Cleanliness, infection control and hygiene

- We found the department was clean, as was clinical and non-clinical equipment, including toys in the children's area.
- During our visit cleaning staff were seen cleaning the department and the equipment in it. This took place according to cleaning schedules, and we found cleaning taking place even at busy times.
- The last hand hygiene audit, undertaken in April 2015, showed a compliance rate of 94% out of a total of 50 observations.
- Audits by the trust for the period January – March 2015 showed 100% compliance with the cleaning of equipment following use on a patient. The audit looked at both patients who had a confirmed healthcare associated infection (HCAI) and patients who did not.
- In the trust as a whole, there were no incidents of hospital-acquired MRSA (methicillin-resistant staphylococcus aureus) infection since 2011. There were no incidents of C-Diff (clostridium difficile) infection in May 2015, and one incident in June.
- Handwashing facilities were available and we saw staff wash their hands and use hand gel in between attending to patients. Personal protective equipment such as gloves and aprons was available and we observed staff followed bare below the elbows policy.

- Over 95% of non-clinical staff had received infection control training whilst an average of 62% of clinical staff had undertaken training. This was against a trust compliance target of 90%.

Environment and equipment

- We found that resuscitation equipment was checked at least once a day and after every usage to ensure it was in working order and that drugs and equipment were in date, and ready for immediate use.
- Portable appliance testing (PAT) had been done on plugs and other electrical equipment, and stickers were visible and in date.
- Equipment was clean and ready for use, with manufacturers' instructions readily available, We examined non-invasive ventilation equipment that was available in the resuscitation area. The machines and face masks were clean and in date. The electrical equipment had also been PAT tested. The single use elements of the equipment were identified as such, and there was a stock of replacement equipment easily available. National guidelines were available, in paper form and on the trust's intranet, for the use of the equipment.
- Staff told us there was sufficient equipment available on both ED and CDU to meet the needs of patients. Staff told us they were encouraged to report any concerns about equipment so that they could be speedily remedied.
- Security arrangements were in place that included cover by security guards and a system of CCTV monitors. Although there was free access for patients this was curtailed at night and the access could be fully controlled during an emergency.

Medicines

- There were electronic medicines' storage cupboards in ED and the CDU operated by a fingerprint locking mechanism.
- Whilst visiting the CDU we observed pharmacy staff undertaking a medicines' reconciliation audit. The reconciliation was undertaken from a team from the main trust pharmacy department. This was undertaken on a regular basis in CDU and in ED.
- Staff told us that medicines' storage worked well except in the case of agency nurses who did not always have immediate access. There was a system in place to provide agency nurses with their own unique access login to the medicine cabinet. This automatically expired after 30 days.
- We found that controlled drugs were correctly stored and administered. Appropriate records were kept including a record of the disposal of out of date drugs.
- Drugs' fridges were temperature controlled and the temperatures were regularly recorded in line with recommended guidelines. The recorded temperatures were at the correct levels.

Records

- There were two electronic patient management and electronic patient management systems being used at the time of our visit. Although the trust were in the process of bringing in a new system the department was still using their previous electronic patient management system, to measure and report on access and flow.
- All staff were provided with smart cards to access the system; this included bank and agency staff
- Patient records were prepared by the department for the transfer of patients to the ward so that a full set of notes accompanied each patient when they transferred to the ward.
- We reviewed five sets of clinical records in the minors' area and found that in only one case had a pain score been recorded. Other areas of the documentation were completed appropriately and the NEWS (national early warning scores) were accurate and comprehensive.
- In the majors' area where we reviewed five sets of records, we found the pain scores had not been recorded in any of these records. Other areas of the documentation were completed appropriately, including NEWS scores, apart from minor omissions on one of the records.

Safeguarding

- Staff were aware of how to report safeguarding incidents on the electronic incident reporting system. They were also aware of the processes for the reporting and investigation of suspected safeguarding incidents.
- We spoke with four staff nurses and a sister about the knowledge and process of safeguarding. They told us they had all received safeguarding training within the last 12 – 24 months and felt confident in their ability to

manage and report safeguarding incidents. They were aware of the process for the reporting of safeguarding suspicions and provided scenario examples of when a person might require safeguarding.

- There were systems in place for the reporting of safeguarding incidents relating to both adults and children. Staff had electronic access to the safeguarding registers for both adults and children, and told us they had a good working relationship with social services safeguarding teams.
- Staff recognised the potential vulnerability of 16-18 year olds in an adult ED setting and set up a system to assess and identify the most appropriate place within ED for the young person to be seen. During our visit staff in the children's area took us through the safeguarding process they were undertaking with regard to a young person who had attended the department.
- CQC undertook a safeguarding and looked after children inspection in November 2014. The final report had recently been received and included recommendations for ED. The trust had an action plan in place which was being implemented and monitored. Safeguarding training was part of mandatory training. Safeguarding adults training had been completed by 42.9% of medical staff, and 75.7% of nursing staff.
- 90.5% of medical staff and 95.7% of nursing staff had completed a safeguarding children (basic awareness) course.
- The trust compliance target was that 90% of all staff should have received training in safeguarding. This target was only achieved for nursing staff who had undertaken the safeguarding children course.

Mandatory training

- Trust records showed that 72.4% of medical staff, and 81.2% of nursing staff had completed their mandatory training.
- The trust target that 90% of staff should have undertaken mandatory training had not been achieved.
- Nursing staff told us that it was sometimes difficult to leave the department to undertake mandatory training and staff who were on part time contracts found this more difficult than full time staff.

Assessing and responding to patient risk

- The emergency department operated a triage system to assess patients arriving by ambulance or 'majors'. However, they did not have a system for triage or initial assessment of patients who did not arrive by ambulance. Receptionists registered patients and contacted a clinician if they believed the patient needed to be seen urgently or required treatment in the major's area. The receptionists had a flowchart to use but had not received any advanced training to make these decisions. We discussed this with staff in ED and senior managers who agreed that trained clinicians should be performing triage or initial assessment.
- Following our visit the trust informed us that they had implemented a system of triage on 30 July 2015.This was performed by Emergency Nurse Practitioners (ENP's), supported by senior ED nursing staff. However, we have not visited the department since these changes and have not been able to corroborate them or judge their sustainability.
- Recognised clinical risk recording tools, such as NEWS (national early warning score) and PEWS (paediatric early warning score), were used to record patients' vital signs, and describe any deterioration in their condition and the actions taken. Both NEWS and PEWS were used in ED whilst NEWS was used in CDU where appropriate.
- We observed staff escalating concerns whenever a patient's condition deteriorated.
- There was also a system for escalating concerns about long waiting times to the rest of the trust so action could be taken throughout the trust. There were bed management meetings and bed and site managers regularly visited the department. The bed management meetings were attended by ED consultants as well as consultants from the medical and care of the elderly teams.
- A sepsis screening and management tool was used to ensure the safe management of sepsis. This was supported by a sticker for the clinical records called "sepsis six" that spelled out the pneumonic "FABULOS" (fluids, antibiotics, blood cultures, urine, lactate and O2 – "sepsis six". We observed the management tool and the sticker being used during the appropriate treatment of patients with sepsis.
- There were also other risk recording tools, used in ED and on CDU where appropriate, for the assessment of patients as well as for the discharge of patients. These included an ambulance handover chart, a SBAR (situation, background, assessment, recommendation) clinical summary and management plan, the fractured neck of femur pathway documentation, the ED SBAR discharge form, the CDU protocol for mobility/care

assessment, and the CDU summary of nursing assistance. There were also treatment cards which included sections for demographics, pain score, allergies, and a prompt for "vulnerable patient protection issues".

- These documents were fit for the purpose for which they were intended apart from on CDU. Documentation on CDU nursing assessments did not cover areas such as nutrition, tissue viability, Waterlow scores or falls assessments. There was no falls risk assessment for a patient on CDU awaiting admission with new onset confusion.
- For high risk mental health referrals the MARAC (multi-agency risk assessment conference) forms were used. There was also a pathway for the management of alcohol and substance misuse, including in patients under the age of 18.
- We observed staff appropriately and effectively using these tools during our time in the department. However, there were occasions when pain scores were not completed fully.

Nursing staffing

- There was a shortage of staff trained to care for children. At the time of our visit there were three registered children's nurses in post. The number of children's nurses required was 9.8 whole time

equivalent (wte) nurses. This meant there was a risk that children were cared for by staff without the relevant knowledge and skills. All staff we spoke with, including senior managers, acknowledged this was a matter for concern.

- On the day we undertook our unannounced visit to the department, there was no registered children's nurse available after 4pm. This meant the children's ED department was staffed by a registered adult nurse. National guidance from the Royal College of Paediatrics and Child Health recommends all emergency departments receiving children have a lead Registered Children's Nurse and sufficient Registered Children's Nurses to provide one per shift.
- Five registered children's nurses had been recruited and were due to commence in September 2015. In addition, four emergency department nurses were undertaking a training course at a local university. Whilst staff were recruited or trained experienced emergency care nurses, who had significant experience of working with children although they did not hold a children's qualification, were rostered to work in the paediatric area.
- Following our inspection the trust informed us that a children's nurse had been seconded to the department from the inpatient children's ward, and were supported by four adult ED nurses with paediatric experience. A new Matron had been appointed for ED who also held the Registered Children's Nurse qualification. In addition, to minimise risk, the opening hours of the paediatric area had been reduced by two hours, with the area closing at 10pm, as opposed to 12am.
- The trust had also secured funding from Health Education England to train a further eight advanced nurse practitioners to support both "Hospital at Night", as well as the ED.
- A recognised staffing tool had not been used to determine staffing requirements in ED and CDU, although staffing requirements were based on historical data.
- The trust provided establishment levels for June 2015 which showed an establishment of 82.46 wte qualified nurses and healthcare assistants (HCA's). There were 77.96 wte in post of which 13.65 wte of these were bank and agency usage. This left a variance against establishment of 4.5 wte.
- All staff we spoke with told us that nurses were leaving the department creating vacancies which it was difficult for the trust to fill. This led to the nurses working extra hours to cover vacant posts. If this was not possible, the trust employed agency nursing staff. Although an effort was made to use agency nurses who had worked in the department before, that was not always possible.
- We noted that agency staff were on duty on all the shifts we observed during our visits to the department.
- Trust figures stated that there was nurse bank or agency usage in ED in December 2014 of 18%. In January 2015 it was 17.1%, in February it was 16.2% whilst in March it was 16%.
- During a handover to the night shift that we attended half the qualified nurses were agency staff.
- On an unannounced visit we made to ED there were eight bank or agency nurses on duty.

- We attended nursing staff handovers where the nurse in-charge of the shift allocated nurses to the various areas of the department. This included ensuring agency staff, if they were new to the department, were placed in the most appropriate areas.
- We spoke with agency nurses who told us they had received an induction; which included a tour of the department, and a review of documentation and the information technology (IT) systems. They were also given electronic key fobs so they could access all areas of the department, although there were occasions when there were not enough of these to give to all agency nurses on duty. These key fobs were signed out at the beginning of the shift and returned at the end.
- The sickness rate for nursing staff in ED was 13% for April 2015 with 32 episodes of sickness, whilst in May 2015 it stood at 12.9% with 22 sickness absences. Over the period June 2014 to May 2015 the cumulative sickness absence rate was 6.5%. This compared with a cumulative rate of 1.2% for medical staff in ED. Nurses we spoke with in ED and CDU confirmed this.

Medical staffing

- There were 8.8 wte consultants in post out of an establishment of 9.8 wte. We were told that the trust were in the process of recruiting another three consultants. When this recruitment was completed the service would meet the College of Emergency Medicine (CEM) recommendation of 10 whole time equivalent (wte) consultants as a minimum in every Emergency Department.
- Of the consultants in post at the time of our inspection there were three who had specialist training in paediatric emergency medicine. The clinical director told us that they were recruiting two more consultants both of whom had the specialist qualification in paediatric emergency medicine.
- There were 2.7 wte specialty doctors in post out of an establishment of 2.7. These were middle grade doctors who were not on a training rotation.
- There were three wte trainee specialist registrars in post out of an establishment of seven wte. The clinical director told us this variance was because of a national shortage of middle grade doctors, which they covered by using locum middle grade doctors. The clinical director, and other ED consultants we spoke with, told us they were satisfied with the standard of locums working in the department. The number of consultants also meant they were able to assist in the middle grade duties.
- There were also two senior house officers and one house officer in post.
- There was consultant presence in ED 14 hours a day, with the rest of the time covered by on-call cover. When consultants were not in the department it was run by a middle grade doctor.
- The CDU was managed by the ED consultants. There was a 9am ward round every day and three medical handovers.

Major incident awareness and training

- We found there was a major incident plan, with sub-plans for CBRN (chemical, biological, radiation and nuclear) incidents. There was also a lead consultant for major incidents and emergency planning.
- There was also a protocol in ED for the reception, isolation and treatment of patients presenting with suspected Ebola.
- There was a designated room which contained decontamination facilities for use during a CBRN incident. This room also contained hazardous material suits, breathing apparatus and other equipment
- There was a management team responsible for the coordination of major incident planning (including CBRN planning), business continuity planning, and security arrangements. They reported to an executive director. They had been responsible for organising desktop exercises in coordination with other stakeholders; including the ambulance service, police, and fire and rescue service.
- The trust had held a number of large multi-agency exercises, which included ED staff.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

The service followed best practice guidelines in the care and treatment of patients and took part in national and medical outcome audits and reviews. There was good evidence of multidisciplinary working and an effective seven day service.

We found that pain relief was provided and nutritional needs were met. .

There was a good system in place for the training of medical staff. All medical staff and 83% of nursing staff had received an appraisal within the last 12 months.

There was limited evidence of both local nursing audits and regular clinical supervision for trained nursing staff.

There were discrepancies between staff as to whether verbal consent should be recorded in the medical record.

Evidence-based care and treatment

- We found the department followed best practice guidelines in the care and treatment of patients. These included those developed by The National Institute of Health and Care Excellence (NICE) and College of Emergency Medicine (CEM).
- The guidance was available to all staff in ED and CDU on "Sharepoint", the electronic intranet that all staff had access to.
- We found admission pathways for patients that included asthma, head injury, chest injury, and other common emergency conditions.

Pain relief

- In the 2014 patient survey of emergency departments, the trust performed about the same as other trusts in questions regarding pain relief.
- There were systems in place for the provision of pain relief to patients.
- We observed the completion of a record of pain scores and the timely provision of pain relief medication to a patient with a fractured neck of femur.
- We asked 13 patients if the issue of pain relief had been discussed with them, and offered where required. All except one patient told us pain relief had been discussed with them and given where appropriate, although this was not always recorded..

Nutrition and hydration

- In the 2014 patient survey of emergency departments, the trust performed about the same as other trusts for patients being able to access suitable food and drink while in the A&E department, if they wanted to.
- We found that patients in the ED and CDU had their nutrition and hydration needs checked by members of the nursing team. In the ED volunteers helped by providing patients with refreshments and whilst we were on the CDU we observed patients receiving nutrition and hydration.

Patient outcomes

- Over the period 2014/15 College of Emergency (CEM) audits were undertaken into initial management of the fitting child, mental health in the department, and assessing for cognitive impairment in older people. These were national audits which benchmarked the department against other emergency departments, and against college standards.
- Results of the audit of the fitting child showed the management according to clinical protocols was in the better other emergency departments, whilst documentation was worse.
- The CEM audit for mental health showed the taking and recording of mental health histories was worse when compared with other emergency departments.
- In the audit into the assessment of cognitive impairment in older people the audit found the department to be worse than expected for the undertaking of a cognitive assessment. However, when a cognitive assessment took place a score of 100% compliance was achieved which was better than expected.
- In 2013/14 a paediatric asthma audit was undertaken. Although areas of good practice were identified there were areas where the department did less well than other comparable emergency departments. These included giving a beta 2 agonist (a drug to treat asthma) within 10 minutes of the patient's attendance, giving

steroids within one hour, and re-measuring the peak expiratory flow rate after giving the beta 2 agonist. In response to these findings the department produced an asthma proforma.

- From April 2014 up until our inspection medical staff had undertaken six audits into records management and aspects of medical care. However, there was no evidence of audits being undertaken into the clinical work undertaken by the nursing staff. Nurses we spoke with could not give examples of audits being undertaken into their work.
- The latest available information showed that the unplanned re-attendance rate for September 2014 was 2.18%, whilst in August it was 2.49%, and 2.74% in July.

Competent staff

- As at 30 June 2015, 83% of nursing staff and all medical staff had received an appraisal within the last 12 months. This was against a trust target of 90%.
- The trust supported staff to undertake further training, for example, registered nurses were undertaking additional training in the care of children to help address the shortfall in children's nurses.
- We found there was no system of clinical supervision for nursing staff within the emergency department. The only form of regular supervision was for newly qualified staff who were new to the department.
- Training was organised by individual staff and managers. There was no clinical educator; however one of the existing band 7 sisters took the lead responsibility for coordinating and organising monthly education and training sessions for the registered nurses.There was a supervision and training programme for trainee medical staff.
- We spoke with a trainee registrar who told us that they had a clinical supervisor with whom they had regular contact. Trainee medical staff had a ten-week training and education programme.
- There was a three week induction programme for all medical staff working in ED.
- All medical trainees had a College supervisor, with extra training support available if required.

Multidisciplinary working

- There was a multidisciplinary approach to bed meetings which were attended by consultants, including from ED, care of the elderly and medicine. Staff we spoke with felt these meetings helped in ensuring the rest of the hospital helped when there were patients who could not be discharged from the department.
- There were links in place for the provision of support from a mental health crisis team, whilst support was provided for people with drug and alcohol problems by a dedicated team. There was also a multi-agency team for staff to refer patients to who had been victims of domestic abuse and violence.
- A frailty team within the hospital worked with staff on the CDU to assist with the care and rehabilitation of the frail and elderly patients and to ensure they did not spend an inappropriate amount of time in ED or CDU.

Seven-day services

- The ED offered a seven-day service with consultant cover in the department for 14 hours a day, with consultants staying until 10pm. There was also on-call consultant cover including during the time when there was no consultant in the department. All the on-call consultants were able to get to the department within 30 minutes of being called. This is in line with national guidance. The College of Emergency Medicine guidance states that when there are 10 consultants in a department there should be 16 hour's consultant cover. We were told that the service would be moving up to 16 hour on-site cover when they had a full complement of consultants.
- Although ED was a seven-day service not all services within or outside of the trust to which patients were referred were-seven day services.
- There was seven-day access to diagnostics and therapy support.
- However, access to the physiotherapy and occupational therapy team dedicated to the emergency care service was reduced because of a shortage of staff. At the time of our visit they worked from 8am – 6pm, as opposed to from 8am – 8pm for which they were commissioned. Although there was an on-call physiotherapist outside of those hours.
- There was a dedicated ED x-ray room available between the hours of 9am – 7pm, seven days' a week. Out-of-hours there were three radiographers on-call for emergencies who saw patients in the main x-ray department. The main x-ray department was based only a short walk from the ED.
- There was portering cover provided seven days a week.

- There was seven day access to a mental health crisis team.

Access to information

- The department used an electronic patient record system that was printed off into hard copy notes when the patient was transferred to the ward.
- Discharge letters were prepared for GP's and there was a multi-agency referral form for patients who required input from mental healthcare professionals, who worked for another trust.
- If staff wanted to access patient advice leaflets, departmental, specialty or NICE guidance they could do so through an electronic departmental intranet called "Sharepoint".

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about consent including the Gillick Competency guidelines, in relation to the obtaining of consent from children and young people.
- We observed clinical staff obtaining consent, from both adults and children, before undertaking procedures. This would often take the form of them explaining the procedure to patients and recording their agreement in the patient record.
- Although there was an understanding amongst staff about consent there were differing views as to whether it was mandatory policy to record patient's verbal consent in the notes. We spoke with a trainee registrar about consent for minor surgical procedures under sedation. They told us they gained consent verbally although not every clinician recorded it in the patient's medical record. They told us there was no departmental policy that consent be recorded in the medical record, and that it was up to the discretion of the individual clinician. It is good practice that consent for minor surgical procedures under sedation are recorded in the medical record.
- Following this we spoke with an ED consultant who told us that it was the policy, and good practice, that consent should be obtained verbally then documented in the notes. This was especially the case when a patient was being treated under sedation.
- Not all staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- We spoke with trained nursing staff who had limited knowledge of the MCA and DoLS, and told us it was not part of the mandatory training programme. However, the trust senior managers informed us it was included in the safeguarding mandatory training programmes.
- We spoke with a trainee registrar who exhibited a good working knowledge of the MCA and DoLS.
- We found a greater knowledge of the MCA and DoLS amongst medical staff than amongst nursing staff.

Are urgent and emergency services caring?

Good

Patients were cared for in a compassionate and understanding manner and treated with respect. Ninety percent of the patients who completed the "friends and family" test between January and March 2015 recommended the emergency department.

The majority of patients we spoke with told us that communication was good and that they were offered emotional support.

Compassionate care

- In the 2014 patient survey of emergency departments, the trust performed about the same as other trusts for patients being treated with respect and dignity and for being given enough privacy during examinations and treatment.
- During our visit in the A&E department we observed staff dealing with patients in a compassionate manner.
- We observed patients and their relatives being treated with dignity and respect.
- Patients and relatives we spoke with told us that staff behaved in a compassionate and caring manner towards them.
- There was a 25% response rate for the "friends and family test" for the last quarter of 2014/15. Out of this number 90% said they would recommend the ED to their friends and family.

Understanding and involvement of patients and those close to them

- In the 2014 patient survey of emergency departments, the trust performed about the same as other trusts for

patients for being involved as much as they wanted to be in decisions about their care and treatment and for being given the right amount of information about their condition or treatment.
- We observed clinical staff explaining to patients their diagnoses and the treatment they required in a manner that would have been easy to understand.
- The majority of patients and relatives we spoke with told us that staff were responsive to their needs.
- We observed information being given to patients and their families in a clear manner which was understood by them.

Emotional support

- In the 2014 patient survey of emergency departments, the trust performed about the same as other trusts for patients for feeling reassured by staff if distressed.
- We observed nursing and medical staff caring for and treating patients in a dignified and caring manner.
- As well as approaching patients in a professional manner staff were open and friendly.
- Patients and relatives we spoke with told us that clinical staff provided them with emotional support.
- Patients we spoke with told us they were treated with dignity, with one patient telling us they were treated as a person.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

The trust performed mostly above the 95% standard for percentage of patients waiting to be seen within four hours since May 2014, with the exception of December 2014 and May 2015.This was an improvement in the previous years. They were also better than other emergency departments with regard to ambulance handover times.

The service met people's individual needs except in the case of the provision of professional sign language support for patients who were profoundly deaf who could not communicate in spoken English.

Service planning and delivery to meet the needs of local people

- The trust used the Emergency Care Intensive Support Team to help improve performance against the 4 hour wait target. This is a nationally recognised team which is composed of experts in the management of emergency services performance.
- The directors shared that approximately 30% of attendances within the emergency department were suitable for primary care.

Meeting people's individual needs

- There was a dedicated paediatric area where children and young people under the age of 16 were sent after booking in at reception or after arriving by ambulance. The room included a dedicated room for adolescents. It was managed by nursing and medical staff, some of whom had specialist qualifications.
- There was a room in the department that was used for mental health staff to consult with and assess patients.
- There were also referral systems in place for the referral of people with drugs and alcohol issues.
- Staff were aware of the needs of people living with dementia and people with a learning disability. We were told that these patients were placed in the quieter atmosphere of the CDU, if a place on the general hospital wards was not available.
- Nursing staff told us how they used the nationally recognised "Butterfly" system to assist them in meeting the needs of people living with dementia, whilst they were in CDU.
- There was a full time Learning Disability Liaison Nurse who is based at Barnsley Hospital. An electronic flagging system for people with learning disabilities was in place. The learning disability liaison nurse received an automatic retrospective weekly and monthly data set for all patients who have a diagnosed learning disability and have attended the emergency department. The information was used to identify any concerns and liaise with the community learning disability team and social care.
- Translation services were available for people whose first language was not English. Due to the emergency nature of the ED this was normally provided by professional staff over the telephone.
- However, there were no systems in place for providing professional sign language support for

patients who were profoundly deaf who could not communicate in spoken English.

- A patient who was deaf and communicated through sign language contacted us before our inspection. They told us that when they attended ED at reception they had to draw a picture to describe their condition. They were then sent to the waiting room where staff called their name although they had presented to reception as being profoundly deaf. When they saw a doctor they had to describe what was wrong with them through drawing a picture.
- Advice sheets were available for patients and for the relatives of children. If required they could be printed off in different languages for patients and relatives whose first language was not English.
- A patient we spoke with told us they had requested that they be seen by a female member of staff only. They told us they were attended by a male member of staff.

Access and flow

- Access and flow was monitored in the A&E department through an electronic database. This recorded all movement of patients within the department from admission until discharge or transfer to a ward.
- The trust performed mostly above the 95% standard for percentage of patients waiting to be seen within four hours since May 2014, with the exception of December 2014 and May 2015.
- In June 2015 the number of patients that waited more than 4 hours between a decision to admit and reaching the ward was 22.
- The trust had improved their performance in regard to the percentage of emergency admissions waiting 4 – 12 hours to be admitted. Between 2 September 2013 and 31 August 2014, the percentage of patients waiting between 4 – 12 hours for admission was 2. 9%. This was against a national performance level of 4.8%. Between 1 September 2014 and 31 August 2015, the percentage of patients waiting between 4 – 12 hours for admission was 2.0%. This was against a national performance level of 6%. The trust had therefore improved their performance against this target in a period when national performance against the target had worsened.
- Patients who arrived by emergency ambulance must be handed over to ED clinical staff within 15 minutes. The College of Emergency Medicine (2011) state that an initial clinical assessment should occur within 15 minutes of arrival or registration. In June 2015, the percentage of patients handed over within 15 minutes was 65.7%. The number of patients who waited over 15 minutes was 20.8%, whilst 13.5% were not recorded. No patients waited over 120 minutes. Waits over 120 minutes were counted as a serious incident. Over the winter pressures' period there were 161 delayed handovers over 30 minutes. This was better as compared with other trusts emergency departments.
- The number of patients leaving without being seen was higher than the national average. In March 2015 this was 2%, whilst in February it was 1.8%, and in January 2%. This was the latest available information.
- The latest available information showed that the unplanned re-attendance rate for September 2014 was 2.2%, whilst in August it was 2.5%, and 2.7% in July.
- There was a 10 bedded clinical decisions unit (CDU) adjacent to the ED and managed by the department. It was used for patients who were waiting for a decision as to whether to be admitted or discharged, although staff told us that in emergency situations, it might take medical patients who were waiting for a bed in the main hospital.

Learning from complaints and concerns

- Complaints and their themes were reported on in a weekly report.
- On 27 April 2015, when an audit was undertaken by the trust, there were 26 open complaints in the directorate covering ED, five of which were outside of the timeframe for complaints' investigations.
- We reviewed four sets of minutes of the ED clinical governance and business meeting. In January 2015 it was identified that patients had commented that waiting times were not displayed in the department. The minutes concluded that they were not able to display the information as it was not possible under the new electronic patient management system which had been introduced. There was also a list of complaints' issues identified in a report from the ED matron. However, there was no discussion at that meeting or in the February 2015 meeting of actions taken in response to these concerns.
- In March 2015, it was stated that a poster had been put up to ensure that learning from a maxillofacial complaint was communicated to all staff. In April 2015 the meeting reported that volunteers had started giving out "Friends and Families" test forms to patients.

- This showed that although the department discussed issues raised through complaints there was not always evidence of practice being changed in response to those concerns.
- We asked 29 patients and parents of children as to whether they were happy with the service or would recommend it to their family and friends. Twenty six said they were happy or would recommend the department to their family and friends. Three patients said they were dissatisfied with the care and waiting times they had received.
- Leaflets and posters were available that told patients how they could complain.

Are urgent and emergency services well-led?

Requires improvement

The management team had not identified the lack of initial clinical assessment or triage as a risk. Limited audits of nursing care were undertaken. There was a system of governance, risk management and quality measurement, aligned with a senior management leadership structure but this had not identified some key risks.

There was limited evidence of engagement with the public.

The nursing leadership in the emergency department and clinical decisions unit was in a period of change. Staff reported an open culture and there were regular meetings.

Vision and strategy for this service

- Staff we spoke with were not aware of any stated values and vision for ED and CDU, however, they all explained how the patient was at the centre of everything they did.
- Staff we spoke with told us they were aware of the trust's values and vision.
- A strategy pack, dated November 2014, was developed by the clinical business unit (CBU) responsible for ED. This outlined a strategy which included the recruitment of advanced practice nurses to work in the minors' area and thereby allow the consultants and middle grade doctors to spend more time dealing with life threatening emergencies and covering the CDU.
- There was also a plan for working closer with GP's and informing patients of alternatives to the emergency department.

Governance, risk management and quality measurement

- The management team had not identified the lack of initial clinical assessment or triage as a risk. In the trust risk register, there were three risks related to ED. One of these was the risk of not attaining the target of 95% of patients waiting no more than four hours before they were admitted, discharged or transferred. The others were regarding staffing issues.
- The ED risk register described their most urgent risk as being that of delivering sub-optimal care due to staff vacancies. However, we did not come across any examples of sub-optimal care during the course of our inspection.
- The ED is part of the emergencies, orthopaedics and elderly care CBU. The trust's management structure showed that the CBU was accountable to the board of directors through the chief executive. In terms of clinical governance the reporting line was through the quality and governance committee to the board of directors.
- We found regular clinical governance meetings were held in the ED which involved all senior members of the senior team, from all the disciplines in the department. Issues of mortality and morbidity were discussed at these meetings when required.

Leadership of service

- We found that although there was regular audit carried out by the medical staff there was less audit carried out by the nursing staff. When we spoke with nursing staff they were unable to tell us about what audits were being undertaken.
- At the time of our visit the department was in a period of change between the ED matron leaving and the appointment of a new one. Nursing staff we spoke with voiced their anxieties regarding this situation.
- Nursing and medical staff raised concerns about nursing staff leaving the department and about what they felt was a high sickness level.
- The leadership of the clinical business unit was headed by a management team composed of a clinical director, who was also an ED consultant; a general manager, and a head of nursing. The CBU reported through the director of operations, and the medical director, to the chief executive.
- At the time of our visit one of the Band 7 nursing leads in the department reported directly to the head of nursing

and took the lead in ED and CDU on a day to day basis. The trust was in the process of recruiting a matron who would lead the ED and CDU, reporting to the head of nursing for the clinical business unit.

Culture within the service

- All staff we spoke with felt that communication within the trust was good.
- Trainee medical staff we spoke with told us there was a good relationship between the trainees and the consultants.
- At the time of our visit the department was in a period of change between the ED matron leaving and the appointment of a new one. Nursing staff we spoke with voiced their anxieties regarding this situation.
- Staff also told us they were concerned that there were not enough registered children's nurses to work in the children's area, and that as a result of staff shortages and sickness there was a large usage of bank and agency nurses.

Public engagement

- There was limited evidence of engagement with the public.
- In addition to the "Friends and Family" test, the trust took part in the 2014 accident and emergency survey of patients.
- Out of the 266 patients who returned a completed questionnaire, 63% said they had waited longer than 15 minutes before being seen by a clinician, which was worse than the 2012 Picker survey results. This was also worse than the national average of other ED departments that took part in the survey.
- A total of 36% of respondents said they waited more than four hours. Although this was also worse than the 2012 figures, it was better than the national average.

Staff engagement

- All staff we spoke with felt that communication within the trust was good, and that they could attend general of specialist meetings.
- We reviewed the minutes of meetings of the ED clinical governance and business meetings. These were attended by senior staff, although more junior clinical staff told us they were able to attend. Although there was no evidence of this occurring on a regular basis.
- Staff told us they had met as a multidisciplinary group and that there were meetings for the individual staff groups. However, these meetings did not take place on a regular basis.

Innovation, improvement and sustainability

- In terms of improvement the trust was placed in breach of its licence by Monitor in May 2014 because of its failure to consistently meet the 4 hour target. In January 2015 this was lifted because of its improved performance against the target.
- Since the inspection the trust has committed to improving the nursing service they provide to children and young people, and the initial assessment provided to patients who self-present at the department.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Medical care services at Barnsley Hospital were managed across two Clinical Business Units (CBU's); CBU1 and CBU 3. There were 213 inpatient beds and the number of medical admissions for July 2013 – June 2014 was 27,673.

We visited the following medical wards; ward 17 (cardiology), the coronary care unit (CCU), ward 18 (respiratory), ward 19 (care of the elderly and endocrinology), ward 20 (care of the elderly), the acute medical unit (AMU), ward 23 (stroke unit), ward 28 (gastroenterology), the endoscopy unit and the discharge unit (ward 16).

We spoke with 25 patients, nine relatives and 80 members of staff. We observed care being delivered on the wards, looked at 44 patient records and 50 medication charts. We observed nursing and medical handovers. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Summary of findings

We rated this service as good.

We saw evidence of learning from incidents locally and across CBU's. Wards were clean and tidy and equipment was available for staff to use and checked regularly. People's care and treatment was planned and delivered in line with current evidence based guidance and there was participation in local and national audits.

Feedback from patients, those close to them and stakeholders was positive about the way staff treated people.

There was a clear statement of vision and values driven by quality and safety. Staff in all areas understood the vision and values. The levels of governance within the CBU functioned effectively and financial pressures were managed so that they did not compromise quality of care. The management team promoted staff empowerment and a culture where the benefit of raising concerns was valued. Improvement and innovation was supported.

Services were planned to meet the needs of local people. There was an openness and transparency in how complaints are dealt with. Informal complaints were logged and reported in the CBU. The bed occupancy was higher than the national average. There were a high number of medical outliers in July 2015 and the trust opened additional medical bed capacity during times of operational pressure.

Medical care (including older people's care)

We found evidence of incomplete action plans of serious incident investigations. We saw breaches in infection control practices during our inspection and there was concern about medicines management. We found that some staff groups were unable to access patients' full clinical record. There was a clinical risk that patients were not fully assessed and treated for sepsis.

Some concerns had been raised prior to our inspection regarding the care of patients with complex needs.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement.

We found evidence of incomplete action plans of serious incident investigations. We saw breaches in infection control practices during our inspection and compliance with infection control training was 12.1% below the trust target. There was concern about the storage, prescription and administration of some medicines. We found that records did not meet national guidance and some staff were unable to access patients' full clinical record to maintain contemporaneous records. There was a clinical risk that patients were not fully assessed for sepsis when an infection was recognised.

There was evidence of learning from incidents locally and across CBU's. Wards were clean and tidy; equipment was clean, available and checked regularly by staff.

Incidents

- There were 2423 incidents reported April 2014 to March 2015, 86% were classified as no harm, 11% as low harm and 2% as moderate harm.
- There were no never events and 19 serious incidents reported April 2014 to March 2015. Falls and grade three pressure ulcers (PUs) were the most frequent serious incidents. There had been six of each reported.
- The trust investigated serious incidents using a root cause analysis process. Specific root cause analysis protocols were used for falls and PU investigations. We reviewed five investigations that all contained recommendations and an action plan. The action plans had not been completed fully and there was no log of when the actions had been completed.
- Incidents were reported on an electronic system. Staff we spoke to were aware of how to report an incident and we saw they received feedback from the Lead Nurse and through the Patient Safety Bulletin.
- We found underreporting of incidents such as out of hours bed moves. Managers told us that out of hours bed moves were reported as incidents. Incident

reporting data showed five reported incidents of out of hours bed moves in 2015. During our inspection staff acknowledged this was inaccurate and we saw other evidence of more frequent out of hours bed moves.

- Staff told us the discharge unit stayed open later than 10pm at times and had done so prior to the week of our inspection. This meant that patients were not being discharged from hospital at an appropriate time of day. There was no evidence that these incidents had been reported.
- Staff on AMU told us an incident form was completed if the ambulatory care unit was open after 10pm. Incident data provided by the trust supported this.
- There was evidence of learning from incidents locally and across CBU's for example staff on ward 16 explained changes that had been made following a medicines incident. A notice had been put up in the office of the procedure to follow with patients' medications. The medications were put in a bag and labelled with the patients name and the drawers where the medications were kept had been labelled with bed and chair numbers.
- The minutes of CBU governance meetings submitted by the trust showed that a mortality review was a standing agenda item at the meeting. According to the minutes it appeared that consultants reviewed each death, however, their capacity to do this was limited. This suggested that further work was required to embed a robust system of timely review of mortality.

Duty of Candour

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm. There was a limited understanding of Duty of Candour at ward level. Staff were aware of the principles of open and honest care but not the specific requirements associated with Duty of Candour.
- The management team had an excellent awareness of Duty of Candour and spoke openly about a situation where they had to act under this duty. There was an agreement within the management team that they would benefit from further training on this.

A general awareness training campaign for all staff was due to be completed in August 2015. The Being Open and Duty of Candour Policy was available to staff via the intranet.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: PUs, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Wards displayed safety thermometer performance information as part of the quality and safety information board on entrance to every ward. The percentage of CUTI's was 1.7% of patients sampled in May 2014 and had reduced to 0% in May 2015.
- The average percentage of patients between May 2014 and May 2015 who developed a new PU was 0.9%. The incidence of PU peaked in November 2014 and had reduced to 0% in May 2015.
- The average percentage of patients between May 2014 and May 2015 who suffered a fall with harm was 0.6%. The incidence of falls with harm peaked in August 2014 and again in March 2015.

Cleanliness, infection control and hygiene

- On nine occasions we observed staff not changing their gloves between patients, entering an isolation room without personal protective equipment and catheter bags were touching the floor.
- There were no Methicillin Resistant Staphylococcus Aureus (MRSA) infections attributed to the medical wards between April 2014 to March 2015. Ten of the cases of Clostridium difficile reported by the trust from April 2014 to March 2015 were attributable to the medical wards.
- Wards displayed infection control information that was visible to patients and visitors.
- Most ward and sluice areas appeared clean and tidy, equipment was clean and consistently labelled.
- We observed compliance with aseptic and scrub techniques in the endoscopy unit.
- Compliance with clinical infection control training was 77.9% in medical care overall and less than 70% in five areas. The trust target was 90%. This meant that not all staff were not up to date with training in infection control.

- The trust provided evidence that the infection prevention and control team visited the wards. This was presented in a document as practice-sharing feedback not as a ward audit.

Environment and equipment

- Resuscitation equipment was available on all wards. We checked the records of 10 resuscitation trolleys; there was evidence that daily checks had been carried out on nine of them. We spoke to environmental coordinators on the wards who were responsible for the environment, equipment and ordering of stock. This role was a support to the nurses on the ward. The environmental coordinators told us they felt part of the ward team.
- We found sharps stored in an unlocked room on one ward and the door to the store room was open on two consecutive days that we visited. We brought this to the attention of the matron and charge nurse who told us they would take action to ensure the door remained closed and was locked. On our unannounced visit on 26 July 2015 we found a key code lock had been fitted and the store room was locked.

Medicines

- Oxygen was not prescribed. Where patients required oxygen this was given. We checked 27 medication records of patients receiving oxygen. The records contained a pre-printed blank oxygen prescription. This had not been completed in any of the records we reviewed. This is not in line with recommendations from the British Thoracic Society guidance on emergency oxygen use in adult patients or the Pharmaceutical Journal oxygen therapy emergency use and long-term treatment guidance. Nurses on the ward told us they reduced patients' oxygen according to a protocol. They were unable to provide us with a copy of this protocol. We requested the oxygen policy from the trust to review the protocol. The trust did not have an oxygen policy.
- We observed a medicines round on two wards. While good practice was observed on one ward, on the other ward drugs were signed for after dispensing rather than after administration and staff did not ensure medication was taken.
- NICE guidance recommends in an acute setting medicines reconciliation is carried out within 24hrs. The trust was working towards the World Health Organisation 90% target for medicines reconciliation in 24hrs. Audits submitted by the trust showed 30% compliance in 2014 and 48% compliance in 2015. Recommendations from the audit were being implemented and include ward visits by a pharmacist at the weekend, the implementation of new treatment cards and setting an achievable CQUIN target of 55%.
- On one ward there were gaps in the fridge temperature records and the minimum and maximum temperatures were not recorded. This was not in line with the trust's standard operating procedure (SOP) on fridge monitoring for storage of medicines. This meant that drugs may not have been stored correctly.
- On three wards we found out of date and unlabelled drugs in the fridge. We informed the nurse in charge of this who contacted pharmacy and took appropriate action. The drugs had been removed or labelled correctly when we visited the wards the following day.
- A re-audit of the safe destruction of controlled drugs completed in 2015 was submitted by the trust. There had been an improvement in compliance with eight standards, however, a reduction in compliance with two standards. The recommendations and action plan of the audit report were blank.
- We checked 23 medication records, 18 (78%) of these were completed fully.
- Records showed controlled drugs were stored and recorded safely.
- We checked three patients' discharge medications and paperwork on ward 16. All three were correct. Two nurses checked the medications before one nurse counselled the patient about their medicines. An audit of the pharmacy discharge waiting times was completed monthly as part of the pharmacy dashboard. The standard was 90% of discharge medications were ready in two hours. Data submitted showed 92-97% compliance from January – March 2015.

Records

- Nursing documentation was completed on an electronic patient record. . This had been introduced within the last year. Medical and therapy documentation was completed in paper records
- Some nursing documentation was still completed on paper, for example intentional rounding and pressure ulcer care. Staff told us they thought the clinical record had become fragmented since the introduction of the electronic record system.

Medical care (including older people's care)

- Staff told us agency nurses did not complete documentation on the electronic record system. We were told that trust staff completed the records for agency nurses.
- Medical staff did not have access to the electronic record system; this meant they did not have access to the full clinical record of a patient.
- We reviewed five medical records; none of the entries were timed and did not meet GMC guidance on keeping records.
- Some staff told us they were unable to look back over the history on the electronic record system. Managers informed us that this was possible, but when we asked three staff to show us patients' history, they were unable to and said further training would be useful. This was a clinical risk that staff looking after patients may not have access to all the information they required.
- The management team acknowledged that the care plans in the electronic record system needed more work. Time was spent on the front sheet which left limited time for the rest of the project. A lead nurse from medicine had been seconded into the project team to work on this.
- The time of the review by staff was not documented on charts to record interventions, for example intentional rounding and repositioning charts. Intentional roundingis a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. A record was made of a check within a two hour period. We saw that these charts were used as evidence in root cause analysis investigations. This does not provide clear evidence of the time an intervention took place.
- We checked eight nursing documentation records. They met NMC guidance for nurses and midwives.
- We checked six intentional rounding charts that were all complete. Of six pressure ulcer charts that we checked four were complete.
- We requested evidence of local documentation audits. The trust submitted the monthly nursing metrics which included a local nursing documentation audit. Most records we saw were securely stored to protect patients' confidentiality. However, on one ward notes were open and accessible in the corridor outside of the team areas.
- Information governance training was included as part of the mandatory training programme. The trust target was 90%. Compliance was 82.9% in medical care overall with six areas below 70% compliance.

Safeguarding

- Safeguarding adults training compliance was 80.4% overall in medical care. The trust target was 90%. Data provided by the trust showed compliance was less than 70% in seven areas in medical care.
- Safeguarding children training compliance was 89.1% in medical care.
- All staff we spoke to were able to demonstrate knowledge of safeguarding adults and children and the process to follow to raise safeguarding concerns.
- Safeguarding information was displayed on all the wards we visited.

Mandatory training

- The trust target for mandatory training was 90%. Data provided by the trust showed that overall training compliance in medical care was 85.4%.
- A lead nurse told us that the management team had prioritised training to support the implementation of the electronic record system in October 2014 over mandatory training.
- The rates for some types of training were worse than others. Resuscitation training compliance was less than 70% in seven areas. Moving and handling for people handlers training compliance was less than 70% in ten areas. This meant that patients could be at risk as staff caring for them may not have had the appropriate training.

Assessing and responding to patient risk

- Early identification of sepsis is known to be important for survival. There was a sepsis screening and management tool in use at the trust. We reviewed two patient records where sepsis screening had not been completed and there was no evidence that sepsis treatment had been started. Both patients had signs of sepsis according to the trust screening tool. A third patient record was reviewed who had been started on the sepsis pathway but the record was incomplete and interventions had not been completed. Patients with sepsis need immediate intervention (within one hour) to determine severity and prevent the deterioration to severe sepsis.
- The medical wards used a recognised national early warning tool called NEWS.

Medical care (including older people's care)

- We checked six NEWS charts across different wards. Three out of six had been completed fully. An audit submitted by the trust showed 30-100% compliance with observations. This meant that the risk to patients was not always being monitored.
- There were local processes in place on wards when there was a variation to the frequency of patient observations. There was a section on the NEWS Clinical Observation Chart that senior medical staff completed a revised NEWS for escalation was in place due to patients underlying pathophysiology. We did not see evidence of this in use.
- Medical staff documented target oxygen levels but not a change in observation frequency or NEWS score escalation plan. The trust deteriorating patient policy was in draft; it did not provide guidance to staff and we did not see it in use during our inspection.
- We observed the initial management of an acutely unwell patient and case tracked their ongoing management and intervention. Two consultants attended within eight minutes of being called, observations and investigations were completed immediately and a management plan was discussed with the team, patient and family.
- We reviewed nine medical records on AMU 77.8% met London Quality Standards of being seen by a relevant consultant within 12 hours of admission. The trust measure their performance against the Society of Acute Medicine Standard of 14 hour senior review from time of arrival. The trust reported a continual improvement in performance against this standard since the introduction of constant consultant presence within the AMU.
- A critical care outreach team was available during the day to support staff with patients who were at risk of deteriorating. The hospital at night team was available overnight.
- We observed a safety huddle that had been introduced on the stroke unit. It was led by a junior doctor and identified the safety risks of the day and allocated required actions to specific staff.
- A new falls risk assessment was being piloted on two wards; Ward 20 and Ward 28, both of which cared for patients at a greater risk of falls.We case tracked a patient who had fallen. The post fall interventions followed NICE guidance. The trust had updated the falls policy in May 2015 in line with recommendations from NICE CG161 assessment and prevention of falls in older people.

Nursing staffing

- Staff sickness was variable across medicine. The average was 3.4% in June 2015 and at 4.4% across the previous 12 months against a trust target of 3.5%.The trust used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. We saw evidence that a review of nurse staffing against NICE staffing guidance had been undertaken in January 2015. The trust had, at the time of inspection, an establishment of staff for a nurse to patient ratio of 1:7.Nursing red flag events' warn nurses in charge of shifts when they must act immediately to ensure they have enough staff to meet the needs of patients. Red flag events include patients not being provided with basic care such as pain relief or help to visit the bathroom (NICE). The trust submitted evidence that nursing red flag events were recorded and reported. This shows that quality indicators that may cause patient harm were being monitored by the CBU.
- The planned and actual numbers of nursing staff on duty was displayed on all the wards we visited.
- We reviewed staffing rotas during our inspection. Where the actual number of staff was lower than the planned number the lead nurse was able to explain how they had assessed and mitigated any risk to patient safety.
- For six weeks prior to our inspection the AMU nurse rota showed nineteen percent of clinical shifts were recorded as understaffed. We did not identify a higher incidence of nursing red flag events or incidents reported on AMU in the evidence submitted.
- We reviewed the monthly update on nursing and midwifery staffing from June 2015 submitted by the trust. Wards 19 and 20 had the lowest fill rates for registered nurses 77.5% and 64.3%. This had been added to the CBU risk register, active recruitment was ongoing and a lead nurse had been appointed to manage both wards and reviewed staffing daily. We did not identify any themes from the evidence submitted such as a higher incidence of nursing red flag events or incidents reported on these wards. The cumulative sickness absence rate on wards 19 and 20 was higher than the trust target.

Medical care (including older people's care)

- The endoscopy unit was staffed to accommodate short notice sickness.
- Data submitted by the trust for March 2015 showed the use of agency or bank nurses from 4-18% across the medical wards. During our inspection lead nurses and ward staff told us most registered nurse shifts were covered by trust staff that worked on the trust bank. Agency staff covered non registered shifts, for example providing 1:1 care for patients who require it. We saw evidence of an induction check list for agency and bank staff.
- Nursing staff told us they were moved from their base ward to cover the escalation ward.
- Advice on managing patients with diabetes was being provided by the specialist registrar in the absence of a diabetes specialist nurse. We were told two diabetes specialist nurses had recently been recruited.
- Staff in the nurse led deep vein thrombosis service reported it was difficult to cover sickness and leave and they had no capacity to audit the service. The DVT service had been a successful initiative within the organisation and had expanded to provide an anticoagulation service to other patient groups. The service was looking at its resources and planned to relocate to the ambulatory care unit which would facilitate collaborative working. We observed handover on four wards where clear information was provided and plans were made for investigations, tests and procedures. An electronic handover document was completed on the ward shared drive and updated by staff through the shift. We followed up a safeguarding issue from a night handover and found the actions had been completed. This showed that information was being recorded and communicated effectively.

Medical staffing

- The medical staff skill mix was similar to the national average for consultants and junior doctors.
- There were three substantive consultants and one locum consultant on AMU. One of these consultants was based in ambulatory care. AMU had an acute medical consultant presence from 8am-5pm Monday to Friday. The general medical consultant on call was present on AMU until 8pm and was able to attend after 8pm if required. The general medical consultant who covered the 24hr on call was present on AMU from 8am to 8pm on Saturday and Sunday.
- A general medical consultant completed a post take ward round at the weekend and was in the hospital from 9am to 5pm on Saturday and Sunday.
- We observed part of two consultant ward rounds; one on AMU the other on a ward. Information was communicated clearly, tasks prioritised and treatment plans agreed.
- We were told that junior doctors were regularly moved to cover the escalation ward and that there were times during annual leave or sickness that staffing was below the minimum required for junior doctors. We requested copies of the junior doctor rota. However, these did not detail staff moves or any additional locum staff. The locum use in medical care was difficult to establish from the data submitted by the trust as different clinical specialities were included in the two CBU's; the figure could range between 16-20%. Managers told us locum consultants were employed to support the acute medical model whilst recruitment was underway.The trust managers told us that each ward was supported by two junior doctors, a middle-grade or specialty doctor supervised by a medical consultant.
- The Hospital at Night team consisted of two Band 6 nurses, three junior doctors and one registrar. The nurses were contacted by the ward staff and allocated the work to the doctors. There was no sickness or annual leave cover in place for the Hospital at Night nurses. One of the general medical consultants was on call overnight. We were told by staff that the consultant would come in if requested.
- We observed a Hospital at Night handover; staff attending the handover signed in, paper handover sheets were used by the doctors. Some information communicated was unclear, for example the length of time a patient had been on antibiotics and who was taking responsibility for some of the individual jobs. Patients who required senior review were clearly identified. An electronic handover was completed by the nurses who logged when doctors had been allocated jobs and signed off the tasks when completed.
- Most of the staff we spoke to told us they were concerned about the number of medical staff to cover the workload overnight. It was logged on the CBU risk register as high risk. A doctor told us twice in four days they were unable to attend an acute situation as they were already in attendance at one. The management teams were aware of the concerns and the Medical

Director said that they had reviewed the shift patterns against the workload and made changes to the afternoon and evening medical staffing as part of plans to address the issue.

Major incident awareness and training

- A standard operating procedure (SOP) for managing emergency demand was in use. The draft SOP had not been presented to the executive team for formal review at the time of our inspection.

Are medical care services effective?

Good

We rated the effectiveness of this service was good. Patients have good outcomes because they receive effective care and treatment that meets their needs.

Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. There was participation in relevant local and national audits. When people received care from the multidisciplinary team this was coordinated and staff worked collaboratively to meet the patients' needs. Deprivation of liberty was recognised and only occurred when it was in a patient's best interests.

Actions plans on some of the audits submitted were incomplete and there were vacancies in some of the specialist nurse posts.

Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust intranet.
- There was a combined myocardial infarction (MI) and acute coronary syndrome (ACS) integrated care pathway in use. We reviewed one that had been completed fully. This care pathway referenced NICE guidance and was due to be reviewed in September 2015.
- The stroke pathway was updated in April 2015 and referenced NICE guidance.
- There was no access to early supported discharge (ESD) or liaison psychiatry on the stroke unit. This is a recommendation in NICE CG162 stroke rehabilitation.
- The trust provided evidence of a hospital wide re-audit of the sepsis six pathway completed in March 2015. The audit showed 50% of interventions were completed within the one hour timescale. This highlighted a clinical risk that patients were not fully assessed for sepsis when an infection was recognised. An action plan had been developed and was led and monitored by the trust deteriorating patient group. The trust was unable to provide evidence that it had implemented the recommendations from NICE CG169 acute kidney injury: prevention, detection and management of acute kidney injury up to the point of renal replacement therapy. NHS England launched a patient safety alert that required trusts to implement an algorithm that standardised the early identification of acute kidney injury by 9 March 2015. This posed a clinical risk to patient care.
- Patients that required non-invasive ventilation (NIV) were managed on the coronary care unit. The SOP for care of respiratory patients within the coronary care unit was written in March 2015 and referenced British Thoracic Society (BTS) NIV recommendations and NICE guidance.
- There was speciality respiratory and cardiology in-reach to AMU. The introduction of respiratory in-reach had been audited by the trust. Results showed that treatment was delivered in line with BTS and NICE guidance and patients were discharged earlier.

Pain relief

- The trust used a pain assessment tool scoring pain from zero to three. These scores were recorded on the NEWS clinical observation chart.
- Most patients told us they received their medication when they needed it.

Nutrition and hydration

- The trust used a hydration assessment tool and introduced a red beaker and jug for patients at risk of dehydration or who required assistance. A red tray was used for patients who required assistance or support with nutrition. We saw this in use consistently on the wards we visited.
- We checked 14 records where patients were using a red jug or tray and found the appropriate risk assessment documentation and actions had been completed 100% of the time.

Medical care (including older people's care)

- We saw patients were supported with menu choices, offered snacks and supported with feeding if assistance was required. Patients told us they were offered food and water regularly.
- Protected meal times were used. Where relatives or visitors supported people to eat, they were encouraged to continue this.

Patient outcomes

- There were no current CQC mortality outliers in medicine. This indicated there had been no more deaths than expected for medical patients.
- The Sentinel Stroke National Audit Programme (SSNAP) showed an improvement from an overall SSNAP level of "D" for July to September 2014 to a "C" for January to March 2015. Most areas were rated C. However, occupational therapy and standards by discharge were rated A. Thrombolysis had deteriorated from a D to an E. The trust had a significantly lower proportion of patients eligible for thrombolysis (according to the Royal College of Physicians guidelines) than the national average however, 100% of eligible patients received this treatment.
- The national diabetes inpatient audit (NaDIA) September 2013 indicated that out of 19 indicators the trust was better than the England average in 15 areas and worse in four. Of specific concern were indicators relating to foot risk assessments and visit by specialist diabetes team. The action plan was blank on the document submitted. At the time of our inspection there was no diabetic specialist nurse in post.
- The Myocardial Ischaemia National Audit Programme (MINAP) audit 2013/14 indicated that the trust was better than the England average in two out of three indicators. The trust's performance has deteriorated over time, for example in 2012/13 98.9% of NSTEMI patients were admitted to a cardiac unit or ward compared to 59.4% in 2013/14.
- The national heart failure audit 2012/13 showed that the trust had performed similar to the England average in seven out of 11 indicators and worse than the England average for four indicators. Specific areas of concern were in hospital care as a cardiology patient and referral to heart failure specialist nurse on discharge.
- The trust participated in two respiratory audits; 2014 Royal College of Physicians (RCP) COPD audit and 2013 BTS NIV audit. We saw evidence of action plans following these audits to increase capacity of respiratory and NIV beds that should improve patient outcomes.
- The trust had achieved Joint Advisory Group on GI Endoscopy (JAG) accreditation and had an excellent 24hr endoscopy service. We observed the WHO five steps to safer surgery performed with 100% compliance.

Competent staff

- Evidence submitted by the trust showed medical appraisals were up to date in most clinical specialities; there was one member of medical staff whose appraisal was not up to date.
- Evidence submitted by the trust showed the rate of up to date appraisals in other staff groups was 81-100%. This correlated with the information that was displayed on ward quality and safety information boards. Lead nurses showed us current staff records and up to date appraisal data.
- The trust was in the process of training advanced nurse practitioners (ANP's) who reported they were well supported and receiving a rolling programme of training.
- Nursing staff from ward 18 were rotating onto CCU to obtain and maintain NIV competencies prior to the development of two NIV beds on ward 18.
- Tracheostomy training had been set up at a simulation centre, a pathway and competency package had been developed but was not yet in place at the time of our visit.
- All nurses on the stroke unit were trained in dysphagia. Fifty five percent of staff on the stroke unit had completed national stroke training and awareness resources competencies. This is a NHS Scotland tool to enable staff to become more knowledgeable and skilful in the area of stroke care.
- Allied health professionals (AHP's) told us they were supported to attend internal and external training courses that helped them to maintain their continuing professional development.

Multidisciplinary working

- Staff across the CBU reported good working relationships within the multidisciplinary teams (MDTs).

Medical care (including older people's care)

- There was an hospital at night team in place which co-ordinated the medical handovers and managed requests for support from the doctors working overnight
- Data submitted by the trust showed a 32% vacancy rate in Occupational Therapy. Therapy managers told us active recruitment was underway but vacancies were difficult to fill as some posts were fixed term. During our inspection we saw notices displayed on wards informing staff that due to staff shortages occupational therapists would only be seeing patients who were medically fit for discharge.
- We saw flow-charts for specialist nurse pathways on display to ensure staff were aware of the services available and referral pathway.
- The dementia specialist nurse, an occupational therapist, physiotherapist and sister delivered person centred dementia care in acute hospitals training.
- A frailty team that consisted of specialist nurses and doctors was introduced in 2014. They assessed and planned care for patients with dementia, Parkinson's disease and delusional states and also carried out mental capacity assessments. The team told us that therapists regularly referred patients they identified with cognitive impairment. The team routinely visited AMU and provided an in-reach service to wards. We saw evidence in records of referrals to the team and the subsequent assessment and plan of care that was made. Since the introduction of the frailty team the length of stay for non-elective medical admissions for the patient group that fulfil the criteria had reduced from 15 to five days.
- We were told that some wards held weekly MDT meetings.

Seven-day services

- Two registrars worked at the weekend one to review the acute patients and one discharge registrar to review patients highlighted by staff as potentially ready for discharge.
- Staff on the wards excluding AMU told us at times they found it difficult to obtain a senior medical review at the weekend. We found evidence of this on incident reports, in CBU governance minutes and in information provided to us prior to our inspection by local stakeholders.
- There was a 24hour, seven day a week endoscopy rota that was covered by consultant gastroenterologists and surgeons.
- Seven day therapy services were provided on the stroke unit.
- Occupational therapy provided a service at to medically fit patients at the weekend to facilitate discharge.
- The urgent care therapy team provided a seven day service to AMU and ED from 8am to 6pm
- An overnight on call respiratory physiotherapy service was provided. Staff working in this service told us they felt confident and supported in this role.
- The pharmacy was open seven days and dispensed discharge medications at the weekend. The pharmacists clinically checked the discharge letters.
- The discharge unit was open at the weekend when staff were available. Staff told us that staff who worked on the trust bank were used. It was open on our unannounced visit on Sunday 26 July 2015; the nurses working on the unit were both regular staff on the unit working bank shifts.

Access to information

- Discharge paperwork was sent electronically to the GP from the ward at the time of the patients' discharge
- GP's had access to Right Care Barnsley (a single 'front-door' to support medical patients aged 18 and over who are at risk of a hospital admission). Right Care Barnsley referred patients directly to AMU if admission was required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated an understanding of consent and the mental capacity act and decision making. They told us they would request assistance from medical staff to assess patients' mental capacity. Guidance was available on the wards for staff to access.
- Staff on ward 28 were able to clearly tell us about best interests meetings and decision making they had been involved in. We saw clear documentation of a patient that was undergoing this process.
- We asked staff about one patient who was detained under a deprivation of liberty safeguards (DoLS) authorisation. Staff were able to explain why the order was in place and until when.
- We observed four DoLS authorisations in patient records that were all completed fully.
- We reviewed three consent forms in endoscopy that had all been completed appropriately.

Medical care (including older people's care)

Are medical care services caring?

Good

We rated medical care services as good for caring. Patients were supported, treated with dignity and respect, and were involved in their care.

Feedback from patients, those close to them and stakeholders was positive about the way staff treated people. Patients were treated with dignity, respect and kindness and were supported in decision making.

Some concerns had been raised by members of the public that contacted us prior to our inspection regarding the care of patients with complex needs.

Compassionate care

- The NHS Friends and Family Test (FFT) response rate was similar to the England average. Between 80 and 100% of patients in medical care were either 'extremely likely' or 'likely' to recommend services to their family or friends.
- The results of the CQC inpatient survey were similar to the national average.
- Prior to the inspection we received information from six relatives concerned about the care of elderly patients and patients with dementia or complex needs on the medical wards. Staff had identified concerns and worked to improve the care provided. During our inspection we witnessed members of staff calming and reassuring patients with dementia.
- We witnessed an unwell patient being informed of their care and given reassurance by all the staff involved.
- We observed patients being treated with privacy and dignity during a ward round. Medical and nursing staff spoke to the patients compassionately, informed them of their treatment, investigation and discharge plan.
- A patient feedback board was displayed in the endoscopy and day surgery suite.

Understanding and involvement of patients and those close to them

- We heard medical and nursing staff discussing treatment plans with families. Seventy eight percent of the comments from patients and relatives during our inspection were positive. Many of the positive comments were around being involved in decisions and planning of care and flexible visiting hours.
- Every ward that we visited had a display of patient and carer information, for example British Lung Foundation leaflets were available on ward 18 and information about services for patients with dementia was displayed on AMU. Some displays contained a lot of information and could be more difficult to read for elderly patients and those with poor vision.

Emotional support

- When a patient became unwell on AMU staff put a privacy screen in place and showed awareness of the other patients by reassuring them and moving those away who were able.
- There was a range of clinical nurse specialists at the trust who supported patients with complex or long term conditions, for example, in dementia, stroke, palliative care and the frailty team. Information about the clinical nurse specialists were displayed on notice boards in wards and departments we visited.

Are medical care services responsive?

Good

We rated responsiveness as good.

Services were planned to meet the needs of local people. There was an openness and transparency in how complaints are dealt with. Informal complaints were logged and reported in the CBU.

The bed occupancy was higher than the national average. There were a high number of medical outliers in July 2015 and the trust opened additional medical bed capacity during times of operational pressure.

Service planning and delivery to meet the needs of local people

- The CBU's had identified strategic initiatives in their 2015/16 strategic plan that included endoscopy expansion, integrated diabetes care and the expansion of angiography services. The regional stroke network was undertaking a resilience review which would be considered by the Working Together group of providers.

A bed utilisation review was another initiative supported by the provision of targeted seven day services in AMU, a new model of care for COPD patients, the development of a frailty unit and the establishment of care home services with a rehabilitation ethos.

- The ambulatory care unit was based on AMU and was staffed by nurses from 8am-10pm; there was a consultant available from 11am-7pm. The lead nurses told us 70% of patients were discharged home from the unit. The unit was process driven rather than pathway driven. This meant there was direct acceptance of all clinically appropriate patients. The Royal College of Physicians recommends an AMB score is used, this indicates if patients are suitable for ambulatory care based on seven characteristics. This score was used on the unit. We received feedback from local stakeholders that the ambulatory care unit had introduced new clinical pathways and reduced unnecessary admissions.

Access and flow

- The average bed occupancy for the trust was 92.5%. This was above the national average and above the 85% occupancy level where regular bed shortages and an increased number of healthcare associated infections can occur (National Audit Office).
- The relative risk of readmission rate was lower than the England average for non-elective admissions and lower than the England average for elective admissions.A medical escalation ward had been open from January to June 2015. During our visit a surgical ward was open as an escalation area.
- Medical patients from the emergency department (ED) were transferred to AMU initially. Stroke patients were transferred directly to the stroke unit. Cardiology patients and those who required NIV were transferred directly to CCU.
- The trust length of stay was similar to England average. However, the elective cardiology length of stay was higher than England average.
- Cardiology staff and patients told us patients waited for transfer to other hospitals for treatment. The management team had identified some reasons for this and actions to improve access formed part of the 2015/16 strategic plan.
- Senior staff told us that the new Chief Operating Officer was having a positive impact on patient flow and moving toward a discharge focus in the trust.
- The trust monitored the number of times a patient moved beds during an admission. The standard operating procedure for managing emergency demand stated that the bed manager must not to move patients between the hours of 22:00 and 06:00 unless for clinical need. Staff told us that ward moves were not uncommon during this time. During our inspection, managers were unable to provide data on the number of bed moves that had occurred during this time. Following the inspection the trust informed us the majority of out of hours bed moves were from AMU to a speciality bed to facilitate flow from the emergency department. Care of medical outliers was discussed at the morning bed meeting. A manager identified consultant teams to be responsible for the patients. We were told this was to ensure equity of inpatient caseloads for medical staff. Continuity of patient care was considered in this discussion.
- We attended two bed meetings during our inspection; at one meeting there were 28 medical outliers. The trust provided records of the number of outliers from April 2015 up to the date of our inspection. There was an average of 30 medical outliers a day.

The list of medical outliers was reviewed daily by service managers and patients were allocated to a consultant and their medical team every morning. The allocation of patients was based on geographical location, continuity of care and consultant workload. Staff of all grades told us that consultant review of medical outliers varied and some medical outliers were managed by junior medical staff. A senior medical review was required to confirm a patient was medically fit for discharge.

- At one of the bed meetings we attended, seven delayed discharges were identified; six were waiting for non-acute NHS care. There were 26 medically fit patients in hospital. This was approximately 6% of inpatient beds.
- The discharge unit was open from 9am-10pm and had facilities to look after patients in beds and chairs and those with complex needs who may have needed a relative or carer to accompany them.
- Staff in the discharge unit reported delays were due to medication issues, either the doctor had not completed the discharge paperwork or there was a delay in

pharmacy. Staff had made suggestions to managers about having a stock of medications or a pharmacy technician on the unit. The matron we spoke to was aware of the issues and suggestions made by staff.

- The risk of insufficient bed capacity for NIV was on the CBU risk register. Staff told us and we saw evidence that recruitment to additional posts and training was underway to increase capacity for NIV patients.
- A respiratory hub was set up 18 months ago and worked with community services and ED to prevent unnecessary admissions. We viewed a respiratory care bundle that provided a pathway from hospital into the community. Of the 390 patients that had used the service 30 (7.7%) required admission. This showed that the service was effective in reducing acute admissions to hospital. Staff attended monthly meetings and reported good relationships with the community COPD team and improved patient experience.
- There were nurse led clinics for transient ischaemic attack (TIA) and stroke follow up patients. The nursing staff could prescribe medications and order investigations which improved access to services for patients.
- A nurse led deep vein thrombosis (DVT) service was based in the emergency department. This had developed from an inpatient service to an outpatient service. Feedback from patients that had used the service was positive and staff wanted to be able to formally evaluate the service and extend it to other specialities.

Meeting people's individual needs

- There was a dementia specialist nurse who had been in post for nine months. We saw evidence of the dementia strategy and work that had been undertaken and was ongoing.
- We saw evidence of patients being screened for dementia on admission. Patients were referred to the dementia specialist nurse and a butterfly symbol was displayed above their bed.
- At the time of our inspection 270 staff had been trained in person centred dementia care in acute hospitals and 800 trained in the Butterfly Scheme. The trust had identified dementia champions who received a higher level of training.
- Staff we spoke to demonstrated an understanding of "this is me" document and we saw two in use during our visit.
- There was evidence that changes to the environment had been made on some wards to make them more dementia friendly.
- Finger food and snacks had been added to the hospital menu to help meet the nutritional needs of patients with dementia.
- There was a telephone interpretation service available for patients and their families who did not have English as their first language. Guidance was available on how to access this service on the wards.
- In the endoscopy and day surgery suite welcome signs were available in different languages. The signs welcomed people with hearing and or visual impairments, breast feeding and people with a physical disability.
- Patient advice boards in the endoscopy and day surgery suite provided information on victim support and local authority housing services.
- A full time learning disability liaison nurse was in post. Any patient who had a diagnosed learning disability and was on the local authority/GP register had an alert on the electronic record system system. This meant the learning disability liaison nurse was able to identify inpatients with a learning disability and offer support to patients, carers and ward staff. The trust used a hospital passport document called All About Me to share information between professionals.

Learning from complaints and concerns

- Information was available in clinical areas for patients and relatives about how to make a complaint and provide feedback.
- 85 formal complaints were made relating to medical and elderly care patients in the last year. This was 34% of all formal complaints made to the trust.
- Examples of themes from complaints were the standard of care provided, communication with family, relatives and patients and staff attitude.
- Lead nurses were able to tell us themes of complaints and show us action plans developed from these. For example, a cordless telephone was introduced on a ward where complaints had been made by relatives about the time taken to answer the telephone.

Medical care (including older people's care)

- We saw evidence of sharing learning from complaints in staff meeting minutes. Complaints and the learning from them were displayed on the ward quality and safety information boards.
- We saw evidence that a record of informal complaints was kept as part of the matron's monthly report to the CBU.

Are medical care services well-led?

Good

The leadership of this service was good. The leadership, governance and culture promote the delivery of high quality person-centred care.

There was a clear statement of vision and values driven by quality and safety. Staff in all areas understood the vision and values. The levels of governance within the CBU functioned effectively and financial pressures were managed so that they did not compromise quality of care. Mechanisms were in place to engage the public and staff. The management team promoted staff empowerment and a culture where the benefit of raising concerns was valued. Improvement and innovation was supported.

Vision and strategy for this service

- The trust had a vision and a set of values and staff we spoke to knew what these were.
- The CBUs had strategic initiatives that were linked to trust's five year strategic plan. The initiatives had consideration of risks and benefits and were timed.
- The management team were able to explain the strategy for medical care to us. The initial focus was on the recruitment to posts to develop the acute medical model. Once this had been done a seven day speciality model was planned.
- The management team engaged with the clinical teams in relation to delivering the strategy and cost improvement plan (CIP) without having an impact on quality.

Governance, risk management and quality measurement

- The CBUs held monthly governance meetings chaired by one of the heads of nursing. The meetings were attended by members of the MDT. We reviewed minutes from these meetings, serious incidents and harm reviews, open complaints and the risk register were some of the agenda items discussed.
- The management team told us that CIP's underwent a quality impact assessment and CIP was a standing agenda item at the governance meeting. We reviewed minutes from four governance meetings; CIP was not on the agenda at any of the meetings.
- Quality and safety information boards were on all wards we visited. Information on these boards included incidents, complaints and current risks. Staff we spoke to on the wards were aware of the current risks within medicine.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded. CBU risk registers identified areas such as NIV capacity, 12hr medical review of AMU patients and the electronic record system training and competence. The risk register showed that controls were in place to mitigate these risks.
- The management team and senior staff were aware of the issues on the risk register and agreed they were representative of the risks they identified in the CBU.

Leadership of service

- Staff told us they felt senior staff and managers were visible, approachable and supportive.
- We met with the management team who felt supported and engaged with the current structure.
- One lead nurse told us they had not had any formal training to investigate incidents or complaints but they had been supported by matrons and managers to develop these skills.
- Allied Health Professionals told us they felt part of the multidisciplinary team. They said working across CBUs could be challenging but felt the new management structure worked.

Culture within the service

- All members of staff we spoke to on the wards were proud to work in the trust and felt part of the team they worked in.

Medical care (including older people's care)

- Staff conveyed a strong open and honest culture in all areas that we visited during our inspection.
- Staff told us they felt supported to report incidents and raise concerns to their line managers.
- During our inspection we saw evidence on the staff intranet of how to raise a whistleblowing concern. This showed the trust supported staff in raising concerns. The trust shared with us whistleblowing concerns that had been raised in the last six months. This showed the open and honest culture the trust was trying to nurture.
- Some AHP staff told us they felt that senior positions in the trust (band 8 and above) were limited to nursing colleagues and applications from therapists were not actively sought.

Public engagement

- During our visit we saw wards displayed FFT results and cards sent by patients and relatives in 2015.
- There was a visitor's book with recent feedback written on one of the wards we visited.
- An open & honest questionnaire was given to ten patients a month on each ward. The results were displayed on the ward open and honest board.
- We saw evidence of public engagement at ward level. The discharge unit completed a patient experience survey and the ambulatory DVT and anticoagulation service planned to launch a patient survey.
- The trust held a well-attended monthly café where patients and carers could talk about their hospital experience and participate in other activities such as singing and knitting. An information leaflet was given to carers and relatives detailing dementia support services.

Staff engagement

- All staff we spoke to felt that communication within the trust was good.
- Staff meetings took place on most of the wards we visited. We reviewed minutes of these meetings and saw a communication book on a ward where regular staff meetings did not occur.
- Open and honest and quality and safety information boards shared information including staff feedback and compliments.
- Lead nurses on AMU had developed a ward newsletter and a monthly staff award scheme that was voted for by staff on the unit.
- Staff spoke enthusiastically about the trust award scheme. Where people and teams had been nominated for or won awards the certificates and photographs were on display.
- There was a senior nurses forum where lead nurses, matrons and heads of nursing shared information.
- A member of therapy staff had been involved in a listening in action event. They said this was positive and engaging experience.

Innovation, improvement and sustainability

- The management team told us they felt supported by the Medical Director and the Director of Nursing and Quality to ensure that quality is not affected with any CIP.
- Medicine dispensers that require fingerprint access had been introduced on some wards. Staff told us this made the administration of medications quicker and safer.
- Nursing indicators and pathways introduced in endoscopy had been nominated for a patient safety award.
- Cardiology in-reach to AMU had been introduced in December 2014. We saw evidence that this had reduced the length of time patients had to wait to be transferred to another hospital for procedures.
- Staff on ward 28 told us about an alcohol detoxification pathway document. The care pathway meant nurses could administer pre prescribed medication when patients needed it, rather than waiting for a doctor to be available to prescribe it. This meant patients received the right medication and care at the right time and reduced risks to themselves and others.
- A service evaluation of care for the dementia patient was due to be completed as part of an MSc degree.
- The management team told us that all clinical specialities in medicine were represented at the trust awards for innovation.
- The presence of a registrar on the medical wards at the weekend who was dedicated to facilitating discharge was a service that would add sustainability to seven day working.
- Senior nursing staff felt that innovation in the trust was driven by the nursing staff.

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Barnsley hospital provided a range of acute surgical services for the population of Barnsley. The hospital provided elective and non-elective treatments for general surgery, urology, ear, nose and throat, ophthalmology, colorectal surgery and trauma and orthopaedics surgery. The hospital carried out 19,368 surgical episodes a year, which was in the lower quartile of NHS, trusts in England. It had a 54% day case mix, 16% elective and 30% emergency admission rate within surgery. Admissions were 48% for general surgery, 23% trauma and orthopaedics, 14% urology and 15% other surgical admissions.

During the inspection we visited the following surgical wards: ward 30 surgical arrivals unit, ward 31 (general surgery), ward 32 (colorectal surgery), ward 33 and 34 Trauma and orthopaedic surgery, surgical decision unit and planned investigation unit as well as visiting all theatres within the main theatre suite, recovery and day surgery suite.

We spoke to 85 staff and 23 patients and relatives. We observed care and treatment and looked at the care records for 15 patients.

We attended the hospital for the announced comprehensive inspection over a four day period and also attended as part of an unannounced inspection during a weekend.

Summary of findings

Significant concerns were highlighted with the trust in relation to suitable patients with colorectal cancer not being offered laparoscopic colorectal surgery; the trust was the only trust in the country to report 0% in the data tables for offering laparoscopic surgery to suitable patients. Non-compliance with national emergency laparotomy audit data was also noted and a lack in trained laparoscopic competent medical staff.

There was learning from incidents; however, this wasn't fully embedded in all investigations. There were concerns about clinical stock being out of date on one ward and drug fridge temperatures were inaccurately recorded on three ward areas. Interim measures were in place due to the condition of some drugs fridges within theatres which were awaiting replacement.

We found evidence of junior and locum medical staff sharing passwords for IT systems. Immediate action was taken to address this. Gaps were found in medical records.

Mandatory training rates were low for surgical medical staff. The World Health Organisation (WHO) five steps for safer surgery process was inconsistently used at Barnsley hospital. Nurse staffing levels in trauma and orthopaedics were lower than the established safe levels; however, staff were taking appropriate action to recruit to vacant posts.

Surgery

Staffing on the escalation ward during the night raised concerns because of the mixed competence of staff from different areas in the trust.

During the inspection there was no clinical lead for surgery in post. Recommendations made in serious incident reports were reviewed in historic serious incidents these had not been consistently acted upon and the similar incidents had occurred since. The lack of offering laparoscopic colorectal surgery to patients at Barnsley hospital had not been addressed. Public engagement was limited.

Departmental policies were based on nationally recognised best practice guidance. Enhanced recovery pathways for patients undergoing hip and knee replacement procedures were implemented to improve the patient experience and outcomes. Protected mealtimes and a duty "snack monitor" had been implemented to improve nutrition on wards and departments.

Throughout the inspection we saw positive, kind and caring interactions on the wards between patients and staff. Patients spoke positively about the standards of care they had received.

There was access to a specialised dementia nurse and learning disability nurse. We saw examples where lessons had been learned and actions taken following complaints.

There were effective systems in place to deep clean equipment regularly. The wards and departments had systems in place to safeguard vulnerable adults. Mortality rates within orthopaedics were below the national average.

Surgical elective and non-elective length of stay data was better in the trust than the England average. The number of patients not treated within 28 days was good and only one patient since 2011 had not been treated within 28 days from cancellation day. During the reporting period April 2013 to November 2014, the trust performed better than the standard and the England average for the 18 weeks from referral to treatment target. The percentage of patients (with all cancers) waiting less than 31 days and 62 days from urgent GP referral to first definitive treatment was better than the England averages. Breaches of national waiting time targets including the cancer waits were occurring in some specialties. Increases in non-elective surgical activity and medical admissions have led to an increasing number of medical and surgical outliers.

A clear vision and strategy for surgical services and clear governance structures within the business units was apparent. Nursing leadership at ward level was good, with positive interactions between staff, ward managers and matrons noted. Some good areas of innovation, improvement and sustainability were noted.

Surgery

Are surgery services safe?

Requires improvement

There was learning from incidents; however, this wasn't fully embedded in all investigations. There were concerns about clinical stock being out of date on one ward and drug fridge temperatures were inaccurately recorded on three ward areas. Interim measures were in place due to the condition of some drugs fridges within theatres which were awaiting replacement.

We found evidence of junior and locum medical staff sharing passwords for IT systems. Immediate action was taken to address this. Gaps were found in medical records.

Mandatory training rates were low for surgical medical staff. The World Health Organisation (WHO) five steps for safer surgery process was inconsistently used at Barnsley hospital. In some areas the use was good; in others it required improvement. Nurse staffing levels in trauma and orthopaedics were lower than the planned levels; however, staff were taking appropriate action to recruit to vacant posts and the ward was supported by advanced nurse practitioners.

There were effective systems in place to deep clean equipment regularly. The wards and departments had systems in place to safeguard vulnerable adults. Mortality rates within orthopaedics were below the national average.

Incidents

- Incidents within the surgical areas were reported through a centralised reporting system. Surgical areas reported 1,287 incidents (rated as harm which was moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between June 2014 to June 2015.
- Reported incidents showed none were graded as severe, 15 (1%) were graded as moderate harm and 99 (8%) graded as low and 1,170 (91%) were graded as no harm/ near miss.
- Senior nursing and medical staff reviewed and analysed the incidents to identify trends and monitor actions and learning. The top four categories of incident reporting was 250 (19%) for treatment and procedure, 173 (13%) treatment care and ongoing monitoring/review, 166 (13%) infrastructure (including staffing, facilities and environment) and 162 (13%) were patient accidents.
- All pressure ulcers classified above a grade 2 or with harm were investigated using a root cause analysis (RCA) process. For pressure ulcer incidents, a panel met every two weeks and the incidents were presented by staff to the panel for discussion.
- Thirteen serious incidents (SI's) had been reported within surgical areas. Themes included pressure ulcers, venous thromboembolism diagnosis, delayed diagnosis and surgical error. We reviewed five SI reports. Lessons learnt, sharing of information and recommendations were clear. We saw evidence of changes to practice as a result of three of the incidents, such as the introduction of a ring-fenced orthopaedic area. However, further similar incidents had occurred recently following two of the SIs. The CBU management team were not aware of the recommendations in the reports and the delays in treatment times.
- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations that provide strong systemic protective barriers are available at a national level. The surgical areas at Barnsley hospital reported no never events between May 2014 and April 2015, however, prior to the inspection one never event had been reported involving wrong prosthesis implantation used in orthopaedic surgery. This never event was in the process of being fully investigated. Managers had reviewed procedures to minimise the risk of repetition prior to the full findings being known.
- Staff we spoke to were aware of their top three risks within their business unit or ward area and received feedback when they had submitted an incident report.
- Learning from incidents was shared internally through business unit clinical governance meetings, weekly CBU nurse meetings noted with action logs, communication with the lead nurse, 1:1 meetings, communication books, quality boards, safety briefings, internal memos and emails. We saw evidence of these.
- Safety champions had been developed; these staff shared learning and supported staff in performing investigations and recording.

Duty of Candour

- Staff spoke to us about their knowledge of duty of candour and talking to patients if an incident, error or mistake had occurred and the need to be open and honest. They spoke to us about the documentation of this discussion on incident report forms, recorded within the nursing notes and progress noted within the national computer patient administration system.
- We reviewed an incident that had recently occurred where duty of candour requirements had been implemented.

Safety thermometer

- In the reporting period May 2014 to May 2015, 66 harms were reported under the safety thermometer reporting system; these include six catheter related urinary tract infections, 17 falls with harm and 43 new pressure ulcers. Catheter related UTIs and falls with harm peaked in January 2015 to March 2015. Falls with harm had three peaks in the reporting period with the worst being Oct 2014 with nine patients reported. Pressure ulcers have had three peaks with October 2014 being the worst period with 22 reported new pressure ulcers reported.
- All wards displayed safety thermometer data in areas patients and visitors could access.
- The number of days since falls, pressure ulcer acquisition MRSA acquisition and Clostridium difficile acquisition on the ward were available.
- Safety thermometer reports were incorporated into the matron's monthly report. Staff we spoke to told us about safety thermometer data being discussed at ward meetings.

Cleanliness, infection control and hygiene

- Compliance with infection control training was 84% and 96.9% for non-clinical staff within surgical and theatres business units and 83% and 80% for clinical staff; low levels of compliance were seen within medical staff. The trust target was 90%.
- Environmental cleaning audit data from 2015 showed that all surgical inpatient areas complied with the required standard.
- We observed environmental cleaning schedules were available and displayed. PLACE audit results indicated the environment supported good care.
- We inspected nine areas in surgical wards and departments and found seven floors to be dusty with visible dirt present. All other areas, including theatres, were clean and well maintained.
- Equipment cleaning assurance labels provided assurance to patients that equipment was clean and prepared for use. We observed equipment was clean and cleanliness was monitored.
- There were some communal items in use on the planned investigation unit, such as tissue packs. These were labelled as single patient only.
- Infection prevention information boards were on all wards and departments we visited. These were visible to patients, public and staff. These had current infection rates and days free of infection displayed; most of the notice boards used throughout the surgical wards and departments were material and were difficult to clean.
- Sharps bins inspected were found to have open apertures and safety closing devices were not used which may pose a risk to staff.
- Hand hygiene audit data showed compliance of 100%. During the inspection we noted mixed availability of alcohol hand rub with four out of ten areas inspected not having access to wall mounted or point of use individual bottles of gel. Soap dispenser were not working in two areas visited. Staff complied with the 'bare below elbows' policy. However, we witnessed four staff enter theatre without performing hand hygiene.
- Adherence with the theatre uniform standards was poor; staff did not wear a gown over their scrubs when outside of theatres.
- There had been one case of Clostridium difficile in the surgical areas in the last year and no cases of Methicillin Resistant Staphylococcus Aureus MRSA. Within the pre-assessment area all patients requiring surgery were screened for Methicillin resistant staphylococcus aureus (MRSA) and patients requiring joint surgery were screened for Methicillin sensitive staphylococcus aureus MSSA.
- Work was in progress to reduce the incidence of some surgical site infections e.g. colorectal and orthopaedic. One clinical business unit had identified the surgical site infection rates for total knee replacement was higher than the national benchmark. Action had been taken which included new procedures implemented including a new pre-assessment route and ring-fenced orthopaedic beds in accordance with national MRSA good practice had been introduced in February 2015.

- The practice of separating medical and surgical patients is identified as good practice to reduce the risks of infection. We observed that no specific separation of medical and surgical patients existed on the surgical arrivals unit during its use as an escalation area.
- We observed sterile techniques being used appropriately in theatres, with personal protective equipment (PPE) used, and sharps management, scrub techniques and swab counts completed as per protocols.
- We reviewed the theatre ventilation and validation reports from the trust and all were up to date.
- Orthopaedic surgery took place in dedicated theatres using specialised laminar flow ventilation; however, no laminar flow existed within the preparation room area. This meant preparation was undertaken in the theatres. Staff told us this didn't delay the lists; however, this is widely regarded as a reason for delay in cases.
- During the inspection we visited a newly re-furbished area that provided lucentis (eye) procedures. This procedure should be delivered in a room with specialised ventilation; we were unable to ascertain whether this was the case. We saw that the couch used to treat patients was split, roof tiles had been sealed, however, gaps existed and the chair used in this room was damaged.

Environment and equipment

- The general environment of the surgical unit was well maintained and wards we visited were tidy and in good order. Access to showers and toilet facilities was good.
- Equipment was appropriately stored.
- We found a large amount of clinical stock to be out of date on one ward. There were 31 pieces of clinical sterile equipment out of date with some dated 2013. These were reported by the inspection team to lead nurse.
- Electrical equipment was tested as per hospital guidelines.
- Resuscitation equipment was checked and found to be signed and dated as per hospital policies.
- Equipment was suitable and available. The main theatres had received new monitoring equipment.
- The sterile services department reported adequate equipment stocks of both of trays and instruments; there were no reports of surgical equipment shortages or delays.
- The theatre environment was observed as small for the numbers of staff within the unit; filing cabinets for staff were stored in corridors as no office space was available and old exit bays were being used as storage areas.
- There was a risk of unauthorised access to the theatres due to the design. Staff were aware of this security risk and a procedure was in place to minimise this risk.

Medicines

- Fridge temperatures were inaccurately recorded on three ward areas. We discussed this with senior nursing staff and corrective action was taken. One fridge subsequently required condemning. During the unannounced part of our inspection, we observed that in one of the same areas, high recordings were again documented, but no actions recorded.
- We observed that 10 drug fridges in theatres were condemned, due to the fridges leaking, reliability and not maintaining correct temperature; these were awaiting replacement and had been ordered. Mitigating procedures had been agreed with the pharmacy department such as identification of the coldest area of the fridge and placing items in that area and drugs being held in a central holding area and removed as needed. The trust confirmed the new fridges had been delivered on 15 July and replaced the condemned fridges following our inspection.
- Processes were in place for keeping medicines secure. Medicine rounds were observed and medication was administered following trust policy.
- Ward controlled drugs were stored appropriately according to legal requirements. Ward controlled drug books completed with signatures and dates; controlled drugs books checked in theatre had three occasions where books were not signed correctly.
- During the inspection we reviewed five drug charts; most charts were clear and accurate and included patient allergy status. However, on one drug chart, new columns had been added to the drug chart instead of it being re-written for two days.
- Oxygen was not appropriately prescribed for four patients we reviewed.
- Audits of medicines administration were undertaken. For example, the audit for the business unit covering trauma and orthopaedics showed 100% compliance on most of the nursing indicators. Low levels of compliance of 70% were noted for allergy status recording.

Surgery

Records

- A national patient administration records system, widely use in NHS had recently been introduced at the trust. All nursing and some medical documentation was stored on this system. Staff spoke to us about the challenges with the implementation of this system and training that had been supplied at the time of "go live". Staff spoke to us about this implementation being a "challenging time." Bank staff were not able to access the system and staff were not aware of how to scroll back in patient's histories on the system.
- We found evidence of junior and locum medical staff sharing passwords for IT systems. We raised these concerns with trust managers at the time of inspection; immediate action was taken to address this.
- We observed that paper patient records still in use were stored appropriately and maintained confidentiality.
- We reviewed eight sets of medical notes (paper and computer based) and found that for two patients, the name, NHS number or date of birth were not completed and doctors signatures were missing.
- We reviewed five fluid balance charts and intentional rounding charts. Most fluid balance charts were up to date and intentional rounding information was complete on all occasions.
- Printed radiology results did not contain the patient's names and no patient identity sticker was attached. This had the potential for errors as the wrong report could be attached for the patient.
- We found that contemporaneous notes were not always made my medical staff in patient notes, for example decisions made during an orthopaedic trauma meeting were not documented. This was confirmed by medical staff. Senior medical staff told us that this information was dictated during the meeting and placed into the noted a day or two later.
- Contemporaneous notes were not made following consultant ward rounds. Two sets of notes reviewed indicated patients had not been seen by an orthopaedic consultant for some weeks; entries were noted from junior doctors and ortho-geriatrician. Staff confirmed that patients had been seen on the ward round, but this was not recorded.
- We reviewed three discharge letters which contained appropriate levels of detail.
- An increase in documentation related incidents had occurred in November 2014. Themes included inadequate documentation, illegible documentation and missing documentation.
- A backlog of urology administration had been cleared in the weeks prior to the inspection and a process had been put in place to prevent the issue from occurring again. However, two patients had had delayed treatment as a result of this issue.
- We observed that revised theatre lists were reprinted immediately following changes, however, no pattern of display to indicate a new list was available existed. Staff could only tell this was a revised list by the time in the top right corner; no revised list heading was in place. There was a potential that staff could still be working to the old list.
- A patient risk indicator flag did not exist on the computer system for patients who were undergoing therapy with anti-coagulants. Staff had highlighted this to the IT department.

Safeguarding

- The wards and departments had systems in place to safeguard vulnerable adults. The nursing and medical staff we spoke to were aware of their responsibilities and appropriate safeguarding pathways to use to protect vulnerable adults and children.
- Staff spoke about a positive relationship with the safeguarding team.
- A safeguarding resource file was available in ward offices and safeguarding posters were on display.
- Safeguarding adults (patient contact) training compliance data across surgical areas showed low levels of compliance when compared against the trust own compliance rate of 90%. In 20 out of 27 occasions, recorded levels were below the trusts 90% compliance rate. For medical staff, compliance rates for June 2015 were below the trust target in ENT (83%), general surgery (63%), orthodontics and oral surgery (64%) and urology (60%) compliance. Nursing staff compliance rates ranged from 75% to 89%. For theatres (CBU 2), the mandatory training compliance for safeguarding adults was 84.5%.

Mandatory training

- Mandatory training compliance rates for nursing staff ranged from 72.3% for resuscitation to 100% for moving

and handling training. The trust's target compliance rate was 90%. Staff told us that they were automatically prompted by the education centre when mandatory training was due

- We found low levels of mandatory training compliance for medical staff in ENT, orthodontics, urology and orthopaedic care. Compliance for these staff ranged between 50 to 81% for fire safety, 44 to 91% for moving and handling and 40 to 86% for infection prevention and control training. Resuscitation training rates for medical staff were below the trust target, for example ENT (86%), urology (50%), orthopaedics (54%) and orthodontics and oral surgery (64%).
- Staff within theatres had basic life support training; trust data from June 2015 showed a 86% compliance rate. Operating department practitioners, who form part of the out of ours on-call team, undertook advanced life support training.
- Mandatory training data was included in the matrons monthly reports and discussed at clinical governance meetings. All senior nursing staff we spoke to were aware of their training compliance rates and areas for action.

Assessing and responding to patient risk

- The World Health Organisation (WHO) five steps for safer surgery process was inconsistently used at Barnsley hospital. The trust had audited compliance between January 2015 and June 2015.This showed mixed levels of compliance that ranged from 33% to 100%.
- During our inspection, we observed seven team briefs within main theatres and found three were completed correctly. We identified missing signatures, missing patient details, missing pause and general poor communication in the other four.
- We observed team briefs in day theatres and this process was fully inclusive, with introductions, details of list changes, reasons and delays were discussed.
- We saw a WHO safety checklist bulletin that had been circulated to all staff in theatres, as an aide memoire to why using the checklist was important.
- Staff used a national early warning score (NEWS) to identify deteriorating patients. We reviewed the records of a patient who had deteriorated and had a cardiac arrest. We saw an early warning score had been recorded overnight and deterioration noted, but no medical review was requested in accordance with the trust guidance. Senior staff on the ward area had identified this and were taking action to prevent recurrence.
- During the inspection, we saw examples of good practice in responding to risk. For example, a patient who had fallen was attended to quickly, fully assessed and actions taken documented.
- An integrated post-operative anaesthetic care unit (PACU)/theatre pathway was in development which incorporated NEWS scores on discharge from recovery.
- SEPSIS 6 bundles were in use in the trust. This is an initial set of medical therapies given to patients with suspected sepsis that has been shown to be associated with significant mortality reductions of patients with sepsis Royal college of Physicians RCP 2014.
- Staff within both surgical ward areas and theatre environments, were aware of the routes of escalation of clinical issues and their role within the escalation policy.
- A dedicated rapid response bay within PACU was equipped with appropriate equipment. This was always kept free to accommodate deteriorating patients. Two beds within the recovery area were slightly bigger by design and these beds were used for patients requiring surgical high dependency prior to their move to a dedicated area.
- One ward was being used to provide additional bed capacity during our inspection. A suitable patient criterion was in use on this escalation ward. Staff said patients that had deteriorated whilst on the ward, had been quickly moved to other more suitable ward areas. The escalation report for this area was reviewed daily by the Head of Nursing for the business unit.
- We found three out of eight pressure ulcer risk assessments charts were completed. Staff told us risk assessments were not completed as patients had "intact" skin; this is not consistent with evidence-based guidance.
- We observed nursing handovers between shifts and staff used a printed pre-generated record sheet saved on a shared computer programme. Handover was clear, detailed and effective and ended with safety information that was concise and thorough.
- Medical handover took place to the hospital at night team every night; handover notes were on a shared drive and printed for oncoming staff.
- Within the day theatre environment, venous thromboembolism (VTE) risk was identified within

pre-assessment, reviewed on the day of operation with the patients and discussed within the team brief. Patients who required thromboembolic deterrent (TED) stockings were identified and these were provided within the theatre suite.
- Within trauma and orthopaedics, patients were measured and had prophylaxis applied within an hour of admission to the ward.

Nursing staffing

- Establishments were identified using a recognised acuity and dependency tool (AUKUH) and safer nursing care tool (SNCT). This was reviewed twice a year. Senior nursing staff told us that they worked to a ratio of 1 nurse :7patients and benchmarked themselves with neighbouring trust.
- Information obtained prior to the inspection, highlighted the number of staffing vacancies within trauma and orthopaedics. Senior staff told us they had six vacancies or 19% of the current workforce. We also noted an increased vacancy rate developing on ward 30 (the escalation ward); staff on this ward said staff morale had suffered due to the mixed use of the ward. The management team were aware of these issues.
- Active recruitment was taking place for all the vacancies. Senior staff on trauma and orthopaedics told us it had become increasingly difficult to recruit to these posts. Senior staff were looking at how to make these posts attractive and had started to offer advanced training within orthopaedics to enhance recruitment to band 5 nursing posts. Advanced trauma nursing, advanced nurse practitioners and arthroplasty nurse specialist positions were developed or in development.
- We reviewed 12 shifts between April to July 2015 on the trauma and orthopaedic unit, 58% (7 shifts) were below planned staffing levels and 42% covered at establishment or slightly above due to 1:1 nursing care being required for a patient. The monthly staffing report to the quality and governance committee in June 2015 showed the average fill rates for registered nurses was 76% and 115% for unregistered nurse during the day on Ward 34. The ward was also supported by advanced nurse practitioners.
- Managers monitored staffing 'red flags.' We reviewed two reports and noted that due to lower than planned staffing levels on ward 31, a patient had had a delayed dose of IV medication associated with a shortfall in staffing.
- Operating theatres were staffed in accordance with the Association for Peri-operative Practice (AFPP) guidance.
- Planned staffing levels were achieved within the post-anaesthetic care unit.
- A stable, dedicated workforce was identified within the sterile services department, with no vacancies and most staff having long service with little staff turnover.
- Ward 30 was staffed as a surgical arrivals area, however, during the time of the inspection was being used as an escalation area. Registered nurse to patient ratios were planned to be 1:7 during the day and 1:12 at night for the 16 bedded ward. During the inspection, we reviewed staffing rotas and found that that staffing levels met these staffing ratios.
- Sickness absence rates for the surgical areas were found to be lower than the England average of 4.7% on half the wards during May 2015. There were higher rates of sickness within the theatre environment. For example, sickness absence was 7.9% in May 2015 against a target of 3.5%.
- We noted a lower than the England average sickness rate for clinical nurse specialist within surgery of 3.7% despite some medical staffing issues.
- Ward managers we spoke to told us they were classed as supervisory and were not included in the ward off duty. This allowed them to take a more management and supportive role.

Surgical staffing

- National data showed the trust had lower levels of consultant cover (26%) in comparison to the England average of 40%. Middle grade cover was higher at 19% compared to England average of 11%, registrar cover was lower at 30% compared to England average of 37% and junior grade cover remained about the same 14% as the England average 13%.
- Vacancy rates at the trust were low for medical staff.
- We were made aware of issues within urology services due to sickness vacancies and trust directors were aware of the lack of senior on site urologists. The trust directors had identified this as a risk and were taking action to recruit staff and make arrangements to ensure that appropriate care was provided.
- Senior medical staff were available on-call over the 24hr period
- Sickness rates were overall below the England average.

- During the inspection we observed that orthopaedic doctors had only one session for ward rounds per week; it is generally accepted that there would be at least two ward rounds.
- We found consultant review documentation in general surgery was good, with daily review on the surgical decisions unit; surgical consultants visited their patients the day following surgery and regularly during admission.
- Junior medical staff told us that they were allocated to a single consultant team for training and supervision, but where arranged into two larger teams to cover out of hours workloads. This was a new system but staff said was working well.

Major incident awareness and training

- Staff we spoke with were aware of the chain of command during a major incident and their responsibilities. They were clear in their descriptions of the command room location and where action cards for responsibilities were available.
- Business continuity plans were available and were clear as to when to defer elective activity and prioritise unscheduled care.
- Major incident policy was available on the policy warehouse.
- A major incident table top exercise was undertaken with theatres business unit in June 2015.

Are surgery services effective?

Requires improvement

Significant concerns were highlighted with the trust in relation to suitable patients with colorectal cancer not being offered laparoscopic colorectal surgery; the trust was the only trust in the country to report 0% in the data tables for offering laparoscopic surgery to suitable patients. Non-compliance with national emergency laparotomy audit data was also noted and a lack in trained laparoscopic competent medical staff.

Staffing on the escalation ward during the night raised concerns because of the mixed competence of staff from different areas in the trust.

Departmental policies were based on nationally recognised best practice guidance. Enhanced recovery pathways for patients undergoing hip and knee replacement procedures were implemented to improve the patient experience and outcomes. Protected mealtimes and a duty "snack monitor" had been implemented to improve nutrition on wards and departments.

Evidence-based care and treatment

- Patients with colorectal cancers were not being offered laparoscopic surgery at Barnsley Hospital. It was unclear if surgeons offered suitable patients a referral to another hospital. The latest bowel cancer audit data from 2014, showed Barnsley NHS Foundation trust was the only trust nationally to have reported 0% in the data tables for offering laparoscopic surgery for colorectal cancer. Laparoscopic surgery for colorectal cancers is widely identified as the surgery of choice for suitable patients according to NICE recommendations for laparoscopic surgery (2006) as this surgery brings increased benefits to the patients of faster recovery. We corroborated this lack of patient choice with the management team which was due to a lack of training and availability of the current surgeons.
- Departmental policies were based on nationally recognised best practice guidance, for example national Institute for health and care excellence (NICE) and the Royal College of Surgeons guidance.
- Policies were all stored on the policy warehouse on the trust intranet. All staff knew how to access policies. Nursing procedure documents were based on the Royal Marsden guidance documents; clinical pathways were stored on the computer system or in paper at the ward clerk area, clinical pathways.
- We observed that the current varicose vein pathway is in line with NICE guidance and currently offers duplex scanning, therapeutic treatment and varicose vein treatment under local anaesthetic.
- Enhanced recovery pathways for patients undergoing hip and knee replacement procedures were implemented to improve patient experience and outcomes. The sterile services department had recently received ISO accreditation in Jan 2015.

Pain relief

- We observed pain scores in use. We observed pain relief being administered appropriately.
- Most patients we spoke to said they had been offered pain relief throughout their stay. One post-operative patient did highlight to us that no pain relief had been

written for them, however, on review of the drug chart pain relief was documented and been administered regularly, however, nothing was prescribed for breakthrough pain. They had reported pain overnight we highlighted this to the nursing staff on the ward.
- No dedicated pain team was available in the trust and this role was allocated to the anaesthetist in charge of the department.

Nutrition and hydration

- Malnutrition Universal Screening Tool (MUST) was in use within the trust to identify adults who were malnourished or at risk of malnourishment; nutritional assessment was not always complete and easily accessible.
- We reviewed five fluid balance charts and found these were completed.
- We observed patients being offered other meal options when they had not eaten much of their meal choice. Patients told us that the food was "ok". When meal trays were being collected following the meal service, we witnessed staff asking if patients had finished and would they like anything from the tray left so they could eat it later.
- Protected meal times were in use on the wards visited. This ensured that staff were available to help patients during a mealtime and patients were not disturbed whilst eating their meal.
- Patients had access to hot and cold meals and were able to choose from a variety of options. Out of hours, staff had facilities to make toast, hot and cold drinks, biscuits and snacks. During restaurant opening hours staff could also use this service for patients.
- A snack monitor was in place. This was a specific role given to a member of staff to attend to all patients throughout the day and provide snacks
- A system of red trays was in use during the inspection for patients who required nutritional support; posters were available for patients explaining the process.
- We observed good support with nutritional needs being offered to patients and positive questions and pace used during nutrition support.

Patient outcomes

- Mortality rates within orthopaedics were noted at being below the national average since SHMI was introduced and has been lower than 100 in 11 of the last 20 months.
- The national hip fracture 2013 and 2014 data showed the trust performed well in six indicators as all were higher than the England average, noticeably better than the England average on admission to orthopaedic care within four hours (62.4%) compared to 48.3% England average. There was only one indicator where the trust performed worse than the England average of pre-operative assessment by geriatrician (35.6%) compared to England average of 51.6%
- Patient reported outcomes measures (PROMS) audit patient outcomes were improving when compared to the England average for the majority of indicators.
- Day surgery rates equated to 54% of all surgical admissions in the trust.
- We reviewed the national emergency laparotomy audit data. The trust had previously self-reported that they were not compliant with all standards. This was due to the provision of facilities to perform emergency laparotomy being unavailable for 15 out of the 28 measures reported on. The medical director was leading work on improving standards.
- Bowel cancer audit data for 2014 showed mixed results. The trust scored better than the England average and good for case ascertainment and multidisciplinary case discussion, but poor for data completeness for patients undergoing surgery. This also confirmed that no laparoscopic surgery was attempted against a national average of 54.8% of cases.
- Length of stay rates were lower for elective and non-elective patients than the England average.
- For June 2014 to May 2015, the overall relative risk of readmission at the trust was lower than the England average for both elective and non-elective surgery. We observed intentional rounding taking place. Intentional rounding is an evidence-based structured process to improve patient care outcomes from pressure sores, oral intake and toileting. We observed this being offered to all patients on a regular basis and documentation being complete.

Competent staff

- Annual appraisal compliance rates for non-medical staff within surgery ranged from 83% for theatre staff to 97% in general surgery. The average compliance rate was 87% across surgery. Medical staff appraisal rates were above 90%.
- Theatre staff spoke to us about issues being raised within appraisals and subsequent action being taken,

for example additional trauma experience being identified by a member of staff during appraisal and supernumerary status being agreed to allow the staff member to work in trauma theatres for a week. Staff spoke to us within the recovery area about recovery services overnight being provided by the theatre team, prior to implementation staff from theatres entering the night on-call rota spent time in recovery and were provided with a template of expectations for recovery patients.

- We observed that the area currently being used as an escalation ward was did not have any establishment for nursing staff after 8pm; staffing overnight was provided by different staff from permanent members on various wards over the hospital; bank staff were identified to be used as backfill. Staff we spoke to told us that this move from their permanent base led to competency concerns and a lack of confidence caring for a diverse group of patients; however, we did not identify any incident forms to support this view. The management team were aware of the challenges this posed in terms of skill mix and increased pressure for staff.
- We observed nursing staff competencies being assessed by audits measuring nutrition, dementia and fluid balance pathway compliance. These audits were carried out via peer assessments with different staff carrying them out every week. The results were contained within the matron's reports and staff told us they were discussed during safety briefs and team meetings.
- When customer care training had been used, competency was assessed through nursing documentation audits, feedback from friends and family test and an open and honest questionnaire.
- Theatre recovery staff spoke to us about competencies in relation to caring for intensive therapy unit patients when there was a lack of available beds. Senior nursing staff had developed a philosophy of upskilling recovery staff with the necessary skills to ensure competency. A competency booklet was in development and agreement had been reached for recovery staff to attend ITU for further development.
- Pre-assessment staff received regular feedback at weekly meetings to ensure competency, e.g. missed documentation and actions taken audits. Two-thirds of pre-assessment nursing staff had undertaken further training through a pre-assessment course at a local university.
- Medical students told us that they had received a very good induction package into the trust; two locum doctors we spoke too had received a locum induction and carried out training on IT equipment, given passwords and mandatory training on the first morning of appointment.
- Urology nurse specialists supported the clinical oversight of urology cancer pathway and ensured patients received appropriate care and treatment. The blurring of professional boundaries was identified as a potential risk.
- Bank and agency staff told us they received an induction which included a written induction document.

Multidisciplinary working

- Within the orthopaedic department, every morning a consultant of the day led a multidisciplinary trauma team meeting which included trauma nurses, advanced nurse practitioners, physiotherapists and junior medical staff.
- A dedicated sterile services department was available onsite with access from 6am till midnight and then on-call access from midnight onwards. We witnessed a good working relationship with theatre staff.
- Staff spoke to us about a positive relationship with the bed management team.
- During the inspection we attended a trauma meeting, this is a consultant led meeting with attendance from the surgical team the meeting was conducted in a professional manner with good discussions held, and a teaching element displayed, lists were prepared in advance and IT systems used during the meeting.

Seven-day services

- During the unannounced inspection medical staff told us that the consultant on call had visited the ward both days of the weekend. Not every patient was visited; however, they were available for questions and support.
- Staff told us that access to out of hours imaging, occupational therapy and physiotherapy and pharmacy provision was good.
- Advanced nurse practitioner roles had been developed. These roles in orthopaedics provided seven day cover and staff told us these roles provided valuable support on the trauma and orthopaedic wards over weekends.

- Sterile services department was available Saturdays, 8am till 4pm, and Sundays via an on-call rota. Staff told us that call outs were approximately 3-4 times per month.
- Pre-assessment clinic opened on occasional Saturdays.

Access to information

- A national recognised patient administration system had been implemented in the previous year, staff spoke to us about issues with implementation of the system and subsequent access to information issues as staff didn't have access to previous day's data if they had recently been on leave or days off. Staff told us that out of hours access to medical notes was good.
- We observed within the theatre reception area good adherence to patient confidentiality guidelines, as patients were sent for only by their hospital number and not by name.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff spoke to us about their knowledge and experience of MCA and DoLS. Staff were aware of procedures for gaining consent and the need for referrals where required.
- We reviewed 3 consent forms and noted all aspects were correctly complete; one consent form had been updated on the day of surgery from the original consent for authorised 3 months earlier.
- Two patients we spoke to spoke about excellent consent process and risks and benefits being explained.
- Staff we spoke to could clearly explain when consent was required and how documentation of consent takes place, and procedure to take should a patient not provide consent.

Are surgery services caring?

Good

Throughout the inspection we saw positive, kind and caring interactions on the wards between patients and staff. Patients spoke positively about the standards of care they had received.

Most patients we spoke with felt they understood their care options and were given enough information about their condition. There were services in place to ensure that patients received appropriate emotional support. Results from the trust friends and family tests showed a slightly higher response rate compared to the England average.

Privacy and dignity was not always maintained consistently within the surgical areas.

Compassionate care

- Results from the trusts Friends and Family test from March 2014 to February 2015 showed a slightly higher response rate (40.1%) compared to the England average (38.9%). Overall, over 95% of responses during the reporting period would recommend the trust for treatment.
- Friends and family information was displayed on the wards and departments we visited and comments were also displayed from the information people had supplied. We noted that these comments were all positive and spoke about "highly committed and capable staff" and "clear explanations provided" and "when you buzzed staff answered quickly".
- All patients we spoke to or observed had direct access to the call buzzers.
- We observed a poster for patients that highlighted difficulty sleeping at night whilst in hospital and offered earplugs and eye masks to make their stay better.
- We observed privacy and dignity was mostly maintained within the trust. We saw and patients told us how their dignity was maintained. There was a mixed sex waiting area in main theatres which potential compromised dignity; this had been identified by the trust and male and female only waiting areas were in development.
- We observed and patients told us that call bells were answered quickly. We observed patients appearing comfortable. Communication with patients and relatives was kind, appropriate, reassuring and caring.
- Staff spoke positively to us within trauma and orthopaedics of the patient having the best journey they could.
- Patient feedback boards were available in endoscopy and day surgery suite with patient's letters and cards displayed.
- We observed a dedicated plaque being on display from a relative to all staff on the ward to thank them for the

care they provided to a patient. The inscription on this plaque read "because you live I have life" and was inscribed with all the staff names that had looked after the patient.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been involved in there care decisions and risks and benefits of surgery had been discussed. Patients on the orthopaedic wards talked about "fantastic explanations" from medical staff.
- Two patients we spoke with said they had experienced some miscommunication as they thought they were being admitted for day surgery however, had subsequently realised they were in-patients with a planned overnight stay.
- Patients we spoke with were happy with their plans of care and understood reasons for admission and what was required to happen prior to discharge, patients said that "staff tell you everything".
- A relative's room was available for patient's relatives to stay on the ward. This two bedded area was well equipped with drink making facilities, bed, chairs and TV. Staff also made toiletries, brushes and towels available for patient's relatives to use.

Emotional support

- We spoke to staff who told us about patients they had cared for; staff told us how they had stayed with a patient who was dying as no-one else had been able to stay with them. Staff also attended the funeral of this patient.
- Staff spoke with genuine fondness about their patients and that sometimes patients just needed a "cuddle" and a cup of tea, and how they enjoyed the stories patients shared.
- Access to Clinical nurse specialist's was good and the colorectal nurse specialists CNS service was offering excellent, patient centred, holistic support to the patient diagnosed with bowel cancers. This included accompanying patients to theatre pre-operatively and collecting them post-operatively and phoning relatives to inform them of when patients were in recovery. A good level of support was offered to ward staff in terms of teaching and advice. A patient's support group had been initially set up by the colorectal CNS, however, this was now run by patients and the CNS attended as members for advice.
- Chaplaincy services were offered throughout the trust.
- Signposting notice boards were available in the endoscopy and day surgery suites to clinical nurse specialists throughout the trust.
- Quiet rooms to break bad news and relative overnight stay rooms were available. These were important areas to promote dignity and confidentiality and communication and support for patients and family members.

Are surgery services responsive?

Good

During the reporting period April 2013 to November 2014, the trust performed better than the standard and the England average for the 18 weeks from referral to treatment target. The trust performed much better than the England average for the number of patients not treated within 28 days of a procedure cancelled at last minute for non-clinical reasons. The percentage of patients (with all cancers) waiting less than 31 days and 62 days from urgent GP referral to first definitive treatment was better than the England averages. Breaches of national waiting time targets including the cancer waits were occurring in some specialties. Surgical elective and non-elective length of stay data was better in the trust than the England average.

There was access to a specialised dementia nurse and learning disability nurse. We saw examples where lessons had been learned and actions taken following complaints.

Service planning and delivery to meet the needs of local people

- Barnsley Clinical Commissioning Group commissioned services at Barnsley hospital.
- Barnsley was not classified as a cancer centre and had developed strong partner relationships with neighbouring trusts.

Access and flow

- Between April 2014 and March 2015 15,390 episodes of surgical care (inpatient, day case and non-elective (emergency)) had been delivered by the trust. This equated to 1,281 episodes per month.

Surgery

- Most attendances were day case admissions (7,729) with an average of 644 per month episodes from April to March 2014. Non- elective surgery accounted for 68% of cases to 32% elective.
- The referral to treatment time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment within secondary care. During the reporting period April 2013 to November 2014, the trust performed better than the standard and the England average. Overall, the trust had been significantly outperforming the standard and the England average prior to May 2014, when a decreasing trend was noted; however, this decreasing trend mirrored the England average.
- The percentage of patients (with all cancers) waiting less than 31 days and 62 days from urgent GP referral to first definitive treatment was better than the England averages. Between Quarter (Q)1 2013/2014 and Q2 2014/2015 the percentage of people waiting less than 31days ranged between 99% and 100%. The percentage of people waiting less than 62 ranged between 88% and 94%, during the same time period. However, some specialities had not consistently achieved the cancer pathway RTT target of 85%. At March 2015, the 62 day cancer treatment wait for lower and upper gastrointestinal tract had been achieved in eight out of the 23 pervious months and 13 out of 22 months respectively. The 62 day GP referral to treatment wait for urology patients had been achieved in 16 out of 23 months.
- Increases in the numbers of admissions had been noted throughout Barnsley hospital and staff spoke to us about issues this had caused and the number of patient outliers from medicine on surgical areas. Trust data showed that within surgery in June 2015, 320 medical patients were nursed within the surgical wards.
- Length of stay data for June 2013 to July 2014 showed overall elective admission length of stay was 2.3 days; this was below (better than) the England average of 3.3 days. For non- elective admissions, the length of stay was 4.4 days and better than the England average of 5.2 days.
- Patients undergoing elective surgical admission were admitted to the surgical arrivals area prior to them going for surgery. However, during the inspection, the arrivals area used as an escalation area and surgical patients were admitted directly to wards. The escalation area was open for 9 days in April and 10 days in May. A process was in place to allocate the most appropriate ward for admitted patients. We observed that a delay in theatre occurred related to poor communication over patient placement.
- There had been 190 cancellations from April 2014 to March 2015. This equated to less than 0.7% of total admissions. This was a mix of cancellations by the patient and the trust for clinical and non-clinical reasons.
- The trust performed much better than the England average for the number of patients not treated within 28 days of a procedure cancelled at last minute for non-clinical reasons. We found that between January and June 2015, 0.1% of surgery was cancelled on the day of the operation. Staff told us that few on the day cancellations occurred due to patient unsuitability and spoke about a positive pre-assessment process.
- Theatre utilisation had recently been reviewed and efficiencies increased to ensure utilisation met the trust 82% target. Trust data for April 2014 to March 2015 showed utilisation rates of 83.3% to 90.3%. Day theatre utilisation rates were lower with 58.7% to 74.1 % and trauma theatres 67.5% to 78.7%. Theatre scheduling was discussed weekly by a multidisciplinary team of business managers, lead nurses, medical secretaries and waiting list co-ordinators, lists agreed were locked down two weeks before theatre was due to commence.
- A mixture of all day and half day sessions were used with theatres running 9am to 5pm during the day. We observed that NCEPOD classification and access to theatres were used. Some concerns were raised that the theatre used for NCEPOD work was furthest from the main department. List overruns were identified in NCEPOD and trauma theatres; staff identified this often occurred weekly.
- Access to a dedicated ophthalmology day case suite was available 7am to 6pm Monday to Friday.
- Main theatres were used for two elective caesarean theatre lists per week and standard operating procedures were in use.
- We observed access to trauma theatres being available seven days a week. Trauma meetings occurred daily to plan the lists.
- We observed systems within pre-assessment clinics and spoke to staff in this area who told us that a “one stop shop” system had been developed and implemented in the two weeks prior to our inspection and was due to run for four weeks. This system allowed patients to

come to pre-assessment clinic direct from outpatient's clinic at the time of listing. Approximately 300 patients were seen per week (60 per day) under the old system and now 100-200 patients per week (20-40 patients per day) were being seen.

Meeting people's individual needs

- Staff we spoke to were aware of the ethnic diversity of their local area. Patient information documents were available electronically and these were available in other languages. A telephone line interpretation service was also available.
- Welcome signs were available in different languages such as Chinese, Russian, Polish and Arabic on the endoscopy and day surgery suite. Signs were available on this poster to welcome people with sign language, breast feeding, visual impairment and disability.
- We observed signing boards being available for patients with hearing impairments
- Access to a specialised dementia nurse was available and staff spoke very positively about relationships with the dementia team. Specialised care plans were available called 'reach out to me' and the butterfly scheme was used. Dementia twiddle mats were available for patients and a sugar cube café had been introduced.
- Access was available to a specialised learning disability nurse and patients with learning disabilities had an 'all about me' care plan. The learning disabilities team supported staff when making deprivation of liberty (DoLS) applications. Staff within pre-assessment clinics spoke about access to the learning disabilities specialist nurse and safeguarding team and staff attending clinic and holding pre-planning meetings prior to admission, to help with patient's needs.
- We saw multiple patient information leaflets available. These provided advice and guidance on domestic abuse, inclusivity to transgender patients. Prostate information was available including for African and Afro Caribbean men and gay and bisexual men
- Two bays within the post-anaesthetic care unit were for paediatric patients; these bays were decorated by the play leaders and had blanket warmers and separate area for preparation of drugs.

Learning from complaints and concerns

- Within the general surgery business unit, 48 complaints had been received between, June 2014 to May 2015. The average time taken to close a complaint was 35 days. The longest response to close a compliant was noted as 116 days and number of re-opened cases was less than 10% of all complaints.
- We reviewed 10 recent complaints and their responses: we saw that apologies where offered and letters were very detailed and provided clarity of responses to concerns raised. Plans to prevent the same complaint from occurring and discussions required of any shortfalls were identified.
- We observed information being available on wards and department how to access the complaints procedure and to access the patient advice and liaison service (PALS).
- Senior nursing staff, were aware of the numbers of complaints received, outstanding actions and themes behind complaints; complaints were shared via communication book discussions, memos and through staff meetings and governance meetings.
- We saw examples where lessons had been learned and actions taken following complaints.
- Staff were able to describe complaint themes and action taken to prevent recurrence.

Are surgery services well-led?

Requires improvement

During the inspection there was no clinical lead for surgery in post. Recommendations made in serious incident reports were reviewed in historic serious incidents; these had not been consistently acted upon and the similar incidents had occurred since. The lack of offering laparoscopic colorectal surgery to patients at Barnsley hospital had not been addressed. Public engagement was limited.

A clear vision and strategy for surgical services at Barnsley existed. A clear governance structure within the business units was apparent. Nursing leadership at ward level was good, with positive interactions between staff, ward managers and matrons noted. Some good areas of innovation, improvement and sustainability were noted.

Vision and strategy for this service

- The trust had a vision for the hospital to be the best integrated healthcare organisation of choice for local

communities and beyond. Three values had been agreed around treatment of people, working together and individual needs. Strategic objectives were identified as the 4 P's; patient, partnerships, people and performance. Staff we spoke with were able to discuss with us the 4P's.
- Senior medical staff and nursing staff were aware of business plans within their business unit.

A strategy document was available for each business unit and we reviewed three for the business units covering surgery. These documents were clear with issues of concern, deadlines and future initiatives identified. Within the strategy documents key risks and timescales were identified.

- Individual senior staff had visions for their service which fitted with the trust vision. As a surgical speciality, no overall specific surgical vision was available as the speciality spanned three business units.

Governance, risk management and quality measurement

- A clear clinical governance structure existed within each of the business units covering surgery.
- A trust wide quality and governance committee received and discussed all the business unit governance minutes.
- We identified that when recommendations made in serious incident reports were reviewed in historic serious incidents these had not been consistently acted upon and the similar incidents had occurred since. For example, patients in the urology service had received delays in treatment.
- We reviewed eight sets of clinical governance minutes for the three business units.
- Trauma and orthopaedic staff told us they held their own speciality governance meetings. We received and reviewed a set of minutes for this meeting held in July 2015. Governance capacity, mandatory training compliance, incidents, friends and family test results, performance, finance, theatre scheduling were documented as discussed. Mortality rates, complaints or learning was not documented as being discussed.
- We reviewed three sets of CBU 2 governance minutes and attendance was good. The meetings well-structured and documented with discussion around incidents, complaints, mortality and learning.
- We reviewed four sets of governance minutes for CBU 4. Attendance was poor from medical staff with no clinicians present in January 2015; the clinical director was present at the other three meetings. Nursing staff presence was good and themes discussed included complaints, risk register, serious incidents, incidents, IPC and mortality.
- Risk registers were reviewed, for surgical and theatre business units open risks were noted for trauma and orthopaedics these themes of these being staffing and vacancy rates, and risk of current staffing levels. The risks were consistent with the findings at the inspection.
- We noted seven open risks on surgical risk register; the oldest open risk was from September 2014. Senior staff explained the action taken to address this risk and explained this was to be removed from the register. High risks were noted for the provision of urology services in Barnsley due to the lack of substantive consultant urologists. Lack of consultant cover in cancer services was noted as a high risk and the stress this placed of the urology specialist nurses. The trust managers were aware of the risks associated with urology in order to sustain a service actions had been taken to mitigate the risks both in the short term and longer term.
- The lack of offering laparoscopic colorectal surgery to patients at Barnsley hospital had not been addressed. National guidance regarding this had been available since 2006.
- Staff told us that Band 6 and above were able to place items on the risk register.
- The CBUs reported to the trust risk management group who reviewed all actions, complaints and SIs within all business units.
- Directors of the trust had recently commenced patient safety and quality visits. These were director led with attendance from governance team, matron and clinical risk team.
- The human resources department provided detailed human resource monthly reports for the business units. These provided key information on sickness rates, recruitment issues and vacancies, staffing levels, appraisal rates and mandatory training compliance data. Senior staff spoke to us about these reports being useful.

Leadership of service

Surgery

- There was no clinical lead for surgery in post. The management team were aware this post was vacant and had not been able to identify a surgeon who wanted to carry out this role. The trust has since confirmed that this post is now filled.
- During the inspection we noted that the clinical director for CBU 4 was also the clinical director for CBU 5. The previous clinical director of CBU4 had stepped down and no one was available to undertaken this role so it was shared. The clinical director was a current practicing surgeon and undertaking both roles and surgery was described as being “very busy”.
- The matrons for the CBUs produced a monthly report which referenced targets and trajectories for their area including sickness rates, environmental audit results, mandatory training compliance rates, numbers of incidents and themes, key performance indicators, e-rostering and staffing issue and friends and family results. The theatre matron produced a similar report, and included observations of theatre practice compliance data, patient’s pre-operative journey audit compliance data and WHO checklist audit data. We saw evidence of these reports being discussed at the business unit governance meetings. All ward managers we spoke to were aware and made reference to these reports. We were told that the theme of these reports was “sharing not accusing”
- Due to the business units covering many areas both medical and surgical some of the matrons had very diverse areas of responsibility such as emergency department, stroke unit and orthopaedics or matrons that looked after areas within three different business units. Clinical business unit one, which incorporated emergency services, trauma and orthopaedic surgery and care of the elderly services had two matrons posts, however at the time of the inspection there was one matron in post with recruitment being undertaken for the second post.
- A trust based leadership programme had been developed. Some surgical staff had been through this leadership programmes in the past.
- Senior staff were aware about succession planning and gave examples of their plans.
- During an interview with the surgical management team they told us that they performed well in providing safe care to patients, they were proud they didn’t have many SI and complaints and were proud of the friends and family results
- Staffing vacancies occurred within the surgical business units, however, the management team talked to us about examples where partnership working with other neighbouring trust was working to improve recruitment e.g. oncology services.
- We observed senior management within theatres management team being visible within theatres and Matron within day theatres holding weekly meetings at a time that meant there was increased attendance.

Culture within the service

- Staff morale appeared good. Staff were positive and told us they felt confident about being able to raise concerns. Staff told us that the culture was more open recently for both patient and staff and described the culture at Barnsley as healthy and supportive.
- Staff told us that the executive team had become more visible over the previous year.
- Staff told us that they “loved working at Barnsley hospital. “They were very proud of working at Barnsley and the care they provided and proud of feedback received from student nurses
- Staff spoke about being proud of the partnerships they had developed to improve patient’s journey such as high dependency unit partnerships and outreach team. They were also proud of the teams they worked in and the service they delivered for patients.
- Staff spoke to us about their concerned about the escalation ward usage and the movement of staff to cover shortfalls in staffing.
- All staff we spoke to spoke positively about the support they received from senior members of staff.
- Staff in theatres reported a family friendly feel to the department, “looking after each other” and theatres been a “happy place to work." A senior medical staff told us that “Barnsley was the best department he had ever worked in”. Another doctor told us they regularly carry out locum work in other trusts and “Barnsley was a much better place to work."

Public engagement

- Friends and family test were used and the data provided was reviewed and acted upon. This data was available for other patients with display on communal corridors.
- Changing lives information was available on wards we visited and on the orthopaedic ward areas best practice tariff data was displayed and compliance with the seven standards.

Surgery

Staff engagement

- Staff had been engaged in the refurbishment plans of the newly developed orthopaedic unit.
- Staff within the theatre suite we spoke to all said they felt empowered to speak out and raise concerns.
- Staff told us that opinions on new projects or proposals were gained prior to development and staff felt valued.
- Band 6 meetings take place in orthopaedics every two weeks and feedback and key messages are provided.

Innovation, improvement and sustainability

- Advanced Nurse Practitioners (ANP) had been developed within trauma and orthopaedics. These staff were nurses who had received extra training and skills to master's levels and were now able to carry out health assessments, diagnostics and investigations. A key part of their role was to identify sick patients and proactively take their management forward and prevent deterioration. ANPs were also able to clerk patients with hip fractures and worked very closely with the ortho-geriatrician to help manage their patients. Staff in this role we spoke to saw themselves as a patient advocate in the trauma meetings and they had helped to deliver excellent compliance rates with the best practice tariff. As they worked weekends they thought that they had a significant effect on patient outcomes on a weekend, as they were on the wards to identify sick patients or to offer support and advice to junior members of staff. Data however, had not been collected to corroborate this.
- Staff on ward 32 had been involved with the local college to develop a care certificate for unregistered staff. This work was carried out prior to a national care certificate being available.
- A project was on-going within theatres about eye protection for anaesthetised patients. This project was being led by a band 6 nurse to improve skin and eye damage during surgery. Engagement from the clinical team was noted and project evaluations forms were seen and were completed by operating department practitioners and anaesthetists.
- We observed development of a surgical decision unit scan pathway which will decrease the length of stay for surgical patients.
- The development of the orthopaedic elective unit had occurred in February 2015 and now ensured compliance with the ring fenced orthopaedic policy.

Critical care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Barnsley Hospital NHS Foundation Trust provided a seven bed Intensive Therapy Unit (ITU) with a separate room for stabilising children or neonatal. The seven bed unit consisted of a main ward with six beds, each separated by curtains and a side ward. The facilities on the unit were prepared to care for five patients with Level 3 and two patients with Level 2 care needs. The stabilisation room for children had one bed and it was used between six to eight times a year. However, due to better facilities in the emergency department at the hospital, the usage of this side ward (stabilisation room) had been further decreased.

There was a surgical high dependency unit (SHDU) away from the ITU on another level of the hospital. It provided four beds for post-surgical and emergency admissions. SHDU accommodated patients with level 2 or level1 needs. - Level 1 is when patients need additional monitoring with clinical interventions and advice. Level 2 care is accessed by patients needing close observations and treatment or pre-operative monitoring due to their medical condition or extended postoperative monitoring following major surgery. Level 3 is when patients require advanced respiratory support with a minimum of two organs support.

During the inspection we visited the ITU and the SHDU units. On ITU we spoke with two patients and four relatives. We spoke with 19 staff including the clinical director, matron, lead nurse, pharmacist, nutritionist, clinical educator, members of the outreach team, on call doctors, domestic staff, healthcare assistant, medical technician, medical, nursing staff and students.

We reviewed three care records from ITU and one from SHDU. We attended handover sessions and observed a ward round to ascertain how information was cascaded among staff.

Critical care

Summary of findings

We rated the care delivered by the intensive therapy (ITU) and the surgical high dependency (SHDU) units as good.

Staff used the trust policies and procedures when reporting incidents. Details of incidents and the lessons learnt were shared among staff and action was taken to prevent or minimise the occurrence of similar incidents. There was a multidisciplinary team (MDT) approach to reviews of incidents, morbidity and mortality. Staff attended organisational inductions, mandatory training which included safeguarding and infection prevention and control.

The Safety Thermometer results between April and June 2015 showed the unit had performed better than the nationally expected targets. The units had sufficient supplies of equipment and cleaning products to maintain safety. Equipment was cleaned in line with the department of health infection control policy. Staff we spoke with were aware of the major incident policy and their role in managing it.

An outreach team made up of a consultant, a nurse, a physiotherapist and a healthcare assistant supported patients when they were transferred from ITU or SHDU to wards. They also assessed deteriorating patients within the hospital and decided whether patients would be appropriately cared for in either SHDU or ITU.An outreach team supported patients when they were transferred from ITU or SHDU to wards. They also assessed deteriorating patients within the hospital and decided whether patients would be appropriately cared for in either SHDU or ITU. A multidisciplinary team approach meant care was delivered in a more co-ordinated and consistent way which had a positive impact on patient progress and the length of time spent on the unit.

The computerised system used by nursing staff was seen as onerous, time consuming and unreliable. Access to information for bank and agency professionals was available after appropriate training. Management told us that there was a system in place to provide agency nurses with their own unique access login. However to maintain safety this automatically expired after 30 days.There was good understanding of the Mental Capacity Act and its application.

Patients and relatives we spoke with told us that they would recommend this service to others. We observed examples of good compassionate care and treatment practices by staff. Staff had implemented the use of 'patient's diaries' on ITU. Relatives had access to a bereavement service and enquiries about organ donation were attended to by a specialist nurse.

The ITU and SHDU services worked collaboratively with the surrounding NHS providers to meet the needs of the local population. Patients discharged from ITU and SHDU had access to a follow-up clinic. Staff were proud to work at the Barnsley hospital and they understood the priorities.

There was a clear structure within the unit for doctors, nurses and the multidisciplinary staff. They demonstrated their roles and their specific responsibilities during our inspection so that patients received consistent care.

We found that 24 hour intensivist cover was not provided for ITU in accordance with Core Standards for Intensive Care Units guidance (2013), however plans were in place to address this. On six occasions over two weeks the lead nurse and the clinical educator were counted in the numbers to ensure safe staffing levels. The fill rate of shifts for registered nurses was 80-85% during days and 93 -97% at nights over the previous three months.

Critical care

Are critical care services safe?

Good

Staff used the trust policies and procedures when reporting incidents. Details of incidents and the lessons learnt were shared among staff and action was taken to prevent or minimise the occurrence of similar incidents. There was a multidisciplinary team (MDT) approach to reviews of incidents, morbidity and mortality. Staff attended organisational inductions, mandatory training which included safeguarding and infection prevention and control. Nurses had a structured training programme however, doctors received ad hoc training. Senior consultants had plans in progress to improve doctor's training once they had filled all consultant vacancies.

The safety thermometer results between April and June 2015 showed the unit had performed better than the nationally expected targets. The units had sufficient supplies of equipment and cleaning products to maintain safety. Equipment was cleaned in line with the department of health infection control policy. Staff we spoke with were aware of the major incident policy and their role in managing it.

An outreach team made up of a consultant, a nurse, a physiotherapist and a healthcare assistant supported patients when they were transferred from ITU or SHDU to wards. They also assessed deteriorating patients within the hospital and decided whether patients would be appropriately cared for in either SHDU or ITU.

We found that 24 hour intensivist cover was not provided for ITU in accordance with Core Standards for Intensive Care Units guidance (2013); however, an identified anaesthetist provided cover overnight. On six occasions over two weeks the lead nurse and the clinical educator were counted in the numbers to ensure safe staffing levels. The fill rate of shifts for registered nurses was 80-85% during days and 93 -97% at nights over the previous three months.

Incidents

- All staff had access to an electronic system for reporting incidents. Staff knew how to use the system and were confident about when they should report incidents, including serious incidents and never events.
- There had been no never events between 1/05/2014 and 30/04/2015. The lead nurse told us that this had not changed at our inspection on 16/07/2015.
- The National Reporting and Learning System (NRLS) records between 1/06/2016 and 30/05/2015 highlighted 32 incidents. Of these 28 were determined to pose no harm to patients, three were low harm and one was rated as moderate harm.
- Records showed that there had been three serious incidents between the beginning of May 2014 and to the end of April 2015. One related to a pressure ulcer grade 3 and two related to the mismanagement of medicine.
- Documents demonstrated that the system for escalation, investigation and for cascading outcomes to relevant people was active so that future incidents could be avoided or minimised. We reviewed documents where incidents had been reported and investigated. Root cause analyses (RCA) were carried out appropriately with action points.
- We saw evidence that lessons learned were shared amongst staff to minimise the risk of further incidents. Different communication channels were used, such as internal email, during shift handover, staff meetings and weekly news letters. We observed the staff communication system at handover where learning from incidents was discussed by the nurse in charge with all staff in attendance. The information included any changes to policies, procedures and practice resulting from an investigation to avoid such incidents being repeated. Staff we spoke with on both units were fully aware of the lessons learned from the incidents.
- We saw minutes of last three monthly morbidity and mortality (M&M) meetings. The review meetings involved a multidisciplinary approach and a critical analysis of the information to find out if the incidents could have been prevented or managed differently. We were informed by the lead nurses on the units that data from these meetings was escalated to board level as required and M&M activities and actions were formally recorded. We saw the minutes of two such meetings.

Duty of Candour

The clinical director, the head of nursing, the lead nurse and the clinical educator in ITU had a good understanding of Duty of Candour principles. They described examples where they had met with families, offered explanations and supported them as soon as they became aware that an incident had occurred.

Critical care

Safety thermometer

- The information from the NHS Safety thermometer was displayed on the unit. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care.
- Staff were able to tell us the rationale and the importance of data collection and were proud of the results. In the last three months, April to June 2015, their achievements have been better than expected national targets. They were:
  - All pressure ulcers on the unit 0% against a target of 1.9%
  - ITU acquired pressure ulcers 0% against a target of 0.7%
  - Falls with harm on the unit 0% against a target of 0.3%
  - All catheter related UTI on the unit 0% against a target of 0.1%
  - New catheter related UTI 0% against a target of 0.1%
  - Venous thromboembolism (VTE) 0% against a target of 1.4%.
- An audit clerk was employed between the two units who worked 12hours a week to collect and submit data for different sectors which also included safety thermometer.

Medicines

- The systems in place for the management of medicines included compliance with the medicines act 1968 and the Misuse of Drugs Act 1971. The pharmacist informed us that they and the nurses on the units monitored the compliance through daily checks and monthly audits. We saw daily recordings and the checks made during June, they showed full compliance.
- We observed nurses and doctors administering medication to patients at the times it had been prescribed for.
- Medication was administered in a person centred way and appropriate checks were carried out beforehand by staff to maintain safety. We observed that staff explained what the patient was given and why even when the patient was ventilated and sedated.
- We reviewed five Medication Administration Records (MAR) and found them to comply with the national prescribing guidelines.
- Allergies were clearly documented in the MARs and patient's name hospital number, date of birth was recorded.
- We noted when a medicine was omitted. The reason for the omission was clearly documented on the MAR as well as in the patient's nursing notes to ensure clarity.
- The pharmacist informed us that medication compliance in the unit was audited regularly; and the results were discussed amongst the multidisciplinary staff and required changes were acted upon. Staff we spoke with confirmed that it happened.
- Controlled drugs (CD) were handled appropriately and stored securely. We looked at the CD records and there was evidence that regular checks had been made by nurse on the unit.
- Nursing staff said they felt confident and competent to administer medication.
- A senior pharmacist visited the unit at least twice daily between Mondays to Friday and there was an on call pharmacist who was in the hospital for advice at the weekends. Pharmacist carried out regular review of the stock drugs in the unit, attended daily ward round with the consultants, sought a general over view of the new patient's medication and offered their view to the doctors.
- Local microbiology protocols for the administration of antibiotics were in use. We were informed that each day a microbiology ward round took place where antibiotic prescribing standards were considered to ensure compliance with national best practice. This ward round happened separately to the consultant ward round. At the microbiologist ward round, notes were completed and information was shared with the medical staff that were on the unit.

Mandatory training

- Within the critical care units i.e. ITU and SHDU there was a clinical educator who was responsible for co-ordinating training for nurses and health care support workers. The clinical educator showed us an up to date training record and the planned training dates for those who needed to attend training to be fully compliant.
- The training records for ITU on 30 June 2015 showed that nursing staff overall compliance was 94%, however resuscitation training was attended by 73%.

- The low attendance of resuscitation training within the critical care units was due to the lack of available training for staff. The management team were aware of this but they were unable to tell us the action taken to rectify this as this was under review.
- We were informed that the medical staff training records were maintained by the Anaesthetic directorate and multidisciplinary staff attended training within their respective disciplines.

Safeguarding

- We found on the units appropriate safeguarding vulnerable adults and children's policies were available to staff.
- The staff we talked with demonstrated a good knowledge of what safeguarding meant in practice and were able to tell us the escalation process to raise a safeguarding concern.
- There has been a recent appointment of a trust lead for Safeguarding and that link staff from each ward/unit had been identified to work with them so that they were able to cascade updates and maintain a consistent approach.
- The clinical educator also played an integral part in making sure all staff complied with attending Safeguarding training.
- On 30 June 2015, the training records showed that 92 % of staff had received in-house training in safeguarding adults and 96% of staff had attended Basic awareness training on Safeguarding children. We noted that staff who were not up to date with training had been allocated dates for training.
- Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the unit.

Cleanliness, infection control and hygiene

- It was over five years since the last hospital-acquired MRSA bacteraemia was treated on the unit. Intensive Care National Audit & Research Centre (ICNARC) data supported this. The data also confirmed that there had not been any patients with C difficile this year.
- All patients in the units had their MRSA status checked.
- There was a side room within ITU which was available if isolation was needed.
- There was a floor to ceiling screen at one end of the SHDU providing enclosure for the end bed. This bed area was to be used as barrier nursing area. It had a separate sink.
- We found the clinical areas within intensive care to be clean and free of offensive odour.
- Areas away from patients were cluttered due to the lack of storage space. This was highlighted in the risk register by staff. The head of nursing and other senior managers were aware of this.
- Sharps bins in use were dated and signed by a member of staff in line with the local policy and not overfilled.
- We saw the cleaning logs used by nursing staff. It included equipment in use by patients and patient areas. We were informed by staff that they had a list of equipment and the member of staff who was responsible for cleaning them. This was audited by the matron and reported to the lead nurses on each unit. The lead nurses shared with us the audit reports which staff had been made aware of.
- The matron carried out monthly audits on the cleanliness and infection control. The findings were reported to the lead nurse. The last audit before our inspection was carried out on 22/06/2015. We saw the actions taken by staff to rectify the areas which needed attention. For example comments were made about dust on trolley base on the paediatric cubicle and suction canisters on the main ITU. We observed these areas during inspection and found them to be clean.
- Staff training in infection prevention and control was 100% compliant on both units.
- Cleaning of the units was undertaken by contractors. The cleaners serviced the unit between 7am and 12pm and a member of the cleaning team visited the unit in the evening to empty bins.
- The Lead nurses told us that yearly deep clean of the units took place. During cleaning the units were decanted into the theatre recovery unit whilst being cleaned. This year ITU was to be cleaned during the August bank holiday weekend between Friday 29 and Monday 31 August 2015.
- We observed staff adhering to infection control policy and using personal protective equipment (PPE) when delivering personal care. Family members we spoke with told us that staff wore PPE when caring for their relatives and changed them once they had completed the task.

- Staff told us that they had access to PPE and other disposable consumables.
- The Clinical Nurse Specialist Infection Prevention and Control (CNSIPC) for the trust carried out an audit in May 2015 of the unit and a written feedback was given which highlighted areas for improvement. The lead nurse showed us the action plan and discussed with us the actions taken so far. The recommendations were mostly good practice examples and working with the available resources. E.g. how to work around the problems with storage was one of the heighted areas.
- Staff we spoke with were well aware of the policy for prevention of infection and the findings of the recent audit by the CNSIPC. They gave us examples such as ensuring they work bare below elbow, removing PPE before moving on to another task such as answering the phone and avoiding storage of boxes on the floor so the floor could be cleaned. This illustrated the information had been cascaded to staff.

Environment and equipment

- The units provided mixed sex accommodation. The main units were separated by curtains. There was a paediatric cubicle situated outside of the unit
- SHDU had an open layout with screens to divide bed areas. There was also a floor to ceiling screen at one end providing enclosure for the end bed.
- The trust was in consultation with the commissioners regarding the open plan, mixed sex critical care unit environment. However, the risks were managed by ensuring there was appropriate screening between beds to maintain patients' privacy.
- There was lack of space between the beds on the unit and posed difficulty if patients were to sit out of bed. We saw patients sitting out of bed and staff had moved the bed to a side to make sufficient room for the patient.
- The lack of windows in ITU was an ongoing problem which could contribute to patients unable to orientate themselves of the time and place.
- Monitoring equipment had been replaced following a successful bid to the Clinical Commissioning Group.
- Staff told us that they were able to request new and replacement equipment they needed to do their jobs and had no problem getting authorisation from managers.
- We saw an equipment log held in the unit by the technician and the nurses.
- We noted that the equipment we saw had stickers in place stating the date they had been serviced or PAT tested.
- A member of the cleaning team told us that they had daily tasks and weekly tasks to complete. These were audited by their manager and they received feedback. They said for example records were kept of curtain changes on the unit to maintain control of infection.
- Resuscitation trolley and equipment was kept within easy reach of staff in the unit. We noted throughout June 2015 and up to our inspection16 July 2015 each day the resuscitation equipment had been checked and signed by staff. Records we saw ensured safety checks were completed without gaps.
- Nursing staff told us that regular and temporary staff received the necessary training to ensure they were able to use different types of equipment available in ITU. The training was supported by the medical devices representatives.
- Doctors did not receive similar training. They told us that they often relied on their colleagues or nursing staff to help familiarise themselves with unfamiliar equipment.
- We noted that the lead nurse and the medical equipment technician were responsible for device availability and compliance with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance.
- We observed the ITU environment did not have sufficient storage space for equipment. We discussed this with the nursing team who agreed that it was an ongoing issue and it had been raised with their risk register. In the interim the room used as stabilisation for children and staff meeting areas were being used. In the event of needing the children's stabilisation room we were informed that equipment stored in there would be moved out to the staff room.

Records

- Patients' records were stored securely on the units to maintain confidentiality.
- We reviewed four sets of patients' records. Hard copies of patients' files contained multidisciplinary professional notes except nurses' notes. Nursing notes were held on the computer system. Records we reviewed were legible and filed in chronological order. This demonstrated a systematic approach to managing patient information.

- Each patients' record included decision to admit to intensive care, individual care plan, risk assessments, daily progress, reviews, multidisciplinary decisions and consent to treatment.
- The records demonstrated personalised care and treatment approach with a multidisciplinary input.
- We noted there was written evidence of regular communication with relatives or patient's representatives.
- Administration staff informed us that the electronic system they used was "marvellous to track down notes" and it ensured patients notes were with them at all times. This arrangement helped clinicians to have access to all the information to aid treatment.
- The written information kept by doctors, nurses and other staff for their personal prompts during the shift was disposed of by them as confidential waste.

Assessing and responding to patient risk

- Elective patients had a comprehensive risk assessment as part of preparation for admission to the units. Patients admitted as emergency had their risk assessment performed whilst they were on the unit.
- We saw samples of these assessments when we viewed the care plans of patients. The risk assessments had been reviewed and amended according to the changing needs of the patients.
- The records showed that risks were managed positively. We were informed that when a patient was on oxygen through a mask for a length of time, risk of soreness on the face where the mask came into contact was identified. To prevent this action was taken to use a helmet or a cap to supply oxygen therefore avoiding soreness to the patient's face.
- When we checked four patient's records we observed that on admission patients had received an assessment of VTE and a clinical risk assessment on bleeding
- A local version of the National Early Warning Score (NEWS) system was used by staff within the hospital to assess deteriorating patients. The NEWS score is an assessment tool that enables the early identification of deterioration in a patient's condition. It was used to identify patients that require input from the critical care outreach team.
- Patients were assessed by critical care outreach team and decisions were made as to the best place patients should be cared for and whether they needed admission to the critical care units ITU or SHDU.
- One of the outreach sisters informed us the process for escalation and that they followed the criteria for admitting patients to ITU or SHDU.
- They told us that once patients were admitted to the critical care unit the NEWS score was discontinued and transferred to the relevant critical care documentation.
- Staff on ITU described the actions they took when they identified deterioration in patient's condition.
- The outreach sister told us when a decision was made that a patient was fit for discharge from the critical care units patients would be commenced on a NEWS score to ensure there was a baseline prior to leaving critical care for the ward to continue monitoring.
- Patients who deteriorated on the hospital wards during the hours of 8am – 8pm had access to the outreach team. Out of hours patients were reviewed by the Hospital at Night and resident on call team.

Nursing staffing

- We were informed by the head of nursing that an acuity tool which was based on safer staffing tool was in use. Acuity and dependency tool is an evidence-based decision making tool to decide on staffing and workforce levels.
- The staffing establishment had been calculated to cover five level three and two level two patients on each shift.
- The planned staffing levels for the three shifts per day on ITU were seven registered nurses during day shifts and six registered nurses at night.
- The numbers did not include the lead nurse or the clinical educator. However, we noted that on six occasions over two weeks the lead nurse and the clinical educator were counted in the numbers to ensure safe staffing levels.
- NHS England 2014/D9/S/a guidance states that, ITU must have a supernumerary clinical coordinator available at all times and one whole time supernumerary Clinical Educator. During our inspection we saw the lead nurse was also working as the coordinator during their shift.
- We found that the team understood the reasons for staff shortages, continuously monitored staffing and escalated appropriately. Nursing staff told us that the current staffing numbers were "a little tight" due to maternity leave and unexpected sickness.
- The healthcare assistants (HCA) worked between 7.30am and 6pm.

Critical care

- We checked three months staffing levels comparing the planned staffing levels and the actual staff who had been on duty. This showed a fill rate for registered nurses of 80-85% during days and 93 -97% at nights.
- To ensure continuity of care staff told us they worked bank shifts when possible and occasionally used agency staff who had experience working in ITU. The records showed that they had not used agency staff during the last two weeks of our inspection.
- We found that regular staff had worked long shifts to cover any shortages due to sickness. These staff included the lead nurse and clinical educator.
- The rota showed that there were four Band 5 nurses on maternity leave. There was no arrangement for backfill to cover their shifts.
- However, the lead nurse informed us that a process for filling virtual vacancies had been introduced. This meant that if there was prior knowledge of permanent staff member going on maternity leave for example, their post could be backfilled by the pre-vetted and inducted temporary staff who had already adjusted to working in the critical care unit environment.
- SHDU staffing on days included Lead nurse, Staff nurse (SN) and a HCA.
- The sickness level on SHDU was 0.9% against a target of 3.5%.
- We checked three months staffing levels comparing the planned staffing levels and the actual staff who had been on duty. This showed a fill rate for registered nurses of 94-100% during days and over 98% at night.
- Nursing handover included a safety briefing followed by a brief update on all patients for staff arriving on duty by the lead nurse/ care co-ordinator in a private room.
- Each nurse handed over the care of the patient they had been looking after to the staff coming on duty using Situation Background Assessment Recommendation (SBAR) format.
- To ensure adherence with the flexible working policy, working hours and preferences of working patterns of staff had been reviewed. The information had been taken into account when rotas were completed. Staff members told us that they also had to be very flexible to ensure safe staffing was maintained and patients' care was not compromised. We reviewed the staff rota and found evidence of staff changing their rota at short notice.

Medical staffing

- We reviewed two weeks planned medical rota to ascertain the medical cover for ITU. According to the planned rota there was first and second on call. Medical cover was provided from Monday to Sunday for ITU.
- We were informed SHDU was covered by the surgical team.
- Consultant intensivists were available during the week between 8am and 8pm and at the weekends between 8am and 2pm. An on-call consultant anaethetist or an intensivist covered ITU the remainder of the time. This meant that a consultant in intensive care was not immediately available at all times (to attend within 30 minutes) in accordance with Core Standards for Intensive Care Units guidance (2013). However, plans were in place to address this.
- Consultants worked a four day block on call. The FICM Workforce Advisory Group guidance states that a five day block of day shifts on ITU reduces burn-out in intensivists and maintains the same patient outcomes as 7 day blocks. Therefore consultant shift cover at the ITU was better than the guidance.
- There were two medical handovers and a consultant ward rounds every day, including weekends, where doctors had opportunities to discuss cases and learn.
- We observed a medical handover one evening. It was consultant led, included the whole anaesthetist team. It took place at patient's bedside with some written information shared amongst them.

Multidisciplinary staff: Pharmacist, Physiotherapist, Nutritionist

- A senior pharmacist visited the units each week day in the morning and also joined the consultant ward round. At the weekends an on call duty pharmacist within the hospital was available to support the unit.
- We were informed that patients were able to receive physiotherapy seven days a week and those who required the service at the weekend were in receipt of the treatment from the on call staff.
- We spoke with the nutritionists who informed us that there were changes to their structure and that in the interim one of their team members provided a daily visit to the units. They attended ward rounds and worked closely with nurses. They said that nurses were good at adhering to the protocols, sharing information and seeking advice. There was an out of hour's protocol and staff were able to be contacted for advice.

- The above staff were managed and their competencies checked by their line managers within individual departments.

Major incident awareness and training

- We saw staff had access to the major incident policy and the procedures.
- Staff we spoke with said they had received training on Major incident awareness.
- The lead nurses had prepared a prompt list for nurses to help them follow the set procedures as part of the business continuity plan if a major incident should happen. For example what action to take if more beds were required within ITU, what to do if electricity, lifts, IT or telephone system failed.
- Staff we spoke with knew their role in managing a major incident. This included multidisciplinary staff.
- Doctors confirmed they had business continuity action cards to refer to.

Are critical care services effective?

Good

We have rated the effectiveness of critical care service delivered by Barnsley Hospital ITU and SHDU as good.

Patients and relatives told us that staff made sure people were kept comfortable and pain free. Staff were aware of their responsibility to assess, plan and deliver the most appropriate treatment in line with up to date evidence-based guidance so that patients received suitable treatment and care. A multidisciplinary team approach meant care was delivered in a more co-ordinated and consistent way which had a positive impact on patient progress and the length of time spent on the unit. The outreach team worked closely with the nursing and anaesthetic staff in the intensive care unit. The outreach team helped to promote a seamless service in the patient's journey. The team remained a point of contact for patients from the time they leave ITU or SHDU and whilst attending rehabilitation when they get home.

Patient diaries kept by nurses on the ITU were known to reduce post- ITU anxiety and post-traumatic stress disorder (PTSD). The outreach team members used the diaries to help patients make sense. Due to the limited number of staff employed in the outreach team not all patients were reviewed by them before on discharge causing gaps in service.

A risk was highlighted with regards to the present system where the responsible consultants did not always visit the patients on ITU when they were under the intensivists (consultant anaesthetist with intensive care speciality). This meant the responsible consultants got to know of their patients only when they were notified by the ITU staff when the patients were ready to be transferred to the wards or the SHDU.

The computerised system used by nursing staff was seen as onerous, time consuming and unreliable. Access to information for bank and agency professionals was available after appropriate training. Management told us that there was a system in place to provide agency nurses with their own unique access login. However to maintain safety this automatically expired after 30 days.

Discussions with medical and nursing staff informed us that it was not always possible to seek consent as patients arriving on the unit may not be able to comprehend and give consent. In such circumstances they told us they applied the best interest principles and made decisions involving patient's representatives or an independent advocate.

Evidence-based care and treatment

- To determine the best treatment for the patients a combination of national guidelines were used. These included guidance from National Institute for Health and Care Excellence (NICE), Intensive Care Society and the Faculty of Intensive Care Medicine.
- The multidisciplinary staff were aware it was their responsibility to assess, plan and deliver the most appropriate treatment in line with the up to date evidence-based guidance.
- We found that there were continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC) by the audit staff on the unit. This meant ICNARC staff were able to provide information comparing Barnsley Hospital ITU patient outcome with similar units nationally. Staff informed us that they used the information to see how well they

were performing and they were encouraged by the results. The results between 2 January and 31 March 2015 showed that the critical care unit mortality was similar to other units.
- Unit acquired MRSA, Clostridium difficile (C Diff) and blood infections were zero.
- We saw staff using patient pathways and specific care bundles which reflected national guidance. We were informed that based on the recent guidance staff have reviewed the eye care and mouth care procedures and had made the necessary changes. This meant staff kept up to date with practice changes.
- We saw evidence and staff we spoke with informed us that all sedated patients had a daily sedation hold. This meant that sedation infusions were stopped to ensure that patients had their level of sedation assessed in line with best practice guidelines.
- Staff had a good understanding of normalising the care environment to minimise delirium and confusion of patients nursed on the unit.

Pain relief

- Staff used a pain assessment tool as well as them speaking to patients and asking them how comfortable they were and offering medicine to control pain.
- Medication administration records demonstrated patient's pain had been regularly assessed and the changes had been made by the doctors.
- We observed all the patients on the unit and they looked comfortable. We spoke with two patients during our visit to ITU about the management of pain who were satisfied with their pain management.
- Relatives told us they were very happy in the way patients were kept comfortable on the unit. They said they had not seen their family member in pain or upset.

Nutrition and hydration

- We found that all patients had their nutritional needs assessed and had a plan of care in place. Malnutrition Universal Screening Tools (MUST) had been used to assess patients' nutritional needs.
- Patients had input from a nutritionist who ensured that patients received an appropriate feeding regime as soon as it was medically feasible.
- We saw patients receiving Total Parenteral Nutrition (TPN) and Percutaneous Endoscopic Gastrostomy (PEG) feeds whilst on the unit. Staff told us that they had received training and were confident when attending to the feeds.
- Feeding regimes were reviewed and adapted appropriately to reflect individualised care by the nurses and the nutritionist.
- Staff we spoke with had a good understanding of the need to keep patients hydrated. They maintained fluid balance charts which included hourly and daily input and output records for all patients. Patients who were able to take oral fluids were encouraged by staff.
- Staff told us that those who were ventilated had their circulatory volumes continuously monitored.

Patient outcomes

- The average length of stay for patients in ITU was 4.1 days and the longest stay in SHDU was three weeks.
- The records showed the patient turnover on SHDU was 35 to 40 per month.
- Results from ICNARC showed that patient outcomes and mortality between 2 January 2015 and 31 March 2015 were within expected ranges when compared with other similar services.
- The trust had two incidents of ventilator associated pneumonia since October 2014.
- Patient specific audits were carried out each month by the matron in charge of ITU to monitor patient's outcomes. In June 2015, the nursing care of four patients was audited. The areas checked included medicines management, privacy and dignity, infection prevention and control, tissue viability, nutrition and hydration, observations and pain control. The audit report was comprehensive and showed a good level of compliance. Any areas for improvement and actions were identified.

Competent staff

- A band 6 sister was appointed as clinical educator and took up post in April 2014. In the last three months they had completed assessments of all staff learning and development needs.
- A chart showing staff attendance of mandatory training was displayed in the seminar room so that information was accessible to all staff and to encourage staff compliance.

Critical care

- The lead nurse and the clinical educator had drawn up staff supervision and appraisal dates. They told us that had completed most appraisals. Trust data showed 98% of non-medical staff on critical care had an annual appraisal completed. Nurses we spoke with confirmed they have had supervisions with the lead nurse.
- The lead nurse informed us that the clinical educator and she worked alongside to observe practice and offered support to nurses. Staff told us that they asked for support if they were not confident in carrying out a procedure.
- All nursing staff were subjected to an annual registration check and were supported to maintain their continuous professional development.
- A total of 47% of staff had completed post registration certificate in critical care nursing. Further staff had been identified to undertake training. The Core Standards for Intensive Care Units guidance (2013) recommends a minimum of 50% of registered staff have a post-registration ward in critical care nursing.
- The lead nurses informed us that they followed the hospital procedures when managing staff performance and development to maintain consistency.
- The pharmacist explained that they had attended training relevant to critical care and maintained their continuous professional development and participated in clinical supervision activities. The units had access to a senior pharmacist.
- We were informed that there was support and guidance for newly appointed consultants within the anaesthetic department.
- Medical staff underwent 360 degree appraisals as part of the revalidation process.
- Records of training and revalidation dates were held within the theatre directorate for the anaesthetists.
- It was acknowledged by the clinical director that due to consultant vacancies there could have been a lack of junior medical staff support and training on the unit; however the feedback from the survey undertaken by the Deanery was positive and did not demonstrate any shortfalls
- They had submitted a business plan for further five consultant anaesthetists and had appointed three so far. The educational supervisor's numbers had also increased from 15 to 19. This meant action was taken to address staff training and support.
- We spoke with three new staff to ITU. They had attended a hospital induction which was followed by a four week clinical supernumerary period on the unit and they were allocated a mentor.
- New staff were subject to competency assessments to ensure they were confident in using the many different forms of perfusion devices, ventilators and infusion pumps.
- Staff we spoke with were very happy with the induction and support they were in receipt of.
- Clinical educator told us and showed evidence that although staff were given time scales for completing competencies, they were not rushed and each member of staff assessed individually for their competence and confidence.
- Medical staff told us that they received the organisational induction and adhoc training on the unit when it was possible. They said they received support from their seniors.

Multidisciplinary working

- We observed good multidisciplinary working within the units and amongst the wards and linked to other organisations.
- Medical staff followed the criteria for people who would and would not benefit from admission to critical care and this was shared with other professionals involved.
- We saw the reasons for admission to the units were clearly recorded in patient's medical notes so that the information was available for the multidisciplinary team.
- Once a patient was ready to leave ITU the relevant medical or surgical team was contacted by each discipline (doctors, nurses, physiotherapist, pharmacist) and information was shared to promote multidisciplinary working. The same principle was followed when patients were transferred to other hospitals.
- The outreach team enhanced multidisciplinary team work. The team involved a consultant, two band 6 sisters, a physiotherapist and a HCA. The nurses discussed the physical and psychological issues and gave detailed explanations to the patient and family regarding what happened on ITU, their recovery and what to expect, and any follow-up services they could offer.

Seven-day services

- ITU and SDU offered a seven days service. There was nursing staff and medical staff available over seven days.
- There was a Monday to Friday 9am to 5pm cover from the pharmacist, microbiologist, physiotherapist and nutritionist. At the weekends and evenings they provided on call cover.
- There was access to radiography and radiology seven days a week.
- Staff told us that getting support from members of the MDT out of hours could be difficult. This was due to staff being busy in other areas.

Access to information

- Patient information came in two forms. Most of the information kept by nurses was on a computerised system and other multidisciplinary team members used paper records to keep information and they were kept in one folder.
- We were informed by staff that when they transferred a patient from ITU to SHDU or a ward, a formal handover took place between the multi-professionals involved in the patient care to the team taking over the care. Medical staff handed over the patient information to the appropriate doctor from a medical or surgical team. The nursing staff handed over verbally and transferred information electronically. Nurses told us that they also provided hard copies of information as part of the discharge as the electronic records were not always reliably transferred.
- There had been problems highlighted with the electronic information system where delays had happened and staff had to provide hard copies of information. This was known to the management and highlighted following introduction of a new computer system.
- We were informed when patients were on ITU they were often cared for by the consultant anaesthetist. Once the patient was ready to be moved from ITU, the speciality consultants were notified and information about the patient was passed on to ensure staff had the necessary data to continue the care.
- A risk was highlighted with regards to the present system where the responsible consultants outside the unit did not always visit the patients whilst they were on ITU under the care of the Intensivists (consultant anaesthetist with intensive care speciality). This meant that on occasions the specific consultant was briefed about their patient only when they were notified by the ITU staff that a transfer back to the ward was planned.The new computerised system used by nursing staff was seen by some as lacking in user friendliness. It was onerous and time consuming. Due to frequent system failure they said sometimes information was not updated. Accessibility of information to bank and agency staff was restricted; keeping patients records up to date was also difficult.
- Other multidisciplinary professionals did not have access to the information held in the computer. This was identified as a risk to accessing patients' information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had systems in place that took into account and respected patients' human rights and ensured valid consent was gained whilst patients were cared for in the unit. Discussions with medical and nursing staff informed us that they understood and applied the Mental Capacity Act.
- The notes of three people we viewed demonstrated that consent had been sought from the patients and families had been involved.
- Relatives told us they were given enough information and support by staff so that they were able to be involved appropriate in the decisions. This was due to the patient being unconscious not having capacity to decide. The relatives said staff asked them if they wanted an independent advocate to be present to help them with their decision. But they did not feel it was necessary. We found the conversation was clearly recorded in the patient's notes to ensure information was available to all relevant people including clinicians to avoid any misunderstandings.
- The trust's Deprivation of Liberty Safeguards (DoLS) policy and the implications for the Critical Care Unit were under review at the time of inspection. We were informed by the clinical educator that plans were in place to implement the procedure by October 2015.
- Staff we spoke with had received training in the Mental Capacity Act. The education co-ordinator shared the records on Mental Capacity Act training and explained that not all staff had attended training and they were being given dates to attend.

Are critical care services caring?

Critical care

Good

We have rated the care delivered by the Critical Care service at Barnsley Hospital (ITU and SHDU as good.

Patients told us that they were looked after by staff who were caring and kind. Relatives said patients received gentle and empathetic care from staff. Patients and relatives were able to access religious representatives through the hospital chaplaincy service to support them with emotional and faith needs.

Friends and Family data collection was not in use on ITU, however, information was sought from the intensive care patient support group (ICPSG). The recent feedback confirmed high levels of patient and relative satisfaction. On SHDU, 3 monthly patients' feedback was sought through FFT and we saw the results which were mostly positive. Two points for improvements were noted and we noted action had been taken.

Doctors told us that information to patients was communicated in a way that was tailored to individual patient's needs. Nurses said that they were often present when patients were given information by other professionals so that they were able to give further support to ensure patients and relatives had understood. We saw written documentation in the medical and nursing notes where patients and their relatives had been involved in making decisions about care and treatment.

Staff, especially the outreach team, promoted the use of information within patient's diaries to assist patient's psychological rehabilitation. Staff told us that breaking bad news about a patient's condition worsening was usually carried out by a doctor in a sensitive and compassionate way that allowed relatives to ask questions about the information they had been given. This was confirmed by two relatives we spoke with on SHDU. Staff knew the procedure for approaching relatives for organ donations when treatment was being withdrawn.

Compassionate care

- We observed all staff treating patients in a kind and compassionate way which promoted patients' dignity and respect.
- Relatives told us that all patients received gentle and empathetic care from staff. They said "Care was wonderful and staff were fantastic".
- Patients told us that they were looked after by staff who were kind. We noted curtains were pulled around bed spaces during personal interventions and during ward rounds regardless of the conscious state of the patients.
- We observed unconscious patients being communicated with by nursing and medical staff in a kind and respectful manner.
- Patients and family members confirmed that staff made sure appropriate measures were taken to keep patients pain free and comfortable.
- Patients and relatives were able to access religious representatives through the hospital chaplaincy service to support them with emotional and faith needs.
- Friends and Family data collection was not in use since there was uncertainty of its relevance. However, information was sought from the Intensive care patient support group (ICPSG) which confirmed high levels of patient and relative satisfaction with the care delivered on the unit.
- On SHDU 3 monthly patients' feedback and Friends and Family test surveys had been carried out and mostly positive comments received. Two points for improvements were noted and action had been taken. For example, soft closing bin lids and the reduction of noise at night.
- Nurses and a doctor told us that information to patients was communicated in a way that was tailored to individual patient's needs and shared examples.
- Relatives told us that they would recommend the service to a friend or a loved one.
- We observed staff respecting patients'' confidentially at all times for example when discussing results of tests, when handing over care. Relatives confirmed this.
- There was one overnight stay room available to those who wanted to stay closer to their critically ill relative. People had access to food and drinks from the hospital canteen.

Understanding and involvement of patients and those close to them

- Three relatives we spoke with confirmed that they felt fully informed by the medical and nursing staff and they were very satisfied. One relative said, "I feel that I have been fully involved in my (family member's) care and treatment."

Critical care

- Two patients commented that they were very happy with the treatment they were in receipt of. Patients confirmed that before staff did anything they took time and explained in a way they could understand. They said they were given time to ask questions. This meant patients were given opportunities to agree or disagree if they wanted to. One patient said, “They are always explaining and asking me. I give them my full consent
- We saw staff interaction with patients and when possible finding out from patients their care needs.
- Staff were considerate when explaining about the treatment and made sure they spent adequate time explaining so that the patient was able to understand and get involved.
- Families were seen by staff either with the patient or separately depending on the information they wanted to share. This was done in the best interest of the patient to avoid unnecessary anxiety and distress. Staff explained the planned treatment and the expected outcome to family members. They also sought from the family members patients’ preferences to care and treatment so that the relative felt being part of the decision making process.
- Nurses and a doctor told us that information to patients was communicated in a way that was tailored to individual patient’s needs. We saw an example where a patient who was very anxious and distressed, was regularly kept informed of progress. Later on in the day the patient seemed settled and understood what had happened.
- Staff members used good verbal and nonverbal methods of communication. That promoted better understanding and reduced patient anxiety.
- Staff informed us that they had access to language interpreters, sign language interpreters, specialist advisors or advocates.
- We saw evidence in the medical and nursing notes where patients and their relatives had been involved in making decisions about care and treatment.
- Staff knew the procedure for approaching relatives for organ donations when treatment was being withdrawn. They told us that the specialist nurse for organ donations would be contacted and with their guidance they would manage the situation. However, the two staff whom we spoke with had not been involved in this process.

Emotional support

- We were told that emotional support was provided by all members of the critical care team.
- Staff were fully aware of the impact on patients’ wellbeing following admission to ITU.
- The service promoted the use of patient’s diaries. The use of diaries are known to reduce post-ITU anxiety and post-traumatic stress disorder (PTSD).This assisted patients with reflecting retrospectively on their experience of critical illness and helped those coping with critical care unit post-traumatic stress disorder.
- We talked to members of staff around breaking bad news about a patient’s condition worsening. Staff told us that this was usually done by a doctor in the presence of a nurse. They said this was done in a sensitive and compassionate way that allowed the relatives to ask questions about the information they had been given.
- Patients and relatives had access to a chaplaincy service. Staff told us that they were able to access representatives from the local religious denominations.
- We were informed through the outreach team that most patients had access to psychological support by a psychologist following discharge. This helped patients with post-traumatic stress from being on ITU.

Are critical care services responsive?

Good

We have rated response to the need of patients by the critical care service at Barnsley Hospital ITU and SHDU as good.

The ITU and SHDU services worked collaboratively with the surrounding NHS providers to meet the needs of the local population. Patients discharged from ITU and SHDU had access to a follow-up clinic. This was usually planned and organised by the outreach team. However, this service was unable to meet the demand due to the lack of staff. The care plans we viewed demonstrated that people’s individual needs and preferences were taken into consideration before care was delivered to ensure people were empowered and care was centred on their needs. Relatives told us that they had seen the leaflet about making a complaint. They said they could speak in

confidence with doctors or nurses if they wanted raise any concerns. The lead nurse told us that there had not been any formal complaints in the 12 months before the inspection and the records kept on the unit confirmed this.

Proposed admissions to the unit were always reviewed by a consultant anaesthetist. In response to deterioration in a patient's condition the nurses working in the outreach team referred patients directly to the ITU consultant for review and with the view for admission.

Service planning and delivery to meet the needs of local people

- Barnsley Hospital ITU and SHDU services worked collaboratively with Sheffield, Doncaster and Wakefield NHS health and social care providers to meet the needs of people. Health watch team members told us how closely the hospitals worked in partnership. Patients who spoke with us explained how their treatment had been planned between hospitals and they were fully aware of the reasons for it.
- Information about the needs of the local population was sought through clinical commissioning groups (CCGs), GPs, local health watch team and historical information held at the hospital when calculating the number of patients needing non-invasive ventilation (NIV) and elective surgery. The staffing on the unit was organised to meet the needs of five people with level 3 and two people with level 2 care needs. The levels of care reflected the dependency and the critical conditions of the patients.
- Patients who had been on ITU and SHDU had access to a follow-up clinic. This was usually planned and organised by the outreach team. We found some patients did not receive the follow-up care arrangements and support on time due to insufficient staff to organise it. However, needs due to the financial constraints within the trust, action to expand the service has been postponed.
- Arrangements were in place to collaboratively manage patients with complex weaning problems to refer them to the regional centres. A protocol was in use to assist staff with the referrals and the transfer.
- In collaboration with North Trent Critical Care Network the unit measured its activities to test their performance. This included occupancy, type of admission, level of care, organ support days and number of delayed discharges. The data between 1 April 2014 and 31 March 2015 showed that the performance was in line with the national average.
- A multidisciplinary disciplinary team (MDT) approach to care meant that care was delivered in a more co-ordinated and cohesive way which had a positive impact on the patient progress and the length of stay on the unit.
- Involvement from the outreach team helped to promote a seamless service. They saw patients on ITU and on the wards after discharge.
- A specialist nurse was responsible for dealing with the process of organ donation. Staff told us that they made the referral if patient's representatives wanted to discuss organ donation. There were leaflets available for families to read.
- Due to the limited number of staff employed in the outreach team not all patients were reviewed by them on discharge. The service was not offered over seven days. The total number of new patients seen between January and June 2015 was 286 which was less than (292) the previous 6 months. This was due to staff leaving and lack of available staff.
- The physiotherapists provided an individualised rehabilitation program for each patient and the HCA provided rehabilitation assistance. The HCA also organised the follow-up clinic appointments, sent out letters, contacted patients at home and entered data so it could be monitored and evaluated.
- Staff told us that patients were transferred between 7am and 10pm. ICNARC data showed that the number out of hours discharges (between 10pm and 7am) was less (better) than similar units.
- We observed a patient being transferred to another hospital at 8.30 pm during our inspection. We noted staff ensuring all the information was sent on to the hospital and staff telephoned the unit to make sure staff had received the necessary information and also to make a link with professionals at the hospital.

Meeting people's individual needs

- The lead nurses and staff we spoke with told us that the criteria used for admission to the units did not discriminate people on their age, gender or ethnicity.

Critical care

- All staff we spoke with included multidisciplinary professionals had attended training on equality and human rights and were fully aware of the relevant legislation and the impact on their line of work.
- The care plans we viewed demonstrated that peoples' individual needs and preferences were taken into consideration before care was delivered to ensure people were empowered and care was centred around their needs.
- The staff working in the units had access to interpreting services to ensure understanding of people's needs. During our inspection we noted that the patients on the units did not require interpreting services. However, staff knew who they should contact and what services were available for people.
- We saw the protocol that staff followed if a patient with learning-difficulties (LD) was admitted to the unit. It was comprehensive and easy to follow. They used a document referred to as 'All About Me' which is specific to people with LD. Two staff who spoke with us were familiar with using the document. The clinical educator told us that further training for staff had been planned to support them when people with a learning disability were admitted. They also told us that training had been planned to familiarise staff with providing care for people with dementia on the unit and the care of patients with delirium. Staff we spoke with had a good understanding of normalising the care environment to minimise delirium and confusion of patients nursed on the unit.
- We found the unit promoted protected rest and sleep times for patients by minimising activities, turning down the lights and minimising all noise in the unit. This was between 2 and 4pm every afternoon and 10pm and 7am. We witnessed the rest time during the afternoon on our inspection.

Access and flow

- The unit provided a service with a capacity of 7 beds. The ICNARC analysis confirmed that the patient stay on the unit averaged at 4.1 days.
- The bed occupancy for adults never reached 100%. It was around 91% and similar to the England average.
- Proposed admissions to the unit were reviewed by a consultant anaesthetist.. Nurses on the outreach team were able to refer patients directly to the consultant in charge of ITU for review and admission.
- The lead nurses from ITU and SHDU met each morning to share information about patients on their unit and make plans for transfers so that elective admissions could be accommodated on the unit. We spoke with both lead nurses about the flow of patients and efficient usage of beds.
- Data reviewed for the last 12 months demonstrated that elective surgery had not been cancelled due to the lack of ITU beds.
- Patients who were transferred from the unit had a critical care consultant review and their care overseen by the outreach team. This meant readmission rates to the unit were reduced because patients' individual care needs were managed effectively after discharge.
- ICNARC data showed that the number of patients whose discharge from the unit was delayed by four hours or more was consistently better than similar units.
- We noted that transfers were delayed due to delay in beds becoming vacant or if patients were being transferred to a different hospital the transport was delayed. We observed a patient waiting from 3pm until 8pm waiting for an ambulance to arrive. However, this delay did not have a negative impact on the bed situation as the unit had an empty bed.

Learning from complaints and concerns

- People who used the service knew how to make a complaint or raise concerns.
- A relative said they had seen the leaflet about making a complaint. Two other relatives said they could speak in confidence with doctors or nurses if they wanted raise any concerns.
- The lead nurse told us that they had not had any formal complaints in the last 12 months and that concerns were dealt with promptly and efficiently by them so that they did not get escalated to a formal complaint.
- There were no records of any complaints whether they were formal or informal. We discussed with the staff team the usefulness of keeping records of any compliments and concerns by patients or relatives to identify any themes.
- We saw a copy of their complaints leaflet which was comprehensive and gave the details of contacts.

Are critical care services well-led?

Critical care

Good

We have rated the services led by the critical care service at Barnsley Hospital ITU and SHDU as good.

The staff on the units informed us that the vision of the unit was to continue to deliver its services in line with the trust values through strong clinical and managerial leadership. They wanted to continue embracing new technology to achieve improved patient outcomes. Staff were proud to work at the Barnsley hospital and they understood the priorities.

A monthly update to the risk register was produced at each Clinical Business Unit (CBU) meeting. At the June 2015 risk assessment meeting, three areas of risks were identified and actions were agreed to minimise the risks. Patient specific audit were carried out each month by the matron in charge and in June 2015, four patients were audited and the outcome demonstrated that staff complied with the standard operating procedure and had delivered appropriate care.

There was a clear structure within the unit for doctors, nurses and the multidisciplinary staff. They demonstrated their roles and their specific responsibilities during our inspection so that patients received consistent care. This also confirmed that the team had the capacity, capability, and experience to offer their service. There was a multidisciplinary team (MDT) approach to treatment and care of patients in the unit. We observed staff teams work collaboratively, constructively and shared responsibility.

Vision and strategy for this service

- We saw information about the vision, the priorities and values of the trust displayed on notice boards around the hospital and in the entrance of wards and ITU. It clearly identified what were the trusts priorities were and the values underpinning them.
- Staff informed us that the vision of the units were to continue to deliver its services in line with trust values through strong clinical and managerial leadership. They wanted to continue embracing new technology to achieve improved patient outcomes. For example, a new medicine management system involving 'Intelligent' drug cabinets –was due to be installed in August 2015. They said the system would improve safety, reduce waste, avoid waiting for medication once prescribed and looked user friendly.
- Vision for the future efficient management of the adult critical care beds were seen as the expansion of the SHDU to accommodate patients who had increased levels of needs, but did not require to be on the ITU but needed to be cared for in a more appropriate environment. Through monthly risk assessments the CBS 2 team has identified the risks and challenges to the service they offer and were working on an action plan. For example lack of Surgical High Therapy Unit SHDU beds for surgical patients due to beds on ITU being used by patients requiring Non-Invasive Ventilation (NIV
- We found there were strategies discussed for upskilling staff who worked on the wards by giving them opportunity to work on ITU and gain skills and knowledge so that they were able to support staff and supervise the care of critically ill patients on the wards.
- There was an overarching strategy for the critical care provision within the clinical business unit (CBU) 2 and the staff on the unit knew of the goals and aspirations of their own department.
- Staff we spoke with were aware of the strategic priorities of the service. Staff were proud to work at the Barnsley Hospital and they understood the priorities.

Governance, risk management and quality measurement

- Due to the changes to the Board members and the senior management structure of the governance framework, we found that members have not had sufficient time to embed its strategies.
- The multidisciplinary staff we spoke with were clear about their roles and they understood what they were accountable for.
- Staff used their organisational policies and procedures when working with outside agencies and organisations. They told us when sharing information they used guidance on Data protection and Information Governance to ensure safety and security of information.
- A monthly update to the risk register was produced at each Clinical Business Unit (CBU) meetings. They included the risks within both ITU and SHDU services. At the June 2015 risk assessment meeting, three areas of risks were identified on ITU and on SHDU five areas had

been highlighted. The risk was described with mitigation, consequences of the risk was categorised and level of risk was agreed with action notes. The risks identified during our inspection corresponded with the ones highlighted by the unit's risk registers.
- Staff responded to suggestions from the 'Patient support group' and the comments by the visitors to the unit by ensuring patient diaries were maintained, psychological support was offered to patients, follow-up clinics were run and patients were left to rest between 14:00 and 16:00 hours when lights were dimmed down.
- We met with members of the Critical Care Outreach Services (CCOS). They had a small team of four members, three qualified and a support worker. CCOS is defined by NICE as 'a multidisciplinary organisational approach to ensure safe, equitable and quality care for all acutely unwell, critically ill and recovering patients irrespective of location or pathway'. It is also fundamental in providing educational support to enhance skills and knowledge of the multidisciplinary ward teams in general ward areas when caring for the at risk and deteriorating patients. This has been identified by the senior management including the clinical director who are looking into expanding the service when the financial state of the trust improves.

Leadership of service

- There was a clear structure within the unit for doctors, nurses and the multidisciplinary staff. They demonstrated their roles and responsibilities during our inspection so that patients received consistent care. This also confirmed that the team had the capacity, capability, and experience to offer their service.
- We met with the Clinical Director for Intensive Care who gave us an insight into the challenges such as needing more intensivists and the plans to resolve some of these issues.
- There was an identified lead nurse who was formally recognised with overall responsibility for the nursing elements of the service.
- Staff told us that they had not seen any board members in person including the Chief Nurse, Chief Executive Officer (CEO) and the Chairman on the unit.
- A Band 6 supernumerary sister was the Clinical Educator within the critical care units. This included ITU and SHDU. They were employed to work 33 hours per week.
- We found the leadership of the unit was not always compliant with the NHS England2014/D9/S/a guidance. Critical Care Unit must have a supernumerary clinical coordinator during each shift and one whole time supernumerary Clinical Educator. During our inspection we saw the Lead nurse was also working as the coordinator during their shift and the Clinical Educator worked 33 hours (89% whole time equivalent) a week.

Culture within the service

- Staff told us that they felt respected and valued by their immediate line managers.
- However, they said that they did not meet or see the senior managers visiting the unit.
- All the staff we met during our visit were friendly and helpful.
- The lead nurse and staff we spoke with knew the vision and values of the organisation.
- The culture was centred on the needs and expectations of people who used service. For example, patient's comments had been listened to and measure had been taken to reduce the noise levels during nights.
- We found the staff we spoke with to be open, honest and happy to discuss any issues about the care and wellbeing of the patients.
- Following the last staff survey, measure such as suggestion boxes for staff, Occupational Health support, appointments with a psychologist, better team work and debriefing had been introduced. However, these options for staff had not yet fully embedded as these were early days. The lead nurse told us that there was emphasis on promoting safety and wellbeing of staff.
- There was a multidisciplinary team (MDT) approach to treatment and care of patients in the unit. We observed staff teams work collaboratively, constructively and shared responsibilities.

Public engagement

- Staff on ITU said they did not use the 'Friends and Family Test' (' (FFT). However, they sought feedback through outreach workers and through the Patient support group. Feedback was displayed for visitors and staff to see.
- SHDU staff used the FFT and had responded to their comments by making changes
- Visitors to the unit told us that they were able to make comments about the care or staff attitude to the person

in charge of the unit and would feel comfortable in doing so. They said staff were very helpful and considerate and their comments praised staff commitment.

- Information about how to make a complaint was available to patients and visitors at the unit. Staff told us that if anyone needed the information in a different format they were able to provide it. The lead nurse and the clinical educator said that they looked at complaints or concerns as an opportunity to look at what they did and make improvement and not as a failure.
- Patients and relatives who were involved in the Intensive Care Rehabilitation service (ICRS) gave their feedback to staff. The information was analysed to reflect on the quality of the service. For example, Comments from the feedback included 'can be noisy, lack of natural light, in general very pleased with the care and felt safe and reassured'.

Staff engagement

- All grades and disciplines of staff we spoke with said that they had opportunities to be engaged and be involved with the future plans of the organisation. They said information was shared through meetings, emails and notices. They were able to give feedback. For example staff have shared their concerns about the lack of sunlight in the ITU which could affect the wellbeing of patients and the workers.
- Staff had raised concerns about their workforce being depleted to cover for sickness and absence in other areas in the hospitals. To address this lead nurses from ITU and Emergency department worked together and introduced a tool to assess and respond to the request. This is known as the Intensive Care Staff Movement Assessment form. At each request the shift co-ordinator needed to complete the form and get guarantee from the person making the request that if staff were required to return to ITU this will happen without delay. This was a result of staff engagement with managers and finding a solution to a problem. SHDU staff said that they rarely got moved.
- Staff surveys had been carried out and the lead nurse shared the outcome of the surveys and the action plan with us. One of the areas staff shared their concern was the lack of debriefing when things go wrong or when they lose a patient they had been caring for. The lack of staff support was attributed to the limited time staff had and the lack of staff availability in the unit. As a result a psychologist had been employed and when they take up post staff would be able to access the service.

Innovation, improvement and sustainability

- The service promoted the use of patient's diaries. The use of diaries are known to reduce post-ITU anxiety and post-traumatic stress disorder (PTSD).This assisted patients with reflecting retrospectively on their experience of critical illness and helped those coping with critical care unit post-traumatic stress disorder.

Maternity and gynaecology

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The maternity service at Barnsley Hospital NHS Foundation Trust (BHNFT) provided antenatal, intra partum and postnatal care. Inpatient maternity care was provided on the antenatal and postnatal ward, (33 beds) and on the delivery suite (birthing centre,) 24 hours a day, seven days a week. Care was also provided on the antenatal day unit; open Monday to Friday, 8am to 6pm, and the antenatal clinic, open Monday to Thursday 8.30am to 5.30pm, and Friday 8.30am to 4.30pm. A team of community midwives provided antenatal care, homebirth and postnatal care in women's homes and Barnsley hospital; together with antenatal and postnatal care in clinics and GP locations in Barnsley.

Between January to December 2014, Barnsley maternity unit delivered 2,791 babies.

Gynaecological services were provided and included 20 inpatient beds. They cared for major gynaecological and breast cases during the working week and a medical gynaecology admission service 24 hours a day, 7 days a week. Gynaecological services also included Termination of Pregnancy (ToP) and an early pregnancy gynaecological assessment unit (EPGAU) for mothers up to 20 weeks gestation.

The ward was supported by clinical nurse specialists, including those for gynaecological cancer, uro-gynaecology and a colposcopy nurse specialist.

We inspected the maternity and gynaecology services, which included the EPGAU, gynaecology ward, antenatal clinic, antenatal day unit, antenatal and postnatal ward, the birthing centre, and obstetric theatre. We spoke with 12 women who used the service, and 35 staff, including midwives and community midwives, doctors, consultants and senior managers. We also held staff focus group meeting to hear their views of the service they provide. We observed care and treatment, inspected 12 sets of care records and we reviewed the trust's audits and performance data.

We reviewed information about the population of Barnsley and found it was in the 20% most deprived areas in the country. Nineteen percent of the population were under 16 years of age, and the level of teenage pregnancy was 2.4% which was worse than the national average.

Maternity and gynaecology

Summary of findings

Staff were encouraged to report incidents and systems were in place following investigation to help rapidly disseminate learning. Both nursing and medical staffing levels were in line with national guidelines. The service was 90% compliant for mandatory training overall and this was in line with the trust target. We saw evidence of how they had recently addressed non- compliance in safeguarding supervision training, and although there were some areas which did not meet the trust target, they had identified further training days to address these shortfalls. We found an unlocked cupboard of diaries which contained confidential information. This was brought to the attention of the trust who acted immediately and addressed the situation.

Women received care according to professional best practice clinical guidelines. The unit provided individualised care to people using the service and they were treated with privacy, dignity and respect. The trust had a specialist midwives in bereavement who provided support, compassion and care for women and their families in time of bereavement.

The trust dashboard showed they were not always meeting their key performance indicators (KPI's) for antenatal bookings for women to be seen before 10 and 12 weeks of pregnancy. The trust target was 90% and the information showed, between April 2014 and February 2015, the bookings for women to be seen before 10 weeks ranged between 53.3% and 81.2%. Women booking before 12 weeks ranged between 72.4% and 96.9%. Trust managers had identified that there were data extraction issues following implementation of the new maternity information system. A manual audit showed the target was met for the 12 week bookings, but not the 10 week antenatal bookings. An action plan had been written to address the issues which included a review and completion dates. A supervisor of midwives was available for all women using the service and feedback/debriefing was offered to patients who had not followed their choice of care pathway.

The service was managed by a cohesive team who understood the challenges of providing good, quality care. They were aware of their shortfalls and had taken steps to address them. Staff were encouraged to drive service improvement and used creative and innovative ways to try to ensure they met the needs of women who used the service and the organisation.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Overall we rated the service as good for providing safe services. Staff were encouraged to report incidents and systems were in place following investigation to help rapidly disseminate learning. Both nursing and medical staffing were in line with national guidelines. There were effective systems in place to monitor infection control. There was a good standard of record keeping however, staff had experienced issues with the implementation of the electronic records to record patient care and data. We also found an unlocked cupboard of diaries which contained confidential information. This was brought to the attention of the trust who acted immediately and addressed the situation.

The service was 90% compliant for mandatory training overall and this was in line with the trust target. We saw evidence of how they had recently addressed non-compliance in safeguarding supervision training, and although there were some areas which did not meet the trust target, they had identified further training days to address the shortfalls.

Incidents:

- There were no never events reported in the time period, May 2014 to April 2015. (Never events are serious, preventable safety incidents that should not occur if the available preventive measures have been implemented).
- Between June 2014 and May 2015 there had been 1613 reported incidents; 1594 (99%) of these were reported as no harm caused, 16 were reported as low harm, and three as moderate harm.
- Midwives and staff told us they were encouraged to report incidents and were able to explain the procedure. Between May 2014 and April 2015 there were two serious incidents reported in women's services. We saw these related to an intrapartum death (the death of a baby during birth after 24 or more weeks of pregnancy,) and a medication incident.
- A root cause analysis (RCA) had taken place in both cases which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons are learned to prevent the same incident occurring again. An action plan and recommendations summary was shared with all staff.
- Staff reported having received patient safety bulletins, a 'Maternity Risk Matters' newsletter, briefings and the maternity 'Ward-book' (Ward-book took advantage of its Facebook setting, linking to staff members' personal accounts and was easily accessible on mobile devices); designed to rapidly disseminate learning from incidents or other concerns which had occurred within the trust. We saw changes as a result of learning from incidents. For example, following an incident acetone in liquid form had been replaced with acetone soaked pads. Staff we spoke with in each area we inspected were able to tell us about this incident and the action taken following lessons learned.
- In November 2014, there was an increase in incidents reported in the category 'infrastructure (including staffing, facilities, environment). The increase was explained as a result of data recording issues on the trust's electronic reporting system. In February 2015 there was also an increase in incidents reported in the category 'documentation (including electronic & paper records, identification and drug charts)'. Again, the data analysis provided by the trust stated it appeared to have been an issue with the system. We were told by staff that midwives had been funded by the trust to help implement the new system and therefore make the transition of use easier.
- There was a Consultant Obstetrician / Risk lead and a Risk midwife lead and both took part in the Women's Governance Meeting where they looked at and discussed incidents, trends, themes and learning.
- We saw in the 'Women's Governance Meeting Minutes' dated March 2015, there had been a delay in gynaecological patients receiving test results and this had been identified as the secretariat not typing up notes. The incident had been recorded on the risk register and action had been taken. We also saw reference of this in the minutes of incident reporting; trends, themes and learning discussed. It included the updating of the risk register prior to each governance meeting and these were circulated to the management and staff.
- Perinatal mortality and morbidity meetings took place monthly. A monthly exception report of the discussions held at this meeting was reported into the women's

governance and performance meetings. We saw evidence of this in the meeting minutes we inspected dated February, March and April 2015. The minutes gave a brief overview of the information and stated the exception report was accepted and discussed.

Duty of Candour:

- The trust had a policy document relating to 'Being open and the Duty of Candour' dated February 2015.
- Within the unit there was information relating to the Duty of Candour. For example we saw in the antenatal day unit a display of the information and how the trust was open and honest when things went wrong. Leaflets were available for people to access.
- We saw an example of a letter from the trust to a mother offering an apology. The person had been referred to another maternity unit owing to the temporary closure of the Barnsley maternity unit. The letter assured the person their health and safety, and that of their baby was their prime concern when the decision to refer was made. The letter also offered the person an opportunity to have further explanation by meeting or a telephone call. The incident had been included in the risk management data and 'Datix' (computerised recording) system for reporting incidents.
- Staff gave a second example of duty of candour, following a clinical incident. The mother was spoken with directly; informed in person of what and how the error had taken place and they received a written response from the lead midwife. This showed the trust was open and transparent with patients about their care and treatment when things went wrong.
- Additionally, the complaints register showed meetings were offered to give feedback to patients when things had not gone according to plan. Staff were made aware of lessons learned and these were included in the staff bulletins/newsletter, briefings and the maternity Ward-book.

Safety thermometer:

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. This information was clearly displayed in each ward we visited. It included information about falls, venous thromboembolism (VTE), catheter use with urinary tract infections and pressure ulcers. Where issues had been identified staff throughout the service were made aware through briefing sessions, and this included learning and preventative measures where appropriate.
- For May 2014 – May 2015 the obstetric department safety thermometer charts, showed delivery suite were 100% compliant for venous thromboembolism (VTE) risk assessments. They performed better than the trust target of 95% for VTE risk assessment completion.
- The obstetric inpatient safety thermometer charts showed from May 2014 – May 2015 with the exception of one month, they were 100% compliant for VTE risk assessment completion.
- The gynaecological safety thermometer charts showed between November 2014 - May 2015 they were compliant for those patients where it was applicable to have a VTE risk assessment completed.
- The Women's governance minutes stated VTE compliance remained difficult to monitor due to the implementation of the electronic record system.
- Staff members at the time of inspection reported they had received training on the system and it was becoming easier to use.

Cleanliness, infection control and hygiene:

- We saw the trust had an infection control policy and staff knew where to locate a copy.
- Trust policies were adhered to in relation to infection control; such as the use of hand gel and 'bare below the elbow' dress code.
- Infection Prevention Control statistics for December 2014 showed hand hygiene was 100% in each area and included community midwives. In January 2015 the score was reduced by 2% in one area and was reported as due to a doctor with poor technique. The lead midwife had addressed the issue with the individual concerned.
- The maternity unit and gynaecology ward were visibly clean and staff reported they had infection control training. However, on the 7 July 2015 the core service training matrix, showed clinical infection control training was 84.5% compliant overall and the trust target was 90%. This meant staff were not all up to date with training in infection control. We were told by one of the lead midwives, further training session dates were available and the staff who had not received their

update training would be booked on a course. We saw on the gynaecological ward a list of the courses and dates, staff who had not received the update training could attend.

- Contract cleaners provided the cleaning services at the trust. We saw each area had a cleaning manual which contained information on the Control of Substances Hazardous to Health (COSHH) Regulations 2002. We saw the cleaning products had been stored correctly as stated in the guidance. We looked at a sample of cleaning records for July 2015 on the antenatal and postnatal ward; there were no gaps in the cleaning record. We were also told by the lead midwife in this area; the cleaning supervisor visited the ward daily and met with them weekly to check there were no concerns with the standard of cleanliness.
- Evidence provided by the trust showed they had not had any reported incidents of Methicillin-resistant staphylococcus aurous (MRSA) bacterial infection cases for four years and across the trust they had reduced their Clostridium difficile cases by seven on the previous year to 13.
- A document published by NHS England, 'Patient-Led Assessments of The Care Environment' showed ward 14, the early pregnancy and gynaecology assessment unit environment had been inspected. Although there were some areas of cleanliness to be addressed, for example marks on a ceiling and dust, the overall score was 'B' which indicated confidence the environment supported good care.

Environment and equipment:

- Access to the delivery suite and wards was via an intercom system and staff were able to monitor people visiting and leaving these areas.
- We were told by the lead midwife, each shift leader carried out daily checks of their equipment to ensure it had been maintained in line with current guidelines and was in working order and fit for purpose. For example, the checks on the antenatal and postnatal ward included the neonatal resuscitaire (new-born life support), Post-Partum Haemorrhage (PPH) trolley, breast pump, sharps bins, hand gel dispensers, fire marshall checks, and the controlled drug register records to make sure they had been completed correctly. The information was then checked monthly, by a matron from another area and recorded on a matrix. The records for 1 July – 14 July 2015 were inspected and we found these were completed with the exception of one day. This had been identified and action taken to prevent recurrence. We also looked at the monthly record checks for June and July 2015 and saw they were taking place as described.
- There were cardiotocography (CTG) machines to monitor baby's heartbeat. We were told and saw the unit had eight CTG machines and had identified a further four were required. As they were not able to purchase these at the time due to financial constraints, it was added to the risk register and noted in management meeting minutes. When speaking with the management team and delivery suite staff at this inspection, they informed us the machines had been ordered and as an interim measure they had been given permission to hire the additional equipment when needed.
- Staff had access to an online training package for the use of the CTG equipment and they were expected to complete this annually as part of a perinatal training programme.
- A wrist band, tagging system was used for the security of babies in the hospital. This meant no one could leave the ward or unit with a baby without sounding an alarm.

Medicines:

- Medicines were safely stored in locked cupboards and trolleys in all of the clinical areas and wards.
- Records showed the administration of controlled drugs (CD) were subject to a second check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded. Monitoring checks had taken place and records kept to make sure they had been completed properly and were safe.
- Ordering and disposal of medicines were in line with current guidance and regulations.
- All midwives were practising under patient group directions (PGDs). (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a predefined group of patients without them having to see a doctor).
- Medicine refrigerators were kept locked; the temperature was monitored daily and was in line with current guidance.

- Audits and stock checks were carried out of medicines by a hospital pharmacist. We inspected the audits which had been carried out on the EPGAU dated 30 March 2015. The information showed no concerns had been identified and medicines were kept safe.

Records:

- Records were in electronic and paper format, comprehensive, up to date and of a good standard of record keeping. When not in use they were kept safe in line with data protection.

However, we did find an unlocked cupboard of diaries which contained confidential information. This was brought to the attention of the trust who acted immediately and addressed the situation.

- The trust had an electronic record system. Staff reported they had received training before implementation of the system and it was becoming easier to use. They said they liked the way they were able to look back at records and print a summary when reviewing patient care.
- Staff told us documentation audits were undertaken monthly and the results fed back to the lead nurse whose area had been audited. For example in April 2015, the audit for gynaecology inpatients identified the ward specific environmental audit was 100% compliant, whilst the patient specific was 92% compliant. We saw the action plan the lead midwife responsible for the area had written and it included how non- compliance had been addressed, together with the timescale and date completed.
- The trust training matrix showed the overall training in Women's & Children's Services for information governance was 88.4% compliance. Antenatal Day Unit was 64.3% compliant and EPGAU 79.5% compliant, all other areas were above 92.5% compliant; the trusts target was 90% compliance. This meant patient confidentiality may be at risk as staff had not received training.

Safeguarding:

- We found there were procedures in place for protecting adults and children from abuse.
- There was a named lead midwife, and a safeguarding link midwife on each ward and unit. The information was displayed on a notice board at the entrance to each ward/area. We saw in antenatal clinic the information included adults and a separate safeguarding children notice board, which included abuse relating to child 'trafficking.'
- All staff we spoke with were able to explain the procedure for reporting allegations or suspected incidents of abuse, including adults and children and confirmed they had received training.
- The core service training matrix for the maternity unit and gynaecology ward dated 7 July 2015, showed 81.9% of all staff who had patient contact, had received adult safeguarding training and the trust target was 90%. This meant staff were not all up to date with training. For basic safeguarding children training, 95.9% of staff had received the training. We saw a list of the training courses available in staff areas and were told by ward managers those staff who were not up to date with their training were required to attend.
- The trust dashboard for August 2015 showed 97.9% of midwives had received adult safeguarding training and 100% had received child safeguarding training.
- Additionally we received from the trust a position statement on safeguarding and supervision for July 2015. It identified only 41% of midwives had received individual supervision; in response, this was escalated to the head of midwifery with an urgent request to prioritise the supervision. As a result, with the exception of those who were on maternity leave, all other staff had the supervision; achieving the target of 100% compliance.

Mandatory training:

- The trust had a Practice Development midwife; staff had a three days annual mandatory programme to complete and this was supported by the this midwife.
- Staff we spoke with including clerical staff told us they were given time to complete their training.
- The trust target for mandatory training was 90% and data provided by the trust showed the overall training compliance in Women's & Children's Services was 90% on the 12 July 2015. However, in several areas mandatory training did not meet the trust target:
- Fire Health and Safety training: Antenatal Day Unit was 82.6% compliant and EPGAU 83.3%
- Moving & Handling for People Handlers (Annual training): Ranged between 70.7% - 88.4% compliant.

- Moving & Handling for Inanimate Load Handlers (2-yearly): With the exception of delivery suite which was 66.7% compliant, all areas were between 95.3% - 100% compliant.
- Resuscitation training: Antenatal Day Unit was 64.3% compliant and EPGAU 79.5%
- This meant some patients could be at risk as staff caring for them may not have had up to date training. We were assured by one of the lead midwives, further training courses were available and those staff who were not up to date with their training were required to attend.
- Staff confirmed they all attended annual obstetric skills drills and the community drills included the Yorkshire Ambulance Service (YAS).

Assessing and responding to patient risk:

- We saw the 'NHS Litigation Authority Clinical Negligence Scheme for Trusts, Maternal Clinical Risk Management Standards 2012-2013', showed the trust were compliant for having an approved maternal risk management strategy which reflected the organisational strategy. It described who was responsible for escalating risk management issues at any time, to board level and under what circumstances.
- The risk management strategy dated 2015 – 2016 incorporated the maternity services; community, gynaecology ward and specialist gynaecology services. It had been produced by the Head of Midwifery, risk midwife on behalf of the Women's Governance and Performance Group and used in conjunction with: the Trust Risk and Governance Strategy, Incident Reporting Policy, Procedures for the management of Serious Incidents and Infection Control Policies.
- The service used the Modified Early Obstetric Warning Score (MEOWS). This assessment tool enabled staff to identify and respond to the need for additional medical support if required. The MEOWS identified directions for escalation, and staff were aware of the appropriate action to take if patients scored higher than expected. We looked at completed charts; the documentation had been completed and escalated appropriately.
- Arrangements were in place to ensure checks were made before, during and after surgical procedures in accordance with best-practice principles. This included completing the 'five steps to safer surgery' World Health Organization (WHO) surgical safety checklist. The documentation we inspected had been completed correctly.
- Delivery suite had the capacity and equipment to care for one high dependency patient with advice and support from the critical care team. We saw there were guidelines for admission to the high dependency unit and transfer to the intensive care unit. (The guidelines had been reviewed and dated 29 June 2015; making sure they were in date and fit for use.) The roles and responsibilities of staff were clearly documented, as was the criteria for admission to the unit and transfer to another unit where appropriate. At the time of the inspection no one was using the facility; we did see the equipment was in date and available for use. We also saw the 'NHS Litigation Authority Clinical Negligence Scheme for Trusts, Maternal Clinical Risk Management Standards 2012-2013', showed the trust were compliant for their documentation which described the process for ensuring women received high dependency care/ intensive care in a suitable environment.
- Antenatal and intrapartum records showed staff used a 'fresh eyes approach' (Fitzpatrick and Holt, 2008) when monitoring foetal wellbeing through the use of cardiotocography (CTG), to improve patient's safety. A 'fresh eyes approach' (Fitzpatrick and Holt, 2008) can enhance the accuracy of CTG interpretation as the tracings are viewed by more than one person. Fitzpatrick and Holt (2008) found that two people operating together as a single unit were able to monitor and help each other, leading to a learning process essential for effective professional practice and can enhance the accuracy of CTG interpretation.)
- The delivery suite had one theatre which they used for emergencies; theatre staff, including an anaesthetist available 24 hours a day. A second theatre was used for planned caesarean sections and emergencies should the delivery suite theatre be in use. There was a standard operating procedure (SOP) for the management of the second theatre and the time it took for a patient to receive treatment in this theatre had been recorded.

Midwifery staffing:

Maternity and gynaecology

- In line with national guidance the births to midwife ratio was 1:28.
- Specialist midwife roles for example the bereavement, teenage pregnancy, and infant feeding midwives were not included in the 1:28 birth to midwife ratio.
- Planed and actual staffing numbers and grades of staff were displayed on every ward.
- The trust used an electronic (e-rostering) system for recording staffs duty. We saw and were told duty rosters were created eight weeks in advance to ensure the levels and skill mix of the nursing staff on duty were appropriate for providing safe and effective care.
- The service used an acuity tool to assess workloads. Week commencing 15 June 2015, we saw the Birthrate Plus Intrapartum Acuity® system had been used to assess the labour ward. During this time there were two occasions of reported unexpected staff absence and the data showed, 'No action needed.'
- We were told by one of the lead midwives that due to staff retirement, long term sickness and staff leaving, the trust were recruiting 3.8 WTE midwives across the unit. The monthly update of the nursing and midwifery staffing report, dated June 2015, showed in maternity there were two vacancies. The information included how the vacancy shortfalls would be addressed.
- The HOM confirmed they checked the acuity through the lead midwives on a daily basis. This was to ensure there were sufficient staff to meet the service needs.
- Safe staffing levels were monitored and managed on a daily basis by the lead midwife for each clinical area. A daily staffing situation report was in place which was supported by an escalation process specifically to manage nurse staffing issues.
- We were told by the lead midwives, high levels of activity together in relation to staffing levels were determined and escalated in line with the trust's staffing and escalation protocol (together with the standard required for Safer Childbirth guidance).
- We saw at the time of the inspection, in delivery suite there were high levels of activity. The situation had been escalated in line with their escalation policy.
- Staff reported cross department/ site team working wherever possible to address shortfalls and for continuity of patient care. In March 2015, 427 hours of bank staff were used across women's services (which included obstetrics and gynaecology). Staff told us some of their permanent staff members worked for the agency and had covered the staffing shortfalls. This had provided consistency of staff and care.
- An assessment form was completed for managing workload and staffing prior to moving any clinical staff. This was to ensure the areas were assessed appropriately and remained sufficiently staffed. Copies of this information were then sent to the Head of Midwifery/Head of Nursing (HOM/HON) Matron and Risk midwife.
- The gynaecology ward had monitored how often staff were moved to assist in another area; to help make sure the same staff did not move each time. We saw in many instances the moves were outside of women's services.
- Women told us they had received continuity of care and one to one support from a midwife during labour. Trust data showed women received 1:1 care in labour between 93.6% and 99.6% of the time.
- We observed handover on the gynaecology ward, delivery suite and the antenatal/postnatal ward. For example, on the gynaecology ward the electronic patient records had been updated by staff through the shift. The up to date information was then printed out and used during the verbal handover to staff taking over the shift. Clear information was provided and included: plans for investigations, tests and procedures; care, compassion and support; and the use of interpreters. This showed information was being recorded and communicated effectively. (The print out was then securely destroyed by the staff prior to leaving the ward; in line with data protection.)

Medical staffing:

- The trusts' monthly, quality, safety and performance data 'Dashboard' report from June 2014 to May 2015, showed the consultant cover on labour ward was 60 hours a week. This met the trust target and was in line with national recommendations for the number of babies delivered on the unit per year.

Maternity and gynaecology

- Staff reported the consultant obstetricians were available when needed and also reported antenatal patients were seen each day in line with current guidance. Patients told us they received consultant and medical care which met their needs.
- Data received prior to the inspection, dated December 2014, showed there were twenty seven WTE medical staff: Consultants 26% compared with an England average of 34%; Senior House Officer (SHO) (level or a higher) grade 8% which was in line with the England average; Registrars 58% compared with the average of 51%; and junior doctors (foundation year 1-2) 8% compared with the England average of 7%.
- The Clinical Director told us there were eight full time consultants; three of whom worked twilight shifts to help support 60 hour labour ward cover. We were told all the consultants helped the junior doctors wherever a workforce problem was escalated and on rare occasions had stepped down and worked as a registrar.They also told us this had been rare; staff were well supported.
- One of the service managers emailed out the medical staff duty rotas each month and the Director told us this person 'flagged up' any shortages to the consultants. They told us the trust escalation policy was followed and where staff had not responded a Datix report had been completed. The consultant said they reviewed and investigated all reported incidents.
- The minutes of the Women's Governance and Performance Meeting minutes held in December 2014 and January 2015, showed medical staffing was on the agenda. This was because they had initially had a staff vacancy, and then had been successful in recruiting. In February 2015 we saw the staff member was in post and the minutes of the meeting confirmed there was nothing to report on medical staffing and it was to be removed from the agenda.
- We observed the medical handover which was attended by the consultant, junior medical staff, anaesthetist and the lead midwife. The handover included feedback on women on the unit who may have caused concern for example, women undergoing induction of labour, postnatal woman and gynaecology patients.
- There was 24-hour anaesthetics cover.

Major incident awareness and training:

- A business continuity plan for maternity services was in place; dated July 2015. It included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incidents such as shortfalls in staffing levels or bed shortages.

Are maternity and gynaecology services effective?

Good

We rated the service as good for effective. Women received care according to professional best practice clinical guidelines. Information about outcomes for women were routinely monitored and action taken to make improvements. Staff had the skills, knowledge and experience to do their job.

Evidence-based care and treatment

- The delivery of care and treatment was based on guidance issued by professional and expert bodies: the maternity services used a combination of National Institute for Health and Care Excellence (NICE) guidelines (for example, QS22, QS32 and QS37) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (for example, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) to determine the treatment they provided. We saw they had used evidence based guidance in providing guidelines on the management of maternal obesity.
- Local policies were written and reviewed in line with national guidance and monitored through the Maternity Guidelines Group, which included a consultant obstetrician. For example: We saw guidelines for the management of foetal/early neonatal loss which included: medical termination of pregnancy for foetal abnormality after 20 weeks gestation; management of foetal loss between 18 weeks and 26 weeks gestation; over 26 weeks, and early neonatal death. These had been reviewed and authorised by the Maternity Guideline Group and were dated May 2015 with a review date of May 2018. We also saw Care Pathways to support the guidance.

- The Local Supervising Authority Annual Audit report, 'Monitoring the Standards of Supervision and Midwifery Practice' dated May 2014, referred to home births. It talked about how they used a pro-forma to record evidence based information which facilitated the multidisciplinary team supporting the woman in giving consistent advice.

Pain relief

- Pain relief was available and this included epidural, and drug free methods such as sterile water injections and use of the birthing pool.
- People we spoke with told us they received their pain relief of choice.
- An 'Intentional Round Form' was seen in use on the gynaecology ward and the two records inspected had been completed. The form was used to assess the patient two hourly and check for example, if they needed pain relief to make them comfortable.

Nutrition and hydration:

- Women had a choice of meals, which took account of their individual preferences, including religious and cultural requirements.
- Beverages were available across the unit and this included the antenatal clinic and EPGAU.
- Meal times were protected which meant patients were able to have their meals undisturbed. However, there was flexibility to obtain food outside set times for example, postnatal women attending the neonatal unit and for unexpected admissions.
- The service had an infant feeding team which included a co-ordinator 37.5 hours a week, and three support workers whose hours added up to 41 hours a week. These staff provided support and advice to women in the community and hospital settings. Women we spoke with confirmed they had received support and encouragement when breast feeding their baby.
- The service had achieved level 3 UNICEF Baby Friendly accreditation and had recently being re-audited. (The UNICEF Baby Friendly initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed.) Figures showed breastfeeding initiation rates had increased from 32% in October 2014 to 68.7% at the time of inspection.

Patient outcomes:

- There were no risks identified for the maternity outliers on the intelligence monitoring report.
- Between January and December 2014 the total number of births at Barnsley maternity unit was: 2,791.
- The normal delivery rate was 67.8%, which was higher than the national average of 60.1%;
- The elective lower segment caesarean (LSCS) rate was 7.8%, against the national average of 10.9%, and the emergency LSCS rate was 13.1% which was lower than the national average of 15.1%. This showed the service achieved better outcomes for women in comparison with the national average.
- Women in labour receiving one to one care was good. The dashboard figures showed it to be between 96.2% and 99.6% from December 2014 to May 2015.
- In the national neonatal audit programme 2013 (NNAP) the service received 100% for babies who had their temperature taken within an hour of being born, and 100% for all babies with a gestational age of less than 32 weeks at birth undergoing screening for retinopathy in accordance with the national guideline recommendations.
- In relation to parents having documented consultation with parents by a senior member of the neonatal team within 24 hours of admission, the NNAP standard was 100% and the service scored 95%;
- The service achieved 72% for women being given antenatal steroids before delivering a premature baby, compared with the national average of 85%.
- When benchmarking against the 2012 results of 58% of babies receiving their mother's milk when discharged from a neonatal unit, the service scored 32%.
- There had been one neonatal death between May 2014 and April 2015. A RCA had taken place which high lightened lessons learnt and the service was proactive in reviewing its practices and made improvements where needed.

Competent staff:

- Midwives had statutory supervision of their practice, and access to a supervisor of midwives for advice and support 24 hours a day.
- Figures provided by the trust showed the supervisor to midwife ratio was 1:14 and this was slightly better than the national guidance of 1:15.

- A preceptorship programme was in place to support newly qualified midwives. We were told by staff a supervisor of midwives was available 24 hours a day.
- We were told that the specialist midwives also worked alongside clinical staff. This kept their skills up to date and gave them credibility in their role.
- Staff informed us they had annual appraisals and figures showed 99.1% of staff had received an appraisal.
- Community midwives rotated into the hospital each year and worked in a supernumerary capacity. This helped them keep up to date with their competencies and skills.
- Junior doctors told us they had good ward-based teaching, were well supported by the ward team and could approach their seniors at any time if they had concerns.

Multidisciplinary working:

- Multidisciplinary working took place across the service and encouraged an integrated approach to the services provided.
- Clinical governance meetings took place and included the consultant obstetrician/risk lead, risk midwife, HOM, specialist nurses/midwives, and included the community midwife, practice development midwife/ supervisor of midwives (SOM) and the clinical governance facilitator**.** Areas discussed included guidelines and procedures which were approved by this multidisciplinary group.
- Staff reported they had good relationships with the medical staff in the care of patients and they worked well as a team. They reported the consultant staff were very approachable and supportive.
- The delivery suite managers told us how the Risk midwife had worked together with doctors in delivering training to staff. We saw this included training relating to the bench marking exercise/action plan which had taken place relating to the Kirk-up report.
- Antenatal clinics were attended by specialist midwives such as the drug liaison midwife, and the young women's midwife.
- There was access to medical care for women who had other conditions for example; clinics were held for diabetes, and mental health.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- Partnership working was taking place between the fire service and the maternity unit in keeping families safe. The maternity web page 'Early weeks of pregnancy' directed women and their family to free home safety checks.

Seven-day services

- The consultants provided five days of cover and were available on call outside daytime hours and at weekends.
- There was medical staff presence on the labour ward 24 hours a day.
- There was 24 hour availability of an anaesthetist and epidural service available 24 hours a day and seven days a week.
- The availability of evening antenatal clinics supported choice for women and those who were not able to attend during the day.
- Access was available to pharmacy and diagnostic services.
- Several midwives were trained in new-born and infant physical examination (NIPE). This helped when women were being discharged from the unit; they did not have to wait for a paediatrician to carry out the check prior to discharge of their baby.

Access to information:

- We observed good communication between teams. This was either verbal, written in the form of an electronic print out.
- Staff notice boards relating to patient care were located away from public view for confidentiality reasons.
- There was relevant clinical information displayed in the clinical and ward areas for women and their partners to read.
- A 'Green book' (the Perinatal Institute booklet) was used for recording women's antenatal, intra partum and postnatal care. This was kept by the women during their care and was completed as part of a record of their care between GP's, midwives and obstetricians.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS):

Maternity and gynaecology

- We found the clinicians understood the purpose of the MCA (MCA) (2005) and the Childrens Act 1989 and 2004. Staff had received MCA and DoLS training and they understood the principles of gaining consent including issues relating to capacity. The training matrix we looked at on the gynaecology ward showed staff had received training.
- Records reviewed showed women were consented appropriately and correctly for surgical procedures. This included consent for surgical or medical termination of pregnancy (ToP) in line with the Abortion Regulations 1991 and the Department of Health guidance, in reference to the Royal College of Obstetrician and Gynaecologists Guidelines (RCOG): The Care of Women Requesting Induced Abortion (2011) and the trust' consent policy.
- Staff also spoke with confidence about Gillick competency assessments of children and young people. These were used to check whether these patients had the maturity to make decisions about their treatment.

Are maternity and gynaecology services caring?

Good

We rated the service as good for caring. The unit provided individualised care to people using the service and they were treated with privacy, dignity and respect. The CQC patient survey 2013 showed positive responses for partners being involved in labour. The trust had a specialist midwife in bereavement who provided support, compassion and care for women and their families in time of bereavement.

Compassionate care

- May 2015 the NHS Friends and Family Test results showed 98% - 100% of patients, out of 401 responses across four 'touch point' areas in maternity would recommend the services.
- Results from the CQC maternity survey 2013 showed the service scored about the same as other trusts. This was relating to antenatal care, labour, birth, and postnatal care.
- Women spoke positively about the treatment and standard of care they had received. They had a named midwife, received 1:1 care during labour and were treated with dignity and respect.
- In delivery suite, in helping to make the patient's experience as comfortable and relaxed as possible, each of the seven birthing rooms had décor in calming colours, adjustable mood lighting and an en-suite toilet and shower room.
- There was a dedicated room for bereaved parents, the Rainbow Room, where those parents who had lost their baby could spend time with their child. The Rainbow Room was supported by the Barnsley Hospital Charity. It was located away from the birthing rooms and had a sound proof door and walls to protect the privacy of the family. There was sufficient accommodation for the women's partner to stay with them in the Rainbow room.
- The maternity service worked with a charity for women and families who are in need of basic baby provision, such as baby clothes and nappies.

Understanding and involvement of patients and those close to them

- Women we spoke with stated they had been involved in decisions regarding their choice of birth and were informed of the risks and benefits of each. They told us they felt involved in their care and supported by staff.
- We received positive written and telephone feedback from women who had used the service about the midwives and staff who had looked after them during their stay.
- In the CQC survey completed in 2013, for being involved enough in decisions about their care during labour and birth, women scored the trust 9.5 out of 10 (average compared with other trusts).

Emotional support:

- The service had a bereavement midwife who was available to give additional one to one emotional support and advice not only to women and their partner who used the service, it included staff.
- An annual memorial service was held once a year in memory of the baby or child patients wanted to remember. An order of service was seen which informed people about the releasing of a balloon from the memorial garden, lighting a candle and the writing on a

leaf the name the person would like to be read out. The leaves were then collected, placed in a book "Our Babies" and kept in the chapel where they were welcome to visit at any time.
- Bereaved families were given leaflets (contact information), for example: "The loss of your grandchild," "Mainly for fathers," from the Stillbirth and neonatal death charity.
- The hospital has a chapel and a chaplain who were there to offer support and comfort.
- Counselling services were available, and a consultant had a lead role in mental health.

Are maternity and gynaecology services responsive?

Good

We rated the service as good for being responsive. Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. A supervisor of midwives was available for all women using the service and feedback/debriefing was offered to patients who had not followed their choice of care pathway. There was a midwife with a lead role for people with learning disabilities. The service had responded appropriately to complaints and taken action to try to ensure they were not repeated.

The trust dashboard showed they were not always meeting their key performance indicators (KPI's) for antenatal bookings. Trust managers had identified that there were data extraction issues following implementation of the new maternity information system. A manual audit showed the target was met for the 12 week bookings, but not the 10 week antenatal bookings. As a result of this information an action plan had been written as to how the trust would address the issues which included review and completion dates.

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

- The service was aware of its risks and the need to ensure services were planned and delivered to meet the increasing demands of the local and wider community.
- The service worked closely with local commissioners of services, the local authority and other providers, GP's and patients to coordinate and integrate pathways of care that met the needs of the local population.
- In meeting people's needs the service had eight specialist midwife roles in the following areas:
- A named lead Safeguarding Midwife and a link midwife on each ward/area.
- Clinical Risk Midwife (as part of their role worked with clinicians, management, staff and members of the public to ensure that patient /staff safety, and risk incidents were identified and reported.
- Practice Development midwife
- Bereavement midwife
- Infant feeding midwife and team
- Drug liaison midwife team
- Young women's midwife
- Public health midwife and smoking cessation team
- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. A supervisor of midwives was available for all women using the service and a debrief was offered following any care which had deviated from the patients choice and plan of care.

Access and flow:

- Gynaecological services were provided and included 20 inpatient beds.
- They cared for major gynaecological and breast cases during the working week and a medical gynaecology admission service 24 hours a day, seven days a week. Staff confirmed that on occasions access and flow had been disrupted due to a shortage of beds in the hospital and therefore patients from other specialities for example, medicine been moved onto the ward.
- Gynaecological services included Termination of Pregnancy (ToP) and an early pregnancy gynaecological assessment unit (EPGAU) for mothers up to 20 weeks gestation.
- The ward was supported by clinical nurse specialists, including those for gynaecological cancer, urogynaecology and a colposcopy nurse specialist.
- Bed occupancy for maternity services for the first quarter of 2014/2015 was 57.9%. On the 28 February 2015 between 2am – 10am the service unit was

temporarily closed due to a capacity issue. In the second quarter of the year the bed occupancy was 50% and was lower than the England national average of 60%.

- Inpatient maternity care was provided on the antenatal and postnatal ward, and delivery suite (birthing centre) 24 hours a day, seven days a week. Community postnatal clinics helped with patient discharge and therefore access and flow on the postnatal ward.
- Dedicated community midwife administration support helped with access and flow between the patients in the community and the hospital.
- Care was also provided on the antenatal day unit; open Monday to Friday, 8am to 6pm, and the antenatal clinic, open Monday to Thursday 8.30am to 5.30pm, and Friday 8.30am to 4.30pm.
- Visiting times were: Partners: 10:00am to 8:00pm, Family and Friends: 2:00pm to 4:30pm and 6:30 to 8:00pm.
- A team of community midwives delivered antenatal and postnatal care in women's homes, clinics and GP locations in Barnsley.
- Due to a lack of dedicated transitional care, over the previous six months 231 babies had received some element of transitional care on the postnatal ward. Work was on-going to provide a dedicated area as part of a trust refurbishment plan. Transitional care is an area where babies who need a little more nursing care and monitoring can stay with their mum rather than going to the Special Care Baby Unit. This means mum can be the main carer of the baby.
- The trust dashboard showed they were not always meeting their key performance indicators (KPI's) for antenatal bookings, to be seen before 10 and 12 weeks of pregnancy. The trust target was 90%, and the information showed, between April 2014 and February 2015 the bookings for women to be seen before 10 weeks ranged between 53.3% and 81.2%. Women booking before 12 weeks ranged between 72.4% and 96.9%. This could have meant some of these women may not have received foetal anomaly screening. Trust managers had identified that there were data extraction issues following implementation of the new maternity information system. A manual audit showed the target was met for the 12 week bookings, but not the 10 week antenatal bookings. An action plan was written as to how the trust would address the issues and the plan included review and completion dates.
- Actions included: checking the accuracy of data produced and displayed on the dashboard with the electronic record system/data analysts; they reviewed the accuracy of data produced by the laboratories; checked the competency document was in place for the midwives and healthcare assistants to address errors; raised the awareness with women the importance of early midwife contact, provided information at family planning clinics, termination services, GP's, children's centres, health visitors, media coverage e.g. involved a service user group, voluntary sector, social media; and raised the awareness with midwives the importance of booking at the optimum time. For example, through the community midwives/staff when they reviewed newly presented bookings at surgeries twice a week. We saw some of the timescales of the actions were due for completion July 2015 and reviewed in October 2015. We also saw the 'Women's Governance Meeting' monitored this information and it was a standing item on the agenda.

Meeting people's individual needs:

- Staff told us they had access to a translation service for patients whose first language was not English; this included a telephone or face to face service.
- There was a trust-wide nurse lead role for people with learning disabilities and they supported staff and patients in their care and staff.
- A patient, who was a Jehovah's Witness and had signed an advanced directive stating their wishes to avoid blood products, told us they had been supported in upholding their wishes.

Learning from complaints and concerns:

- The service had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and they had designated staff who handled complaints in the service.
- Staff we spoke with were aware of the complaints policy and the procedure to follow should someone wish to complain.
- None of the 12 women we spoke with during the inspection said they felt the need to complain or raise concerns with the service.

Maternity and gynaecology

- We saw between 1 July 2014 and 30 June 2015 the trust had received 14 formal complaints relating to the service. Where mistakes had been made, the service had responded appropriately and taken action to try to ensure they were not repeated.
- The complaints register also showed meetings were offered to give feedback to patients when things had not gone according to plan.
- We saw complaints, trends and themes were reviewed as a standing agenda item at the monthly Women's Governance and Performance Meetings. Staff were made aware of lessons learned and these were included in the staff bulletins/newsletter, briefings and the maternity Ward-book.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology services were good for well-led. The service was managed by a cohesive team who understood the challenges of providing good, quality care. They were aware of their shortfalls and had taken steps to address them. Staff were encouraged to drive service improvement and used creative and innovative ways to try to ensure they met the needs of women who used the service and the organisation.

Vision and strategy for this service:

- The vision of the service was 'To be the best, integrated healthcare organisation of choice for our local community and beyond.'
- Staff were clear about their roles and responsibilities and the vision of the service; they were committed to the delivery of a high standard of service and individualised care.

Governance, risk management and quality measurement

- The Women's governance committee for the maternity service met monthly. We looked at the minutes of meetings and saw agenda items covered areas such as accidents, access to appointments, admission, transfer and discharge. We saw actions taken to address shortfalls and lessons learnt.
- We saw in the minutes of the Women's governance meeting for the maternity service dated March 2015, there had been a delay in gynaecological patients receiving test results. The incident had been recorded on the risk register and included time scales and the action taken to address shortfalls. We saw in the minutes that the risk register would be updated prior to each monthly meeting. This showed the service monitored and responded to identified risks.
- We also saw on the risk register the maternity unit had experienced difficulties due to the unavailability of paediatric medical staff. This had an impact of a delayed discharge examinations of babies on the postnatal ward. We were told by staff, several midwives had received training in these examinations and this had helped address some of the shortfall. The risk register showed the service was reviewing the doctor's rota in addressing the shortfalls.
- The 'Women's Services Risk Management Strategy 2015-16' had been written in conjunction with the Trust wide Risk Management Strategy and clearly outlined their responsibilities and this included, "Ensure that all staff follow the Trusts Incident Reporting Policy" And "Ensure and continuously promote a culture which values risk management, encourages the learning of lessons from experience, and be fair and supportive of staff involved in incidents."
- The strategy had been circulated, discussed and approved by the Women's Services Governance and Performance group, followed by ratification at the Patient Safety and Quality Group. A copy had also been circulated to clinical areas and made available to staff via various forums, the Trusts Intranet and Supervisors of Midwives. This showed the service were open, transparent, supportive of staff and took their responsibilities seriously in their management of risk.
- Managers demonstrated awareness of governance arrangements. They detailed actions taken to monitor patient safety and risk. This included incident reporting.
- Staff were aware of their responsibility to report incidents. A root cause analysis into serious incidents occurred which provided learning points for staff and this was then used to make improvements in care.
- The Quality and Governance Committee met monthly and included the Director/ Deputy Director of Nursing and Quality and heads of nursing for each clinical business unit. Information discussed included monthly update of nursing and midwifery staffing.

Maternity and gynaecology

Leadership of service:

- Management structures showed clear lines of accountability and staff were aware of their roles and responsibilities.
- All staff told us the executive team communicated well and information was disseminated to them via email, bulletins and Wardbook.
- Staff told us their line managers and senior managers were approachable and supportive.
- Staff told us there were good flexible working arrangements in place, teamwork was very good and they felt listened to.
- We found managers encouraged staff to participate in on-going learning, professional development and were open to ideas and suggestions for improvement.

Culture within the service:

- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles.
- They told us they felt valued, involved in decisions and kept up to date with changes in the service.
- Several staff had worked for the service for many years and following retirement had returned on a part time basis. They told us they were supported by their colleagues and the trust was a good place to work.
- Staff reported managers operated an 'open door' policy for them to raise any issues or concerns and felt confident they would be acted upon. Staff told us they would recommend the service as a place to work.
- Staff told us there was an open and supportive culture and were encouraged to report incidents and risks. They told us they were kept up to date with any action taken following an incident or complaint and this included lessons learned.
- The gynaecology specialist services aim was "to provide safe, effective and evidence based care that is patient centred consistently with extra care for sensitivity, privacy and confidentiality for specialist services." "To be open and transparent whilst being compassionate to the needs, support the vulnerable and listen actively so as to be a patient's advocate at all times."
- Staff were passionate and motivated in delivering a service which they were proud of.

Public engagement:

- The service took account of the views of women and their families through the Barnsley Maternity Service Feedback Group. They met every month to discuss new developments, the current service and any feedback from the families of Barnsley. The service promoted the group through their web page and encouraged women and their families to get involved.
- For the past six years the trust had held an annual Heart Awards, which recognised the hard work and dedication of their staff and volunteers. In the past only staff were able to make nominations for the award, however, a 'Patient's Choice' category had been added. This category gave patients (past or present), or their representatives, a chance to nominate a member of staff, or a team, who they felt had made an outstanding contribution to their care. In the June 2015 'Barnsley Hospital News' we saw one of the volunteers had won for providing engagement for mums and facilities in women's services.

Staff engagement:

- Around October each year a nursing conference was held in the hospital and this gave staff the opportunity to meet all the senior members and board members of the hospital. The event was attended by CCG members and patients. All departments were encouraged to bring to this conference good practice ideas to share with others across the service.
- Most of the staff we spoke with felt valued, engaged with the organisation and were able to share feedback and suggestions to improve services. We heard examples of where had innovative ideas and these had been acted on to improve services for example, Ward-Book.
- Staff were kept up to date through monthly team briefs, emails, newsletters and Ward-Book.

Innovation, improvement and sustainability:

- In 2013 the unit secured a bid which allowed them to transform the birthing experiences of women, their partners and their babies. Improvements include: three birthing pools, seven delivery suites with en-suite facilities, dedicated bereavement suite, (the rainbow suite,) and an overnight room for partners to stay for emotional and physical support.
- A Midwife won the prestigious 2015 Royal College of Midwifery's (RCM) Philips AVENT National Award for Innovation in Midwifery. They created a secure staff

social networking site called 'Ward-book' which was used by midwifery staff at the hospital to communicate important messages across the department. Each week the HoM wrote a departmental update which gave staff the opportunity to feedback in real-time and this was posted on the system. The Ward-book was used as a virtual notice board. It helped communication between managers and staff and helped improve the outcomes for patient care.

- Barnsley Hospital has been awarded £748,482 funding from the Department of Health to improve facilities on the maternity unit.
- The unit successfully was awarded funding from The Perinatal Institute, of 18 hours per week. This was to support midwives in the implementation of the 'Care Bundle for Stillbirth Prevention.' It was aimed at improved antenatal detection of babies at risk.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The paediatric services at Barnsley Hospital NHS Foundation Trust (BHNFT) included a 24 hour, seven days a week paediatric inpatients ward with capacity of 24 beds, however, only 18 were open at the time of inspection. There was also a children's assessment unit (CAU) which operated between the hours of 10.00 – 20.00 and a neonatal unit (NNU) with 14 cots: two intensive care, three high dependency and nine special care cots. The paediatric outpatients department (POPD) included the community children's nursing team (CCN). The trust also undertook a small number of paediatric surgery cases and there was one paediatric cubicle in the critical care unit (CCU).

There were 4038 paediatric admissions to BHNFT between July 2013 and June 2014; 96% of these were emergency admissions, 3% were elective and 1% were day case.

During our visit we visited all clinical areas where children and young people were either admitted or attended. These included the children's ward, CAU, NNU, theatre suite, critical care, ED and POPD. We spoke with two consultants, one matron, three lead nurses, five registered children's nurses, one support worker, two play leaders, the children's safeguarding team and we met with the senior management team. We also spoke with nine families and two teenagers during our inspection. We observed care and treatment and examined 20 medical/nursing records from across the service.

Summary of findings

Overall we rated the service as requires improvement. We rated safety and well-led as requiring improvement. We rated effectiveness, responsive and caring as good.

There were significant gaps in medical and nursing staffing which had led to high usage of locum staff and the regular movement of nursing staff across all the areas attended by children and young people to attempt to meet the service needs. In the POPD, the CCN team records were not stored in secure cupboards which presented an information governance risk.

The service had a system for reporting incidents; however, there did not appear to be a culture of reporting incidents and complaints. Data provided by the trust identified incidents which had passed the date by which they should have been investigated and reported on. Senior management staff we spoke with told us there had been challenges feeding back from incident reporting and were looking at improving feedback mechanisms.

There were outstanding follow up outpatient appointments following a change to record keeping. These records were being assessed for follow up appointments. Waiting times on the CAU were long for some children.

There was a board level Executive Director for Children's Services, as required by the National Service Framework for Children.

Services for children and young people

The service had processes in place to implement NICE guidelines and other best practice guidelines, and the service participated in national audits. The service implemented local audits and had developed a local safety thermometer tool for paediatric services. The service had care pathways in place, but some policies were out of date. There was evidence of multidisciplinary working across all the children's services; children and families were provided with timely and appropriate advice.

The children's services worked together to promote early discharge and reduce readmissions. The children's service had responded to feedback with a 'you said – we did' project which is displayed on the wards. The play team work across the trust providing support to children in any department of the hospital, the sensory equipment was mobile which enabled them to also meet the needs of children with special needs. There was a pathway to promote a safe transition to adult services for children.

Throughout our inspection we saw children and their families were treated with dignity, respect and compassion. We heard staff using language that was appropriate to children's age and level of understanding. All the children and their families we spoke with were happy with the care and support provided by the staff. Parents felt confident when leaving their child on the wards that their child would be safe and well cared for.

Are services for children and young people safe?

Requires improvement

Overall we rated children's services as requires improvement for safety. We had concerns about the nursing and medical staffing covering the service. There were significant gaps in medical staffing which led to medical locum staff being used on a regular basis, delays in discharges and delays in onset of treatment across the service, particularly out of hours. Nursing staff were moved within the service to cover staff shortages and despite lowering the bed capacity on the children's ward, there were still staff shortages. The children's ward had a reduced bed capacity of 18 children.

The service had a system for reporting incidents; however, there did not appear to be a culture of reporting incidents and complaints. Data provided by the trust identified incidents which had passed the date by which they should have been investigated and reported on.

The CCN team records were not stored in secure cupboards and the safety of the records relied on staff locking the office when empty.

We found all clinical areas visibly clean and the equipment was fit for purpose and well maintained.

Incidents

- We found there had been one serious incident investigation. A confidentiality leak was reported in paediatric outpatients. Immediate actions were taken and the incident investigated. Ten recommendations were made and an action plan put in place. We were told that system changes had been applied in the POPD and staff reminded of information governance training.
- There had been no never events reported in the service between 01/05/2014 and 30/04/2015.
- Between 01/06/2014 and 31/05/2015 there were 30 reported incidents on NRLS of which 100% resulted in no harm.
- Incidents were reported through an electronic incident reporting system. Between April, 2014 and April, 2015 there were 32 incidents reported.

- The governance meeting minutes of May 2015 recorded there were 19 incident reports still open for investigation, 11 of those were outside the expected timescales for completion.
- Staff we spoke with were aware of how to report an incident; however, they talked of constraints to using the system, for example, not having the time after a long shift at work, and not seeing the importance of recording incidents such as long waiting times.
- Staff reported to have received feedback from incident reporting through the team meetings, there was a handover book for staff that may have been on leave to update on issues such as incident reports. There were no specific examples given of lessons learnt from the incident reporting by the staff.
- In July, 2015 the service produced its first edition of a children's services quality and safety newsletter. This provided an overview of incident reporting across the trust and the changes implemented as a result of incident reporting.
- Staff we spoke with demonstrated knowledge of duty of candour and were aware of the trust's training in this area; however, we were not able to obtain any examples of practice.

Cleanliness, infection control and hygiene

- All of the areas visited were visibly clean and uncluttered, including communal areas, toilets and bathrooms. Bins were clean and not overfull and there were adequate bins for both clinical and general waste. All sharps bins were below the marked levels.
- Clinic rooms were clean, with storage areas adequately stocked and well organised and the sluice areas were observed to be clean and tidy.
- NNU had three isolation cubicles. MRSA swabs were taken on admission and then weekly and reported to infection prevention and control. There had been no reported cases of MRSA bacteraemia since 2008, across the trust. There were no reported cases of Clostridium-.Difficile (C Diff) within children's services.
- Wall mounted alcohol gel was available at all entrances and exits to the departments, personal protection equipment (PPE) and alcohol gel was available at all sink areas. We observed staff to be compliant with bare below the elbow (BBE) policy.
- Staff were observed using the hand gel when entering the ward and also to undertake hand hygiene before attending to children. Hand hygiene audits between January and March 2015 reported 100% hand washing compliance on the children's ward, CAU and NNU.
- Approximately 81% of clinical staff on the children's ward and neonatal unit had undertaken training in infection control against a trust target of 90%.

Environment and equipment

- The children's ward, which was located with CAU, and NNU were locked to prevent unauthorised access; there was also CCTV in situ outside the NNU. Parents and visitors gained access via a buzzer.
- The children's ward was spacious with lots of natural light and there was a communal play area with toys available for a range of ages. The room was also used as a dining room at mealtimes.
- POPD had a reception area which also acted as a waiting room. This area was observed during a busy period in which it was cramped and there was little space for pushchairs or wheelchairs. There was a table and chairs with toys appropriate for toddlers and older children, however, there was no space for babies and no comfortable sitting area for mothers to breast feed.
- It was also noted that the blind cords in the clinic rooms were not secured. This was raised with the lead nurse at the time of inspection as it could potentially be a ligature risk for toddlers and young children.
- We visited the critical care unit where there was a designated paediatric cubicle. We found there were limitations on storage space in the department which had led to unused equipment, such as drip stands and ventilators, frequently being cleared from the paediatric cubicle prior to use.
- Theatre suite had dedicated lists for children and had a separate waiting area and a recovery area which was segregated by curtains.
- Resuscitation trolleys were observed in all areas attended by children and young people. There was evidence that daily checks were undertaken and recorded. The drugs drawers were sealed in all of them except the trolley in POPD; this was a newly acquired trolley and staff were waiting for a lock to be fitted by medical physics.

- On the children's ward there was a respiratory trolley. This had an equipment checklist but there was no evidence to suggest it had been checked or the frequency that this should occur.
- In the bathrooms there was no temperature gauge on the bath taps and no water thermometer available to ensure bath water was at a correct temperature for children. This was raised with the lead nurse at the time of inspection.
- There was an issue with the children's ward buzzer system which needed replacing. Replacement would mean closure of the children's ward and CAU for a period of time, according to the risk register. Senior staff did not provide information as to when this would happen. We were told that the buzzer system had undergone a service and was tested two weeks prior to inspection. We found when we tried the buzzer system it was working.
- All the equipment observed was PAT tested; ventilators were maintained by medical physics and had service stickers. Staff reported to understand how to report faulty equipment.
- There was an escalation policy for ventilators. Medical failures were reported to medical physics and working equipment would be sourced from somewhere else in the trust. If this was not possible there was an agreement to source equipment from Sheffield Children's Hospital.

Medicines

- Medicines were stored safely on the wards, with no excess or expired medicines. The temperature of the medicines fridges was recorded once per day and was within range, however, minimum and maximum temperatures were not recorded. This meant staff would only be able to see the current temperature of the fridge and would not be aware if the temperature had been outside of the 2-8 degree range.
- Controlled drugs were handled, stored and recorded correctly.
- We looked at 15 prescription charts across the children's ward and NNU.
- We found on one prescription chart that a baby's weight was recorded without a decimal point. This had the potential to affect drug dosages and it was drawn to the attention of staff at the time of inspection.
- We found two prescription charts where drugs had been drawn up and signed for by the nursing staff but the medicine was given in small amounts at feeding times to reduce the risk of regurgitation. This was not how the drugs were prescribed.
- Two medicine errors had been reported in the last twelve months; these were reported through the electronic reporting system. No harm was recorded and the staff were supported to undertake medicines management training.

Records

- For inpatients, all the health professionals documented in the same paper record, which were at the children's bedside. Any safeguarding documents were separated and stored in a locked cupboard.
- NNU had recently implemented personalised care plans, but had not yet audited their effectiveness.
- We examined 20 records across the services and found that the majority of notes were well maintained. However, we found in some records not all the documents were completed accurately, for example weight charts.
- All records seen were legible, dated and signed.
- Community children's nurse records were stored on open shelving in the entrance of the staff office in POPD. The office was reported to be locked when no staff present. However, there was a risk that records were accessible by persons without the right to access, when the office was open.
- Medical notes in POPD were stored in a secured filing cabinet. No medical or nursing notes were observed unattended.
- The trust also used an electronic record documentation system. At the time of inspection the system was used differently across the trust. The impact of this on NNU was that staff did not have access to the child's information following admission. This was highlighted on the service risk register.

Safeguarding

- The safeguarding team consisted of 1.5 WTE named nurses, 0.5 WTE midwife, 1 WTE link nurse, named consultant and named doctor.

- The team undertook the children's safeguarding training for the hospital and report 91% compliance for level 1 and 2, and 93% compliance for level 3 within children's services, which was above the trust training target of 90%.
- The safeguarding team annual report 2013/14 stated that safeguarding supervision was available for staff but there was no indication as to how often this occurred.
- The electronic patient record system included a notification tab when there were safeguarding concerns about a child to alert staff.
- POPD had used the trust's escalation policy to safeguard a child twice in the last twelve months. The department had the facility to examine children who had experienced historical sexual abuse to avoid them going to other centres.
- We spoke with the safeguarding team who showed us the pathways for staff to implement when concerned of a child's risk of Female Genital Mutilation (FGM) or Child Sexual Exploitation (CSE). The FGM policy was ratified in June, 2015 and online training was implemented. At the time of inspection staff were not able to provide data on training participation due to its recent implementation.
- POPD staff reported to understand the impact on children of FGM and CSE and to recognise when referral needs to be made.
- POPD operated a Did Not Attend (DNA) policy (updated March, 2015). If a child failed to attend a clinic appointment the family were contacted. If staff were unable to contact the parents or child, the local children and families service were consulted to identify any concerns about the family. The safeguarding team were also notified. An example of this practice was observed at the time of inspection.
- Safeguarding records were kept separate from the nursing/medical notes in a locked cupboard.

Mandatory training

- Staff told us they received mandatory training and appraisal. They said they had training opportunities. One staff member we spoke with was undertaking a course in neonatal care.
- According to data provided by the trust nursing staff in POPD and CCN had almost 100% compliance with mandatory training. The outstanding compliance was for Safeguarding Adults, patient contact, which was at 89%. The community paediatric medical staff had a low level of compliance with mandatory training across all areas. Significantly low for this group of staff was infection control and moving and handling. Staff in paediatric inpatient services did not meet the trust target of 90% compliance across all mandatory training areas.
- Staff on the children's ward were 78.8% compliant in basic life support which incorporated paediatric life support. Senior staff told us that there had not been any training available since January 2015.

Assessing and responding to patient risk

- The children's ward used the Paediatric Early Warning System (PEWS) to monitor and assess a child's condition.
- If a child became unstable or deteriorated the trust had a contract with Embrace, a paediatric medical transfer service. Guidance on how to access Embrace was seen on the wards and it was also available to staff on the intranet. The Embrace service provided support in advisory capacity over the telephone when children deteriorated and would also come to the hospital to help stabilise the child as necessary.
- They would locate a bed in a specialist paediatric service if necessary and would transfer the child. Sometimes this required a nurse from the ward to go on transfer with the child. On two occasions that this had been required the children's ward had closed to admissions due to staff shortage.
- During our visit we were provided with information as to how the service had been used in its advisory capacity to help stabilise a child during the previous night. The child did not have transfer to another hospital due to the input and support from Embrace.
- The POPD had a policy for safe transfer of children to ED or the children's ward from their department. An example was provided of a child who attended POPD reception in crisis. The child was stabilised by the community paediatrician through liaison with ED. The safe transfer policy was followed and the child went to ED safely.

The national paediatric safety thermometer tool had recently been adapted for use in the trust, however the initial pilot had identified data quality concerns which were being addressed prior to formal rollout.

Nursing staffing

- Senior staff reported there had been on-going issues with maintaining the staffing levels on the children's ward and CAU. Staff from NNU and POPD had been used to cover those staff shortages. In the week before inspection the beds were reduced from 24 to 18 on the children's ward. This was based on an audit which showed bed occupancy did not exceed 18 during twice daily recording. However, this strategy had not improved staff shortages in the short term and during the inspection a member of staff from POPD was working on the ward.
- We were provided with information that the children's ward often had 20 children since the Executive Board agreed to reduce bed capacity to 18. During our unannounced inspection staff told us that there had been 20 children on the ward in the previous days. However, trust managers informed us there was only one reported incident of an increase to 19 beds between 6 July 2015 and the inspection.
- Bed occupancy within paediatrics fluctuated and it was reported that at times during low bed occupancy, paediatric staff have covered other acute services.
- Staff absence was at 7.5%; this included long term sickness. The trust's target was 3.5%.
- Data provided by the trust reported there had been unfilled shifts of all nursing staff grades between 18 May and 24 June 2015.
- During this period the children's ward's had 114 shifts where staff levels were below the establishment figures of staff required for the bed numbers in this areas.
- During this period the NNU had 100 shifts where staff levels were below the establishment figures of staff required for the bed numbers in this area. Trust managers informed us that data showed that during this period there were only three shifts with a shortfall of 0.5 wte against the British Association of Perinatal Medicine (BAPM) standards.
- The trust managers informed us that these shifts were covered by movement of staff across the units which led to an overall shortfall of staff in 39 shifts. There was one occasion when a staffing gap on a night shift on the children's ward was not able to be covered by NNU. This was escalated and the ward closed to admissions.
- According to the Royal College of Nursing, 2013, neonatal services should provide a staff to child ratio of the following:

  Intensive care cots – 1 registered nurse : 1 child

  High dependency cots – 1 registered nurse : 2 children

  Special care cots – 1 registered nurse : 4 children

- For children's wards the staff to children ratio should be:

  Children under two years of age: 1 registered nurse : 3 children

  Children over two years of age: 1 registered nurse : 4 children

- The Royal college of Nursing recommended these levels of staff for day and night shifts.
- The trust was aware it was not meeting staffing guidelines and there was a bed management protocol.
- Senior staff used a non-validated acuity tool to identify staffing needs. A request for funding for Paediatric Acuity and Nurse Dependency Assessment tool (PANDA) had been presented to the Executive Team and this was proposed to be implemented in August 2015 for a six month trial.
- POPD had 2.3 WTE paediatric nurses supported by 3 healthcare assistants to run a capacity of nine clinics in the morning and afternoon each day, and met the standard minimum of one qualified member of staff in outpatient departments as recommended by the Royal College of Nursing (2013). Staff from the department supported staff shortages across the service.
- The CCN team had 17 members of staff across a skill mixed team. These included specialist nurses for diabetes and neuro-disability and a generic team. There were staff on long term sick and maternity leave.
- Senior staff reported an on-going recruitment drive to fulfil the 5.2 WTE vacancies across paediatric services. Three WTE newly qualified staff had been recruited to commence in September 2015.
- Handovers were observed. We observed morning to afternoon staff handover and also a day staff to night staff handover. There was the correct ratio of staff skill mix to children on the shift handovers observed (BAPM, RCN).
- The handover incorporated safety information regarding recent changes to medicine management, mandatory training and safeguarding alerts. An electronic print out of children was referred to and basic information of children was shared from team leader. Staff then had a one to one handover from the child's named nurse.

Services for children and young people

Medical staffing

- Medical staff covered children's ward, CAU, ED, NNU and the post natal ward.
- During the day (until 7pm) the medical team consisted of a consultant, two registrars and two junior doctors (SHO).
- Out of hours (OOH) was covered by a consultant, a registrar and a SHO. Staff told us that during these hours doctors were delayed for ward rounds resulting in delayed discharges and delays in the commencement of treatment such as phototherapy.
- There was a lower percentage of consultants and a higher percentage of junior grade doctors when compared to the England average.
- Locum doctors were used to support the service. Both registrar and SHO locums were used up to six times per month on nights and up to eight times per month on days between April and June 2015, according to data provided by the trust.
- We observed a medical handover. A consultant was present. Children who had not been seen by a consultant were reviewed first to ensure they were reviewed by a consultant within 24 hours of admission.

Major incident awareness and training

- There was a major incident policy. Staff we spoke with were aware of the policy and of online training.
- There was a children's services response in the emergency and resiliency policy.

Are services for children and young people effective?

Good

Overall we rated children's services as good for being effective. The service had processes in place to implement NICE guidelines and other best practice guidelines, and the service participated in national audits. The service implemented local audits and had developed a safety thermometer for paediatric services. The service had care pathways in place, but some policies were out of date.

Readmission rates following discharge from emergency admissions were lower than the England average; however, readmission rates for asthma, diabetes and epilepsy were higher.

There was evidence of multidisciplinary working across all the children's services; children and families were provided with timely and appropriate advice.

Evidence-based care and treatment

- Staff told us they used Great Ormond Street Hospital (GOSH) clinical guidelines for nursing care and procedures. Staff had access to Embrace procedures and Neonatal Network Guidelines on the trust intranet.
- Paediatric policies were accessible on the intranet. The policies we saw included care bundles and case note templates, however, one of the examples we saw was three months out of date. The information was accessible to staff and there were links to NICE guidelines.
- Staff used care pathways for children with asthma, epilepsy, diabetes and head injury.
- Nursing quality audits were performed weekly for handwashing and cannula care. We found no evidence of other nurse initiated audits.
- UNICEF Baby Friendly Initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships. The trust maternity unit had full accreditation and the NNU had support from the peer support workers whose role was to promote breast feeding to improve infant outcomes.
- The service was contributing to the Saving Lives audit for July and August, 2015.
- The wards had quality boards in the staff rooms to inform staff of audit outcomes and mandatory training status.

Pain relief

- Children's pain was monitored within the Paediatric Early Warning Score (PEWS) and by clinical assessment from the nursing staff.
- Children we spoke with reported their pain was monitored and they had received appropriate pain relief.
- There was no dedicated pain relief team for paediatric services.

Nutrition and hydration

- Families and children we spoke with had no concerns regarding the quality and availability of meals and drinks. Drinks and snacks were available on the wards.

- Fluid balance records were completed accurately for those children who required monitoring.
- Breast feeding was encouraged on NNU and breast pumps were available. There was a facility for the storage of breast milk. The bottles were clearly labelled and it was reported that two nurses would check the labelling to ensure correct redistribution to babies.

Patient outcomes

- The service had undertaken audits on compliance with NICE Quality standards. This included NICE Quality Standard 62 for the treatment of children with constipation, NICE Quality Standard 4 in specialist neonatal care and compliant with NICE Quality Standard 27 in treatment of children and young people with epilepsy. Data showed the service was compliant with these.
- The NNU participated in the National Neonatal Audit Programme (NNAP) 2013. It scored lower than the England average on two points but not significant enough to be an outlier. An action plan for improvement was provided which showed that the NNU had commenced recording 2 year developmental outcomes on a specialised perinatal IT reporting system (BadgerNet).
- For children with diabetes, the median glycaemic level was similar to that of England, (Barnsley NHS Foundation Trust 71, England 69 mmol/mol).
- NICE define excellent diabetes control as HbA1c levels less than 58 mmol/mol as this indicates good glycaemic levels. The higher the HbA1c levels the greater the risk of complications.
- 10% of the trust's children were reported as having an HbA1c under 58 mmol/l which was a lower proportion of children with well managed diabetes than the England average of 16% with an HbA1c under 58 mmol/l.
- The rate of multiple emergency admissions within 12 months for asthma, epilepsy and diabetes was higher than the England average.
- The emergency re-admission rate within 2 days of discharge was lower than the England average for non-elective admissions. Whilst there were emergency readmissions following elective admissions, no treatment speciality reported more than six emergency readmissions.

Competent staff

- Staff we spoke with said they were supported to develop their skills and knowledge and had access to appropriate training.
- The service had an appraisal system for staff and we were told the rate was 97% for completing appraisals. However, data provided by the trust showed that children's ward and NNU rates of appraisal were below this level, 82% and 89% respectively.
- Staff we spoke with were unable to explain the system for clinical supervision, or recall the last time they had safeguarding supervision.
- The General Medical Council, National Training Survey (GMC NTS) which assesses the quality of postgraduate medical education and training, report a red RAG rating for the provision of educational resources at the trust. The trust undertook extensive work through 2014/15 around internal educational resources to ensure that the trust met the requirements of the trainees.
- The service had access to link nurses, specialists in the care of children with diabetes, cystic fibrosis, epilepsy and asthma.

Multidisciplinary working

- The paediatric service benefitted from a Play Team, which consisted of 4.4 WTE play leaders, who were part of the corporate division. This allowed the team to work anywhere in the hospital where paediatric patients were to promote their safety and emotional wellbeing.
- The wards had access to physiotherapists and dieticians to meet the needs of children.
- We were told that if a child was admitted who was at risk of actual or potential harm they would be seen by CAMHS within 24 hours.
- Staff we spoke with told us there were close working relationships between inpatients and the CCN team. We were told the CCN team would ring the wards each day for a handover regarding admissions and children ready for discharge that required nursing care in the community.
- There was a process for informing GPs, health visitors and school nurses of discharges. We saw examples of the handover documents in health records.
- Staff were members of the Transitional Care Steering Group, as the health representative, working with outside organisations.
- We saw the transition to adult services pathway for 14-19 year olds.

Services for children and young people

Seven-day services

- Consultants provided 24 hour on call service for seven days and undertook ward rounds at the weekend.
- There was 24 hour support from pharmacy service and a seven day service from diagnostics.
- There was no OOH service from therapeutic services or the play team.

Access to information

- The families we spoke with said that they had been informed of the decisions made about the care of their child. One child had been delayed for surgery. The family told us they were happy with the decision as they had been fully informed at the time and found the ward environment to be safe and comfortable.
- The areas we visited had notice boards for family and visitors with information on the quality of services, visiting times and there was one example of responding to feedback 'you said-we did' as a response to the family and friends test.
- There was evidence of information leaflets and contact details for support organisations.
- There was a process for informing GPs, health visitors and school nurses of discharges. We saw examples of the handover documents in children's care records.

Consent

- Staff we spoke with told us they were aware of how to apply Gillick competency and Fraser guidelines to assess the decision making competency of children and young people. However, they told us that they would obtain consent from parents when a child was below the age of 16 years old. Staff said it would be unusual for a young person under 16 to attend the services without a parent. This process was seen in the trust's consent policy.
- We saw good examples of consent documents for surgery in the records.

Are services for children and young people caring?

Good

Overall we rated children's services as being good for caring. Throughout our inspection we saw children and their relatives were treated with dignity, respect and compassion. We heard staff using language that was appropriate to the child's age and level of understanding. All the children and families we spoke with were happy with the care and support provided by the staff. Parents felt confident when leaving their child on the wards that their child would be safe and well cared for.

Compassionate care

- During the inspection we observed staff to treat children and families with dignity and respect. We heard staff using language that was appropriate to childrens' age and level of understanding.
- During our inspection we spoke with nine families to gain an understanding of their experiences of care. They said they with were happy with the care and support provided by the staff. They felt confident when leaving their child on the wards that their child would be safe and well cared for.
- Families had access to the wards day and night.
- Friends and Family test results for June 2015 reported that families would recommend the services in the following areas:

Children's Ward – 88%

NNU – 100%

POPD – 89%

- The trust took part in the national paediatrics diabetes audit survey 2013/14. The trust scored better than other paediatric diabetes unit's average for overall satisfaction of the service and scored well regarding staff interactions, including support and access to the team. Children/carers scored overall satisfaction as 9.9 out of 10.

Understanding and involvement of patients and those close to them

- We observed staff explaining to families the care their child was receiving and the purpose of the equipment helping them to do this. This was done in a compassionate way allowing the families to ask questions to understand what was happening.
- Most families we spoke with felt involved and well informed about the care of their child.

Services for children and young people

- A children and families satisfaction questionnaires was undertaken on the children's' ward. We reviewed comments from April and June which indicated that staff and children were kept informed and felt involved in their care.
- We observed a range of information leaflets across the service.

Emotional support

- We saw parents being reassured by nursing staff and heard explanations of their child's care being given.
- The NNU had a family room to support parents with terminally ill babies. There was support from the chaplain team and families were referred to a bereavement midwife for support on discharge from care.
- The NNU was supported by a BLISS volunteer. BLISS was a UK charity of peer support workers who supported parents of premature babies.

Are services for children and young people responsive?

Good

Overall we rated children's service as good for responsive.

The children's services worked together to promote early discharge and reduce readmissions. They had responded to feedback with a 'you said – we did' project which was displayed on the wards.

The play team worked across the trust providing support to children in any department of the hospital; the sensory equipment was mobile which enabled them to also meet the needs of children with special needs.

There was a pathway to promote a safe transition to adult services for children.

The trust had identified outstanding follow up outpatient appointments following a change to an electronic record system. Immediate action was taken and follow up appointments were being sent following a validation process. Waiting times on the CAU were long for some children.

Service planning and delivery to meet the needs of local people

- Senior staff reported a good relationship with local commissioners of services and were negotiating to re-establish an enuresis service which had been discontinued by community services.
- The CCN team worked with local schools to develop care plans for young people with diabetes to promote reduction in hospital reviews and admissions.

Access and flow

- The trust had recently implemented an electronic patient record system. This had resulted in a large number of patient records not being highlighted as needing follow up outpatient appointments. It was estimated that approximately 200 of these records were for children requiring follow up for cardiology and epilepsy. The trust had identified the issue and had taken immediate action to review of all the paediatric records found to be outstanding a follow up, within the POPD. Appointments were being sent if it was clinically indicated.
- Children were referred to CAU via GP's and following triage were then admitted or returned home. There was no system for recording waiting times within the CAU and we saw two examples where children had waited for a long period of time, several hours in one case, before seeing a doctor.
- One family we spoke with had been waiting for a long time to see a surgical consultant. There had been lack of communication between the consultant, the family and the ward as to how the child was to be managed. The family took the child home and returned the next day rather than staying overnight. This resulted in them missing the early morning ward round and they had to wait several hours to see the consultant.
- Another family we spoke with whose child had access to the service on an 'open door' basis attended CAU in the evening to see a doctor. When CAU closed at 8pm they continued to wait on the children's ward. They returned home without having seen a doctor after five hours at the hospital. The family attended POPD the next morning where they had a consultation with the specialist diabetic nurse. The family were positive overall about their experience at the hospital and said the specialist diabetic team in POPD were excellent.
- There was an admissions pathway provided by the trust which showed that a stable paediatric patient would be seen within 60 minutes by medical staff from admission to the ward. This was dated May 2015.

- Bed occupancy on the children's ward, between 18 June 2015 and 2 July 2015, fluctuated between 29.2% and 75% with an average occupancy rate of 48.6%. This data was collected when there were 24 beds on the children's ward. It is generally accepted that bed occupancy rates of below 85% does not meet the threshold for affecting the quality of care.
- There was no data provided of the occupancy rates following the reduction to 18 beds in the week before the inspection. We were provided with verbal information that bed occupancy had at times increased to 20 following the bed reduction. However, incident reports showed there had been an increase to 19 beds on one occasion.
- The children's ward had daily contact with the CCN team to promote early discharge and reduce readmissions. This included a neonatal outreach team.
- The number of attendances to POPD from 1 July 2014 to 30 June 2015 was 8341.
- Children requiring developmental assessments were seen by community paediatricians within 6-8 weeks in a community clinic.

Meeting people's individual needs

- The paediatric ward had separate male and female bays. There was a room specific for use by teenagers to allow support from peers and the room was equipped with age appropriate facilities, such as DVD's, books, music.
- We observed staff involving children and relatives when delivering care and worked in a way which was family centred.
- NNU had two rooms which were specifically used for parents to stay overnight and care for their babies in preparation for their discharge home. This was to ensure the parents had the confidence to care for their babies when at home.
- The paediatric ward had a sensory room for children with complex needs; the equipment was portable so it could be used by the play team in different areas of the hospital to promote the needs of children in other areas of the hospital being met.
- Staff told us they used the 'Language Line' translation service to meet the needs of families from different cultural and ethnic backgrounds.
- During inspection no families from diverse backgrounds were met so it was not possible to assess how well this group of people's needs were met by the paediatric service.
- POPD referred to CAMHS to promote intervention for young people with mental health needs.
- On the children's ward we were told there was no formal pathway to meet the needs of inpatients with behavioural and mental health issues other than isolating the child and informing security that there may be a risk. We were told that if a child was admitted who was at risk of actual or potential harm they would be seen by CAMHS within 24 hours.
- There was a pathway for young people to promote a safe transition to adult services. This pathway was for 14 -19 year olds.
- The POPD ran a 16-22yrs transitional diabetic service. Staff told us this was a MDT approach supported by specialist nurses, paediatricians and dieticians. The service prepared children from the age of fourteen for the transition to adult services. A leaflet to promote the service to children was seen. Diabetic clinics were held in age bands so that children were seen at clinics with their peers.

Learning from complaints and concerns

- Friends and family questionnaires were observed on the children's wards and in the POPD. They were all in a child friendly format.
- We saw an example of responding to feedback. 'You said-we did' was a response to the family and friends test.
- Complaints reported were few and were generally about the waiting times in CAU and POPD. Staff we spoke with said they deal with these informally by apologising and offering refreshments and referring the children and families to PALS. Staff we spoke with did not routinely report the complaints about waiting times through the incident reporting system
- Staff received information about complaints during handover and from a communication book. The communication book was used to share information with staff that had time away from work. This was to ensure important changes in systems and practice was cascaded to all staff.

Services for children and young people

Are services for children and young people well-led?

Requires improvement

Overall we rated children's service as requiring improvement for being well-led. We had concerns with the nursing and medical staff shortages. We were told by staff that the shortages were a long standing issue and a short term solution had been implemented immediately prior to the inspection. We did not see a business plan with a long term solution to address staff shortages.

There was evidence that incidents reported were not always investigated and cascaded to staff in a timely manner. Staff reported they felt senior management were not approachable.

There was a board level Executive Director for Children's Services, as required by the National Service Framework for Children.

Vision and strategy for this service

- We met with the senior management team for children's services. The service had undergone a restructure in 2014 into a business unit. The future strategy for the unit was to reduce the bed capacity of the service and to promote ambulatory care and to support care closer to home. This was reflective of the Royal College of Paediatrics and Child Health, Facing the future, Getting it right for child health, 2015, overarching principle of care by the right person at the right time for children.
- There was a board level Executive Director for Children's Services, as required by the National Service Framework for Children.

Governance, risk management and quality measurement

- There was evidence that incidents were not always investigated in a timely manner. The governance meeting minutes of May 2015 recorded there were 19 incident reports still open for investigation, 11 of those were outside the expected timescales for completion.
- Senior management staff we spoke with told us there had been challenges feeding back from incident reporting and were looking at improving feedback mechanisms.
- Nursing and medical staffing were identified as risks for the service. On-going recruitment was reportedly taking place to overcome nursing shortages, with the purpose to recruit staff to work across all paediatric clinical areas, including ED, and this was seen as an attractive recruitment strategy.
- The executive board minutes reported approval for extra funding for medical staff for six months. Senior management told us the funding was used to increase cover at the weekends from existing medical staff.
- We met with the children's services management team who told us they had been coping with staffing shortages over a long period of time, and that national paediatric medical and nursing staff shortages were the issue rather than workforce planning. They had considered introducing Advanced Nurse Practitioners.
- The closure of 6 beds on the children's ward prior to the inspection was validated by bed occupancy levels and the management teams expectations that staff shortages would increase over the holiday period. Senior staff told us the children's ward would increase back to 24 beds in September 2015, when newly qualified members of nursing staff commenced employment. They could not tell us how much time the newly qualified staff would have for preceptorship before the beds increased.
- Monthly governance meetings were well structured to include the reporting of complaints, incidents, audits, risks, safety thermometer, innovations, improvements and feedback. However, it was not always clear from the minutes how issues were discussed and actions implemented and cascaded to staff.
- Hip screening was highlighted as an issue within governance meeting minutes provided by the trust. There had been no agreement towards a screening protocol and there had been two occasions where hip dysplasia had been missed. As a result the business management team was informed and a review carried out at a senior level. This resulted in short and long terms management plans being put in place.
- A monthly children's services newsletter was introduced in July 2015 which informed staff of key issues in children's services.
- The wards had quality boards in the staff rooms to inform staff of audit outcomes and mandatory training status.

Leadership of service

- Nursing staff we spoke with said they were supported at ward level but felt senior management were not approachable.
- Staff were worried about their competency to cover staff shortages when they were not familiar with the clinical area, in particular ED as they were often working alone. The trust had implemented a risk assessment for use when moving staff to unfamiliar areas.
- Medical staff we spoke with told us that they felt management had a good understanding of the issues facing the service and they felt supported.

Culture within the service

- Staff we spoke with talked positively about the service they provided, they enjoyed working at Barnsley. Some members of staff had worked there for many years. They felt part of the team and felt staff worked well together and supported each other.
- Inpatients staff told us that morale had been affected by staff shortages.

Public and staff engagement

- The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.63. This score placed the trust in the lowest (worst) 20% when compared with similar trusts.
- We saw evidence that the service was active in seeking feedback from children and their families in a format appropriate to the service. We saw evidence of positive feedback which was displayed for staff and children and their families to see.

Innovation, improvement and sustainability

- The service had developed an allergy service. A multidisciplinary team supported children in the community to develop care plans with schools to improve care and reduce hospital admissions and reviews.
- A bid had been presented to the executive team for two electronic tablets to be used within the service to improve the engagement and feedback from young people.

End of life care

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

End of life care services were provided across Barnsley hospital. The specialist palliative care team (SPCT) had both a clinical and educational role within the hospital. The service offered by the team was an advisory one, in which patients remained under the care of the referring medical team. The SPCT were involved with patients who have complex palliative care needs. There had been 550 referrals to the palliative care team from April 2014 to March 2015. This had increased from 480 referrals the year before.

The SPCT worked closely with the end of life care team, community palliative care team and local hospices. As part of our inspection, we specifically observed end of life care and treatment on wards and other clinical areas. We looked at 25 sets of patient care records, including medical notes, nursing notes and medicine charts. We visited the bereavement service, multi-faith centre, mortuary, emergency department (ED), clinical decisions unit (CDU), and oncology suite. We spoke with 31 staff including ward nurses, the patients bereavement officer, the mortuary team, doctors, porters, chaplains, the SPCT, frailty team, end of life care facilitators and senior managers. We also spoke with eight relatives of patients who were receiving treatment. Before our inspection, we reviewed performance information from, and about the trust.

Summary of findings

We rated end of life care services at Barnsley hospital as good. There were some outstanding examples of compassionate care. There were areas where there was potential for improvement and these had been identified by the trust. We saw evidence that work was in progress to further improve the service.

The end of life service was led by committed leaders. There was good visibility of senior staff and end of life care was high on the agenda of the trust. The trust's end of life steering group, which was responsible for providing clinical leadership and implementation of the service, told us they provided assurance to the trust. Procedures had been developed to support a smooth transition of care from hospital to the community. There were strong links with community teams.

There had been 550 referrals to the specialist palliative care team from April 2014 to March 2015. This had increased from 480 referrals the year before. We saw 100% of the referrals made to the team from April to June 2015 were seen within 24 hours. Most of the referrals (85%) were for cancer related diagnosis and the palliative care team were aiming to address the imbalance by working with other services to reach end stage heart and respiratory failure patients. The AMBER care bundle had been implemented using a rolling programme across medical wards at Barnsley hospital since May 2013. There was a dedicated AMBER care pathway facilitator. The AMBER care bundle is an

End of life care

approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live.

We saw outstanding compassion for patients at the end of life and their families, particularly from the porters, mortuary staff and bereavement officers. Porters told us they looked after deceased patients as if they were their own parents and were committed to caring for them in a dignified manner. The mortuary team provided training to a wide range of staff from inside and outside the trust. There were comfortable, sensitively decorated areas for bereaved families; we found that a number of staff in a variety of roles supported them.

During our inspection we found that oxygen was rarely prescribed. The National Patient Safety Agency (NPSA) indicates oxygen should always be prescribed except in emergencies, as there is a potential for serious harm if it is not administered and managed appropriately. We pointed this out to senior managers at the time and immediate action was taken to address this.

We found that advance care planning was rare. If patients brought in a preferred place of care folder into hospital from the community, hospital staff thought it was not relevant, as it was a 'community document'. Senior nurses and doctors told us they did not understand the concept of advance care planning; they thought this could only be done in the community. Some staff told us it was often too late to have care planning discussion with patients by the time it was recognised they were dying. This was reflected when we found three patients on the respiratory ward had become too poorly to be transferred. We found that advance care planning would have prevented these situations and enabled patients to achieve their preferred place of care at the end of life.

Are end of life care services safe?

Good

We rated safe at Barnsley hospital for end of life services as good.

There had been no 'never events', nor any serious incidents related to end of life care between May 2014 and Apr 2015. (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented). There were systems in place to report incidents.

There were good infection prevention and control practices carried out in the mortuary and by porters. There were well-equipped areas for clinical practice and sensitively decorated areas for bereaved families. The specialist palliative care team and end of life team both gave advice on anticipatory medication to ward doctors and nurses. The aim of anticipatory prescribing is to ensure in the last hours or days of life there was no delay in responding to a patient's symptoms.

There had been three incidents related to end of life care in March and April 2015. These related to a lack of appropriate equipment availability and staffing. We found that oxygen was not prescribed on the respiratory ward nor on other wards we visited. We pointed this out to senior managers during the inspection and immediate action was taken to address this.

There were variable standards of compliance in record keeping, particularly on the 'do not attempt cardiopulmonary resuscitation' forms (DNACPR).

Incidents

- There had been no 'never events', not nor any serious incidents related to end of life care between May 2014 and Apr 2015.
- There were systems in place to report incidents. We reviewed four incidents; three had occurred on CDU. It was not clear that learning had taken place in all incidents. For example, a lack of specialised equipment on CDU had been resolved for the individual patient, but

lessons learned to minimise recurrence were not clear. However, we also saw that lessons had been learned and changes implemented following a serious incident in April 2014 involving chemotherapy administration.
- The SPCT told us if an incident or serious incident was reported, the whole team were involved so that lessons may be learned. The team told us serious incidents were managed by the team, supported by a director.
- Mortuary staff told us they completed incident reports if there were issues with the identification of patients or jewellery left on the deceased.
- Senior managers told us there had been five such incidents in the six months prior to our inspection.

Duty of Candour

- Duty of Candour is a legal duty on NHS trusts to inform and apologise to patients if there had been mistakes in their care which led to moderate or significant harm
- Staff spoke to us about their understanding of duty of candour and talking to patients if an incident or mistake had occurred. They were aware of the need to be open and honest. Staff told us they would document discussions about duty of candour on incident report forms, the patient notes and record progress within the national computer patient administration system. We saw evidence where duty of candour had been used in a variety of trust documents including board papers.

Cleanliness, infection control and hygiene

- There were good infection prevention and control (IPC) practices carried out in the mortuary and by porters.
- Deceased patients were cared for appropriately in the mortuary fridges. There was a physical barrier between clean and 'dirty' areas in the mortuary. This acted as a reminder for staff to change footwear and put on other PPE as needed.
- There was a circulating air system in the mortuary which complied with regulation..
- We observed a good supply of PPE in the post mortem area
- Porters told us they cleaned the concealment trolley after each use. When not in use the trolley was stored with covers on to keep it clean.
- Disposable pillow cases were used on the concealment trolley. There was a large 'dignity' cover which was washed every two weeks and a record was kept of this.
- We observed one nurse exit a side room on ward 18 wearing personal protective equipment (PPE). They did not remove their apron or gloves and left the door open as they left. A patient with MRSA was being cared for in the room. When we asked the nurse about this, they were not able to explain why they had not removed the PPE.
- We observed one patient at the end of life on the coronary care ward. Their mouth was very dry and the mouth care pack was out of date by 24 hours. We pointed this out a nurse who said they would replace the pack and provide care for the patient.

Environment and equipment

- We visited the end of life room in the emergency department. There was soft lighting, and the room could be entered through a separate door which meant bereaved families did not have to go through the emergency department. There was a comfortable, sensitively decorated and well-equipped separate room where families could spend time in the room next to the deceased person. There was a privacy sign on the door to avoid disturbances.
- We visited the viewing room in the mortuary; it was also sensitively decorated and furnished. The lights could be dimmed and there were soft cream bulbs to avoid harsh lighting conditions. There was a separate door into and out of the family room, so bereaved families did not have to see the 'working part' of mortuary.
- We visited ward 33, the trauma ward; there was no designated room for relatives. If family were staying with patient at the end of life, they had to use a quiet room on a neighbouring ward.
- There was a good security system at entry to the mortuary. There were two locking systems at the rear of the building. There was a 'signing in' system for all visitors and staff to the area. The fridge doors were linked to an alarm system.
- The temperature recording system was calibrated so in the event of a fault or temperature dropped an alarm sounded both in the mortuary and on the main switchboard; the estates team would then respond.
- There was capacity for 62 deceased patients in the mortuary fridges. There were two fridges for deceased bariatric patients and a storage area for deceased infants.
- McKinley syringe drivers were in use on the wards. Staff told us these were obtained for use from the medical device library and there were no delays in obtaining them when needed.

End of life care

- Mortuary staff told us all the mechanical fixtures and equipment was replaced in 2013 to bring it up to date.
- There was a deep freeze storage area. This was used if there were delays in locating relatives of a deceased patient.
- Staff told us the Health and Safety Executive had inspected the area about 18 months ago and they had passed the inspection.
- There was a viewing gallery where students or other staff could observe post mortems without being in the same room.
- The mortuary had been updated to try to improve the layout. It had been updated to include a female changing area and staff toilet facilities. The 'garage' area for funeral directors cars was where the bariatric fridges were located. This was a secure undercover area.
- A porter told us there were extra supplies of bags to hold the deceased patients in the emergency department, and on other wards.
- We observed a secure lift up to the mortuary area from the underground corridor; this was the route taken by porters when transporting a deceased patient. Access to the lift was by a set of keys and a swipe card.
- We were shown an electrically powered vehicle which the concealment trolley was attached to part way along the underground corridor up to the mortuary. This vehicle was designed to drive quite slowly and was specifically for this use.

Medicines

- The SPCT both gave advice on anticipatory medication to ward doctors and nurses. We saw a flowchart used as guidance which had been incorporated into the 'my care plan' used at end of life. The aim of anticipatory prescribing is to ensure in the last hours or days of life there was no delay in responding to a patient's symptoms.
- We spoke with a middle grade doctor and a senior nurse on the respiratory ward and found there was a lack of awareness for routine use of anticipatory medications for symptoms of shortness of breath at the of end of life.
- We reviewed several medicine charts on the respiratory ward; one had no allergy status completed. The patient was receiving 60% oxygen, which was not prescribed on the medicine chart. The National Patient Safety Agency (NPSA) indicates oxygen should always be prescribed except in emergencies, as there is a potential for serious harm if it is not administered and managed appropriately.
- We spoke with two middle grade doctors who told us it was "rare" for oxygen to be prescribed.
- An end of life care nurse told us she was regularly asked to order oxygen for home use for end of life patients when it had not been prescribed in hospital.
- Information received from the trust after our inspection noted oxygen therapy prescribing had been implemented with immediate effect on the respiratory ward, ward 18. An audit had been planned for November 2015. There was a planned roll out of oxygen prescribing for the rest of the organisation.
- One of the medicine charts we reviewed on ward 32 had a very high dose of haloperidol prescribed for patient at the end of life which was against the anticipatory medication symptom guidelines. The doctor was not able to tell us why this dose had been prescribed. We spoke with a pharmacist who told us the dose was unusual, there was unclear titration (gradual adjustment) of the dose, but confirmed the dose was acceptable.

Records

- There was some use of an electronic palliative care coordination system (EPaCCS).

This is a patient register which can be accessed by primary care services in the community such as GP's, district nurses, and hospice at home teams, and also the hospital and community SPCT team. Use of EPaCCS minimises the likelihood of patients at the end of life being asked sensitive questions more than once. There were plans to further develop EPaCCS in September 2015.

- We saw good evidence of clear end of life documentation by a junior doctor on ward 17.
- We were told patient care plans were stored electronically on a an electronic record system. Medical records were kept in standard notes trolleys. Four nurses told us they do not read the medical notes to find out what the plan was for the patient. The end of life care coordinator also told us nurses did not always look at medical notes for a variety of reasons; this meant that there could be delays or miscommunication in the patient pathway.

End of life care

- A senior nurse on the respiratory ward told us the consultant had long discussions with a families in distress, but when we checked the notes there was no evidence of this.
- When it was ascertained that patient were nearing the end of life, a care record known as 'my care plan' was commenced. We reviewed one 'my care plan' on the surgical high dependency ward; the signature page was incomplete, there were conflicting dates in the record. An additional photocopied sheet had been stuck to the medicine chart with tape. The chart should have been rewritten. The patient name was not included on each sheet which meant there was potential for errors to occur.
- In the same records, there was a syringe driver record chart. It was very difficult to ascertain what time the syringe driver had been started, and changes to prescriptions were not signed or initialled.
- We observed a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form in some patient notes on ward 32. It was written in the records that it was for a previous admission four months ago, and was not in place for the current admission. Nursing staff told us they would have still performed CPR on this patient. We checked the same records later during our inspection and it had taken two days for the DNACPR form to be rewritten.
- We checked records in the mortuary, there were both hand written and electronic records.
- We were shown the system whereby porters removed an ID card which came with the deceased patient, then would transfer it to the outside of the door on the fridge they had been placed in. The next working morning a member of the mortuary team would cross check the register and names on the fridge doors. There were separate mortuary records for infants.
- We observed good standards of patient identification in the mortuary; a coloured card was placed on the fridge door if any deceased patients had similar or the same second name.
- We reviewed 25 DNACPR records on a variety of wards. Out of these there were nine which had gaps such as capacity assessments not being completed, no evidence of discussion in the records with the patient or family, and being filed in the middle of the medical records. The forms with gaps were on wards 18, 33, 19 and acute medical unit.
- We checked other DNACPR records on wards 17, 20, 23, 30, 31, and ICU, they were all well documented and filed appropriately.
- The SPCT showed us a DNACPR 'aide memoir', which they had created. This acted as a prompt to doctors to ensure they completed all the steps in the DNACPR process including communication with the patient and/or their family.
- Healthcare assistants told us they were not able to record aspects of care they had given to end of life patients as the electronic record system was only accessible to registered nurses. Healthcare assistants could document care given on the paper record 'my care plan' for those patients with an individual care document.

Mandatory training

- There was variability in the levels of compliance with mandatory training. Up to the end of May 2015 the mortuary staff had achieved 100% compliance with all mandatory training apart from fire, health and safety, which was recorded at 50%.
- The SPCT attained 100% in certain areas including information governance, equality and diversity and moving and handling. However, compliance was recorded as 66% in safeguarding adults and children, infection control and resuscitation in the same time period.

Assessing and responding to patient risk

- We saw comprehensive risk assessments completed in medical and nursing records. These were commenced on admission and there was evidence that risk assessment continued throughout the patients stay in hospital. Examples of this included skin assessments for pressure ulcer risk and updated care plans for patients with mouth care needs.
- There was some concern over the management of one deteriorating patient. We saw the family had documented the patient was in pain and felt constipated. Three days after that date there was no evidence that action had been taken to address this. There was no evidence of constipation management in the records The patient was taking opioid medication, which can contribute to constipation. The patient was still uncomfortable; we reported this to a nurse who said they would address this.

End of life care

- We were told about the use of non- slip foot wear which was provided for patient who did not have any slippers to try reducing the risk of falls.

Nursing staffing

- The specialist palliative care team was a nurse led team, led by the lead cancer nurse, who was also the associate director of cancer services in the trust.
- There were two SPCT nurses who were employed by the trust and a further two nurses funded by the local hospice. There were four staff in post, however one of these was on maternity leave. Funding had been agreed for a further post but this had not yet been appointed to.
- The planned establishment was for five whole time nursing posts, there were fouractual posts currently filled.
- We were told the team had just secured funding for two new full time oncology nurse specialist posts and was going to advertise for those posts.
- There were five band 7 nurses in the specialist care for elderly patients' team (known as the 'Frailty' team).
- We visited the clinical decisions unit (CDU) where end of life care patients were cared for. We saw on the duty rota that nurse to patient ratios were 1:10. This meant one nurse to 10 patients. On the day we visited the CDU, there was one registered nurse, one healthcare assistant and one supernumerary student nurse. A nurse told us they had been sent from the emergency department (ED) to cover the ward, but were moved from CDU back to ED sometimes two or three times per shift to provide cover. We did not see this reflected on the rota; the nurse told us she would be replaced by a bank or agency nurse during those times which made it difficult to provide good continuous care for end of life patients.

Medical staffing

- Information provided by the trust indicated there were currently seven hours of consultant palliative care available each week. This was confirmed by the team during our inspection. The planned establishment was for 2.2. WTE consultant posts for the local population of 250,000. A locum doctor had been supporting the SPCT. The team told us that medical cover was slightly below the national requirement for the size of population.
- The SPCT told us there was an acute oncology service but doctors were not able to do daily ward rounds.
- The palliative care consultant told us the lead chemotherapy consultant provided advice for solid tumour investigations. (A solid tumour is any type of type of cancer apart from those of the blood system or lymphatic system such as leukaemia or lymphoma).
- There was one pathology consultant who was employed to cover the mortuary.

Other staffing

- The mortuary was fully staffed with one full time band 6 pathology technician and a band 4 assistant technician.
- We met with four chaplains from different faiths (Muslim, Church of England, Catholic and the Free Church) who provided a variety of cover for the trust, ranging from two hours a week to five days. The chaplains provided 'On call' cover.

Major incident awareness and training

- The mortuary staff told us they were part of the South Yorkshire response plan for major incidents. They told us of detailed plans and partnership agreements with other hospital mortuaries in the event of a major incident with 100- 200 fatalities.
- In such an event the temperature in the post mortem area can be altered to create further storage space for the deceased.
- On a daily basis if there were less than 15 spaces in the mortuary it was escalated to the manager.

Are end of life care services effective?

Good

We rated the effectiveness of end of life care services at Barnsley hospital as good.

The end of life care pathway used at Barnsley demonstrated the team had referred to National Institute for health and Clinical Excellence (NICE) guidelines and the Gold Standards Framework (GSF) for end of life care. There were both local and national audits undertaken to review how effective care was for patients. Mortuary staff told us they participated in audits of their own performance, and had recently carried out a user survey of local funeral directors.

End of life care

The specialist palliative care team supported ward staff in the prescription of anticipatory medication at end of life. There was guidance for medication in the individualised care pathway. Family members told us pain was well controlled for their loved ones.

The national care of the dying audit was carried out in 2013 and results were published in 2014. Results in the clinical performance indicators showed that Barnsley was better than the England average in all 10 clinical indicatorsbut worse in four out of seven organisational key performance indicators.

The SPCT and Mortuary staff had achieved 100% compliance with appraisals by July 2015. The mortuary staff provided training to porters, ambulance staff and the police in one-hour long sessions related to dignity at end of life, and moving and handling of the deceased. The mortuary staff also provided training to nursing and medical students, and other staff undertaking advanced practitioner courses.

There was variation in the percentage of registered nurses and healthcare assistants who had received training in priorities for care at end of life; this ranged from 27% to 95%. However, over 300 staff had been trained in use of the AMBER care bundle from 2013 to 2015.

We observed good internal multidisciplinary team (MDT) working between all staff we came across. There were volunteer staff who also worked collaboratively for the benefit of patients. We found good cooperation between community and hospital teams; they participated in shared palliative care meetings and constantly communicated with each other about patient need.

There was a service level agreement with Barnsley hospice in order that palliative consultant cover was available 24 hours a day. There was a 24-hour phone advice service for patients, families and professionals, which the hospice provided. Ward 24 also offered a 24 hour advice line to oncology patients and their families. We saw a very good end of life care website, which had been developed with the CCG. It included advice for patients and carers. There were details about bereavement support, benefits advice, and a staff education section. We were shown advice leaflets for relatives related to the withdrawal of treatment in intensive care. This leaflet included information about the symptoms which might occur during the final stages of life. It was well written and very sensitive.

Evidence-based care and treatment

- The end of life care pathway used at Barnsley demonstrated the team had referred to National Institute for health and Clinical Excellence (NICE) guidelines and the Gold Standards Framework (GSF) for end of life care to ensure patients were appropriately assessed and supported with their end of life needs. A senior manager told us NICE quality standards were reviewed every three to six months at the end of life steering group in order to maintain evidence based care.
- Audits carried out included the national care of the dying audit, effectiveness of the AMBER care bundle, and an audit of use of the comfort care packs given to families.
- Mortuary staff told us they participated in audits of their own performance, and had recently carried out a user survey of local funeral directors. The results were not available when we asked but we were told the mortuary had performed well.
- We saw the results of an audit of bereaved families, which was carried out by the general office in April 2015. Of 88 participants, 34 said the overall care was very good. The results were shared with all wards in the aim of achieving improved results in the future.

Pain relief

- Symptom management guidance had been produced by the SPCT and was available on the trust intranet and within the 'my care plan' documents on the wards. The guidance covered key symptoms in the last days of life and key prescribing points, such as pain relief and advice on dosage as needed or over a 24 hour time range.
- We spoke with several family members who told us pain had been well controlled for their loved ones.
- We observed very basic pain scores in use on wards we visited. Patients were asked to score their pain between 1-3, as mild, moderate or severe. We found this did not allow for the site, intensity or type of pain to be discussed with the patients. We asked two 'frailty' nurses about pain scores. They told us different methods were used on different wards, for example in elderly care, pictures of faces were used to ask patients about pain; other medical wards used a 1-3 score on the national early warning score (NEWS) observation chart.

We asked senior managers to clarify whether more detailed pain assessment took place. They told us if pain was a problem for a patient then a more detailed pain assessment tool was used.

Patient outcomes

- In the 2013/14 Cancer Patient Experience Survey, the trust was in the top 20% of trusts for 17 out of 34 indicators.
- The national care of the dying audit was carried out in 2013 and results were published in 2014. Results in the clinical performance indicators showed that Barnsley was better than the England average in areas such as recognition that the patient is dying, and discussions with both the patient and their relatives regarding their recognition that the patient was dying. There were good results in communicating the patient's plan of care, assessment of the spiritual needs of the patient and their relatives; there were good results also for the prescription of medication as required for the key symptoms that may develop.
- In the key performance indicators for the organisation, four out of seven were not achieved. These included access to specialist support for care in the last hours or days of life, continuing education, training and audit in the care of the dying, clinical provision for promoting patient privacy, dignity and respect, and formal feedback processes regarding bereaved relatives or friends views of care delivery.
- Recommendations were made which included:

-the provision of a face to face SPCT service from at least 9am to 5pm, 7 days per week to support the care of the dying patients and their families, carers or advocates

-Development of end of life care policies and procedures regarding mouth care and dignity

-Delivery of end of life care training to appropriate staff members

Improve quality of last days of life care.

-Regular local clinical audits to include views of bereaved family or carers.

- An action plan was developed and completed by December 2014, including an ongoing training programme.
- The DNACPR audits were carried out by the resuscitation team supported by the end of life care team. A senior nurse told us there was a local CQUIN (Commissioning for Quality and Innovation) related to improvements in the quality of discusisons around the DNACPR process. (The CQUIN payments framework encourages care providers to continually improve how care is delivered and to achieve transparency and overall improvement in healthcare).
- There was an action plan in place to improve the recording of DNACPR. This included documenting the reason in the medical notes and the use of a prompting sticker to remind doctors to consider the patients capacity status.
- There had been an internal health and safety inspection on ward 24, the chemotherapy ward in April 2015. Action plans because of this included improved compliance with daily resuscitation equipment checks, improvements in the temperature of patient's food and increased staff awareness of risk regulations. These were all rated as amber in a red, amber green rating and had been due for review just after our inspection.
- We asked the SPCT and senior leaders about how many patients achieved their preferred place of care. The results of this were not known, as there was only partial use of an electronic system to record this. Further work was due to start on the system in September 2015.

Competent staff

- Ward staff had been supported with a 'major education drive' by the end of life care team, as ward nurses were the ones who delivered day to day care for end of life patients.
- There had been a programme of 'priorities for care' training from May 2014 to March 2015. There was variation in the percentage of registered nurses and healthcare assistants who had received training. This ranged from 27% of the registered staff in the emergency department and clinical decision unit, 50% of the registered staff on the chemotherapy ward, to 95 % of staff on ward 19. There had been 31 doctors and three allied health professionals who had received the training, in the same timeframe. This was a rolling programme so it was expected the training rates would improve after our inspection.
- There had been a programme of AMBER care bundle training, originally from 2013-2014 for staff in the areas of wards 17, 18, 27 (now closed), 28, the outreach team,

SPCT, staff in intensive care and physiotherapy. This training was delivered to 148 staff including doctors. In 2014- 2015 there had been further 'roll out' training delivered on wards 10, 20, and 20, and refresher training was planned for wards 17, 18, 28. Extra training was requested and delivered to wards 19, 23, 28, coronary care and the Frailty team. A further 177 staff were trained from 2014-2015.

- Two of the SPCT were nurse prescribers and all other team members were undertaking the training course for this. Nurse prescribing improves patient care by ensuring timely access to medicines and treatment.
- The nurses in the SPCT had master's degrees in supportive and palliative care and another team member was studying for her masters. All of the SPCT had advanced communication skills. All of the SPCT had advanced communication skills.
- The SPCT told us ward nurses had adapted well to the use of the 'new' end of life care plan.
- Some of the nursing staff on the chemotherapy ward had advanced communication skills.
- Two consultants told us they were very happy with the knowledgeable support provided by the SPCT. They said the SPCT had a "huge positive impact" on end of life patient care.
- There was a band 5 end of life 'link' nurse on ward 19. She acted as a connection between the SPCT and other ward nurses and provided updates and support for nurses on her own ward area. We saw minutes from the link nurse meetings, which showed there had been improvements in care after death for patients on ward 19. The end of life team told us not all wards had link nurses due to staffing pressures.
- We spoke with a number of registered nurses and doctors on wards 17, 18, 20 and 33. There was a lack of awareness of advance care planning. Staff told us they had not received any training on this.
- The mortuary staff provided training to porters, ambulance staff and the police in one-hour long sessions related to dignity at end of life, and moving and handling of the deceased. The mortuary team also arranged for the contracted funeral director to provide some training for university medical students on placement at the hospital.
- The mortuary staff also provided training to nursing and medical students, and other staff undertaking advanced practitioner courses. This training included learning the role of the coroner, the observation of a post mortem and discussions with the pathologist. Feedback from these sessions was very positive and staff said it gave them awareness of good continuity of care, before and after death.
- Both the band 6 and band 4 mortuary staff demonstrate very good knowledge.
- We spoke with porters and were impressed that and had set goals and objectives for themselves which were in line with those of their manager. One of the porters had attended a leadership course and had been encouraged to further his career at the hospital. We saw that other porters all had been appraised in the last year.
- Two nurses from the Frailty team told us they had completed a six-day course at the local hospice; this had enabled them to deliver syringe driver training to ward nurses. They also delivered training related to dementia and delirium to nurses and doctors. The frailty nurses were also trained to recognise when patients were approaching the end of life. They became involved in discussions about resuscitation and care planning with patients and their families.
- The bereavement staff in general office were all up to date with appraisals, had clinical supervision every three months and weekly team meetings.
- The SPCT and mortuary staff had achieved 100% compliance with appraisals by July 2015.
- The SPCT had delivered a programme of syringe driver training across the hospital. There was some variety in the numbers of staff who had been trained.
- Information shared with us by the trust showed in the medical clinical business unit, there were 223 suitable staff for training, however, only 9% had up to date training. There were also gaps in the numbers of staff in the children's, surgical, maternity and critical care areas who had received training.

Multidisciplinary working

- We observed good internal multidisciplinary team (MDT) working between all staff we came across. This included including ward nurses and doctors, the SPCT, the end of life care team, allied health professionals, the bereavement officers, mortuary staff, porters and chaplains. There were volunteer staff who also worked collaboratively for the benefit of patients. We found good cooperation between community and hospital teams; they participated in shared palliative care meetings and constantly communicated with each other about patient need.

End of life care

- We were told the clinical nurse specialist team leader participated in ward rounds and attended MDT meetings to provide specialist advice to general staff.
- The clinical nurse specialists participated in cancer MDTs in order to keep up to date with plans for their patients on a daily basis.
- We observed a good relationship between the SPCT and ED staff, who would readily contact the SPCT if an end of life patient were in the department.
- Staff on the CDU told us they had a high level of support from the SPCT in caring for end of life patients.
- We were told the critical care outreach team would review patients who were on the AMBER care pathway. This meant there was support to help consultants and anaesthetists to meet the needs of patients.
- We found the occupational therapists and physiotherapists on the stroke ward were proactive in working with the SPCT and end of life teams for the benefit of patients. Therapists had suggested patients who had an uncertain prognosis and who might be suitable for the AMBER care pathway.
- There was good cooperation between the different chaplains and a joint approach in supporting staff and end of life patients.
- We were told by staff on the children's wards that there was good joint working in end of life care situations with Sheffield children's hospital.
- Senior staff told us there was good external collaboration with the clinical commissioning group (CCG) in order to speed up funding decisions and plan care for patients at the end of life.
- We found good collaborative working between the hospital staff and the community SPCT team and the Marie Curie supportive care at home team in order to meet patient need on discharge from hospital. Barnsley hospice provided 24 hour on call consultant cover for the hospital and two clinical nurse specialists.

Seven-day services

- There was a service level agreement with Barnsley hospice in order that palliative consultant cover was available 24 hours a day.
- There was a 24-hour phone advice service for patients, families and professionals, which the hospice provided.
- Ward 24 offered a 24-hour advice line to oncology patients and their families.
- The SPCT provided a Monday to Friday service at the time of our inspection, but told us they were soon to move to a seven-day face to face service and reflect that which was provided in the community.
- Mortuary staff had a 24 hour, year round on- call rota. Out of hours, the duty manager would meet bereaved families at hospital reception and accompany them to the mortuary.
- The frailty nurses worked seven days a week; they covered the hours of 8am to 8pm during Monday to Friday, and 9am to 3pm on weekends and bank holidays.

Access to information

- We saw a very good end of life care website, which had been developed with the CCG. It included advice for patients and carers. There were details about bereavement support, benefits advice, and a staff education section with secure login facilities.
- We were shown advice leaflets for relatives related to the withdrawal of treatment in intensive care. This leaflet included information about the symptoms which might occur during the final stages of life. It was well written and very sensitive.
- GP's were informed that a patient required end of life care on discharge from hospital by phone calls and faxes and via an electronic system. When the EPaCCS electronic system was further developed later in the year, this system would be used.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw there was a comprehensive four-part capacity assessment in use in patient records. Doctors told us they were responsible for completion of capacity assessments.
- We were told the local authority were responsible for best interest assessments if someone was deemed to not have capacity.
- Five nurses from different wards told us they were not familiar with deprivation of liberty safeguards. They told us they would refer to the safeguarding team during usual working hours, but were unsure of the process out of hours.

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- On the acute medical unit, two out of six records we looked at indicated patients were deemed to not have capacity to make a decision related to resuscitation, but no capacity assessment had been carried out. We could not find evidence in the medical records.
- On ward 18, we checked seven DNACPR forms. Two forms indicated the patients did not have capacity to make a resuscitation decision, but there was no evidence of a capacity assessment in the medical notes when we checked. One patient with a DNACPR decision had a severe brain injury and could not participate in discussions; there was no evidence of a discussion with his family in the medical notes when we checked.

Are end of life care services caring?

Outstanding ☆

We rated end of life care services at Barnsley hospital as outstanding for caring.

We found evidence of very compassionate end of life care to patients at Barnsley. We heard of several examples where staff went above and beyond their roles to provide compassionate care, for example a ward sister who stayed after her shift ended to take a patient outside, as they wanted to feel the sunshine and wind on their face for a final time.

Feedback from patients and families was positive about the care they had received; one family said, "The staff and doctors on this ward stand for all that is great about NHS, kindness, compassion, professionalism and patience". An end of life patient had fulfilled their final wish, and recently was married on one of the wards. In the emergency department, patients identified as dying were cared for in a single room and moved from a trolley to a bed to increase their comfort.

We spoke with caring and compassionate porters. They told us when they took deceased patients to the mortuary, they looked after them as they would if it was "our own mums or dads". Most of the porters spoke to the patients and told them were they were going, and what the mortuary would be like. They told us "this is where our dignity training comes in". The porters spoke with ward staff and sometimes families about individual ways to transport deceased patients to the mortuary. If a midwife had brought a deceased infant to the mortuary, the porters told us they would walk with them and accompany them back to the ward afterwards as a way of supporting them.

We found the mortuary staff to be caring and compassionate. They had received bereavement training and felt able to support bereaved families when they visited the mortuary. If there had been a miscarriage on a maternity ward, the mortuary staff were involved in cremation if the parents wished for this. If a family wanted cremation to be done on their behalf, then staff arranged this at no cost and for the ashes to be scattered in a 'Peter Pan' garden at a local cemetery. The chaplains told us they carried out blessings and naming ceremonies on maternity wards if bereaved families wanted this to happen. We spoke with some volunteer staff who told us they accompany bereaved families to and from the mortuary so they did not have to go alone.

We found bereavement staff in the general office to be caring and compassionate. The bereavement team made appointments for bereaved families with the registrar to register someone's death; this was very unusual and showed a high degree of compassion. Out of hours, the switchboard staff kept a diary and booked appointments for families to go to the bereavement office.

We saw in one individual care plan that a family had written the patient preferred music to television. When the family visited next time staff had obtained a radio from the medical devices library and put music on for the patients

We were shown some information leaflets for families in the intensive care ward, which were written in a very sensitive manner. Multi faith chaplaincy support was available 24 hours a day. Two of the chaplains told us how they often supported staff as well as patients and families. They told us how they would sit and listen to staff in the middle of the night when there was a little more time. The chaplains were a close team, differences in faith were not a barrier and they referred to each other as 'brothers'.

Compassionate care

- In the national care of the dying audit in hospitals (NCDAH) of 2013- 2014, Barnsley achieved good results in three organisational key performance indicators.

End of life care

These were access to information related to death and dying, trust board representation at end of life, and having clinical protocols for the prescription of medications for the five key symptoms at the end of life.

- In clinical key performance indicators within the national care of the dying audit in hospitals (NCDAH) of 2013- 2014, Barnsley achieved higher than the national average in all 10 indicators. This included recognition that the patient was dying, discussions with both the patient and their relatives / friends regarding their recognition that the patient is dying, and communication regarding the patients plan of care for the dying phase. Other better than average results were attained in assessment of spiritual needs, consideration of nutritional and hydration needs and a review of the care after death. The average percentage of cases achieved was 73.7% for Barnsley compared to an England average of 55.7%.
- We found evidence of very compassionate end of life care to patients at Barnsley. Staff told us about weddings and funerals of patients they had attended. Feedback from patients and families was positive about the care they had received.
- We were told of a ward sister who stayed after her shift ended to take a patient outside, as they wanted to feel the sunshine and wind on their face for a final time. She took the patient and his family outside to a private area. The family said they would always remember this small gesture.
- During our visit a family approached us and told us their relative was dying; staff were keeping them informed every step of the way, they could ask any questions. They told us the doctors and nurses were very approachable and happy to listen to the family suggestions. The staff always included the patient in all decisions and had managed symptoms such as pain very well. The family said, “The staff and doctors on this ward stand for all that is great about NHS, kindness, compassion, professionalism and patience”.
- A family member on another ward told us they were very pleased with the care; she said she felt valued and part of her loved ones care.
- An end of life patient had fulfilled their final wish and recently was married on one of the wards.
- In the emergency department, patients identified as dying were cared for in a single room and moved from a trolley to a bed to increase their comfort. There were arrangements that if a patient were imminently dying, they would not be moved from the department as staff had already built a relationship with the patient and family.
- We spoke with caring and compassionate porters. They told us when they are taking deceased patients to the mortuary; they look after them as they would if it was “our own mums or dads”. Most of the porters spoke to the patients and told them were they were going, and what the mortuary would be like. They told us “this is where our dignity training comes in”.
- They showed us how they would use pillows for a deceased patients head and feet on the metal concealment trolley when taking them from the ward to the mortuary. The trolley cover was referred to as a ‘dignity sheet’. They told us they made sure deceased patients were properly covered before they leave the ward.
- We were shown an electrically powered vehicle which the concealment trolley was attached to part way along the underground corridor up to the mortuary. This vehicle was designed to drive quite slowly and was specifically for this use.
- The porters spoke with ward staff and sometimes families about individual ways to transport deceased patients to the mortuary. For example, some bereaved parents wanted to carry their child or use a pram rather than using a trolley. In such cases, the porters would accompany them and take a different route to the mortuary to avoid the basement corridor. They would also accompany the families back afterwards. A porter told us if there were any doubt about a bariatric patient being too large for the trolley, they would take the patient on their bed to maintain their dignity.
- If a midwife had brought a deceased infant to the mortuary, the porters told us they would walk with them and accompany them back to the ward afterwards as a way of supporting them.
- We found that porters were supportive of each other and if one felt unable to be involved with deceased patients because of a personal reason, their colleagues would stand in for them. We were told counselling was available for porters as well as other staff.
- We found the mortuary staff to be caring and compassionate. They had received bereavement training and felt able to support bereaved families when they visited the mortuary.

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- They told us they would clarify issues with families if they were uncertain about information they had been given on the ward. Staff took steps to ensure deceased patients were presented in a dignified way when families saw them in the viewing room. Staff were trained in facial reconstruction and if the appearance of a deceased person had been affected by trauma, such as a road traffic incident, they took steps to make the viewing less traumatic for families.
- We found the mortuary staff followed Royal College of Nursing guidelines (2007) for sensitive disposal of foetal remains. If there had been a miscarriage on a maternity ward, there were two ways the mortuary staff were involved in cremation. If a family wanted cremation to be done on their behalf, or to be involved, then staff arranged this at no cost and the ashes could be scattered in a 'Peter Pan' garden at a local cemetery. If the family did not wish to know, then the mortuary staff arranged cremation and some ashes were scattered in a garden at the crematorium. Families were given time to decide and there was accurate documentation and an audit trail should families wish to enquire about disposal arrangement some time later.
- The chaplains told us they carried out blessings and naming ceremonies on maternity wards if bereaved families wanted this to happen.
- Outside the mortuary there was a garden area planted with lavender and other scented flowers. There was a bench where people could sit and face either way so they did not need to look towards the mortuary building.
- We spoke with some volunteer staff who told us they accompany bereaved families to and from the mortuary so they did not have to go alone. If family members wanted to view their loved one out of hours the hospital duty manager met them and accompanied them along with porters who enabled access.
- We found bereavement staff in the general office to be caring and compassionate. When a patient died in hospital, the ward nurses contacted the bereavement team and made an appointment for the family to collect the death certificate. The bereavement team were doing a pilot study at the time of our inspection where two consultants looked at medical notes and made recommendations for the cause of death. This was done to support junior doctors. If the junior doctor disagreed or wanted to discuss further this would happen. The bereavement team told us this system was done in a neighbouring trust and worked well.
- The bereavement team made appointments for bereaved families with the registrar (to register someone's death) to make this easier for families. In most cases of deaths in a hospital, families have to do this themselves. The bereavement officers explained what needed to be done, provided families with a map of how to get to the register office, and other written information in the form of a booklet. They then accompanied them out of the hospital
- Out of hours, the switchboard staff kept a diary and booked appointments for families to go to the bereavement office.
- We were shown some information leaflets for families in the intensive care ward, which were written in a sensitive manner.
- On ward 17, we spoke with an end of life patient in a single room. He told us he was uncomfortable and thirsty. His mouth was very dry, his call bell was out of reach and the mouth care pack was out of date. We pointed this out to a nurse who said she would make him comfortable and replace the mouth care pack.

Understanding and involvement of patients and those close to them

- In 'my care plan', there was space for family to write comments or messages to staff. One relative told us he found it too emotional to speak to staff so he communicated to them via the care plan.
- We saw in one 'my care plan' on the stroke ward that a family had written the patient preferred music to television. When the family visited next time staff had obtained a radio from the medical devices library and put music on for the patients. The family had written in the care plan that they were "very touched by this".
- One of the end of life team told us she knew Barnsley people well, how they respond best and how they like to be treated.
- Mortuary staff told us if it was recorded that patients wished to donate organs after death they respected this. Some organ donation took place in the post mortem room by an external team from Liverpool; whole organ donation took place in theatres. There was a specialist nurse for organ donation who was a shared service with another hospital..

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- We noted a general lack of awareness about advance care planning (ACP) for end of life patients. We saw one or two preferred place of care folders, which had come in with patients when they were admitted to hospital. Nurses and doctors we spoke with said ACP happened in the community after discharge when the patient was imminently dying. Staff did not appear to understand the concept of advance planning in order to meet the patient's wishes.

Emotional support

- A number of staff told us they could have counselling and debriefing if they wished.
- Multi faith chaplaincy support was available 24 hours a day. Two of the chaplains told us how they often supported staff as well as patients and families. They told us how they would sit and listen to staff in the middle of the night when there was a little more time.
- The end of life nurses provided support to bereaved families and signposted them to additional sources of support, as did the bereavement office staff.
- The hospital provided individual memorial services for relatives of patients who had died at the hospital. We were told about a multi faith memorial service planned for later this year for all those who had died.
- The chaplains were a close team, differences in faith were not a barrier and they referred to each other as 'brothers'.

Are end of life care services responsive?

Good

We rated the responsiveness of end of life care services at Barnsley hospital as good.

The palliative care service was widely embedded in clinical areas of the hospital. There was an 'alert' system in use; if an oncology patient was acutely admitted, the SPCT were informed and could become involved quickly. There had been an increase in the number of patients referred to the SPCT in the last year. From April to June 2015 there had been 94 new referrals and 23 re-referred patients. 100% of these were seen within 24 hours.

Personalised care plans were used to tailor care for patients at the end of life. There was a 24-hour advice telephone line for chemotherapy patients and their families, which was staffed by nurses on ward 24. Patients were triaged to support and could be admitted directly to the ward if necessary. The mortuary staff told us that the coroner offered a 'digital' post mortem to families, if it was appropriate. We found there was a strong ethos of learning from complaints. The SPCT told us this had improved since the current chief executive came into post. We heard of two patient 'stories' being heard at clinical governance meetings as a way of learning from complaints.

We found a general lack of awareness of advance care planning on most wards. If patients brought in a preferred place of care folder from the community, hospital staff thought it was not relevant, as it was a 'community document'. Senior nurses and doctors told us they did not understand the concept of advance care planning; they thought this could only be done in the community. Some staff told us it was often too late to have care planning discussion with patients by the time it was recognised they were dying. This was reflected when we found three patients on the respiratory ward had become too poorly to be transferred. We found that better planning would have prevented this situation.

Service planning and delivery to meet the needs of local people

- The palliative care service was widely embedded in clinical areas of the hospital.
- There was an 'alert' system in use so when an oncology patient was acutely admitted, the SPCT were informed and could become involved quickly.
- We saw an increase in the number of patients referred to the SPCT from 2013- 2014 to those in 2014- 2015. Most referrals were cancer related, and this showed some imbalance between cancer and non-cancer patients. The palliative care team had done work with other professionals to develop clinical pathways for patients at the end of life with specific conditions such as heart failure and patients with chronic obstructive pulmonary disease (COPD). Members of the SPCT told us they acknowledge a 'shortfall' in non-cancer referrals, they hoped the AMBER care bundle would bring a change in referral patterns.
- There had been 550 patients referred to the SPCT from April 2014 to March 2015. This had increased from 480 referrals the year before. The vast majority, 85% of the referrals from 2014-2015 were for cancer related diagnosis, and 15 % were related to non-cancer

End of life care

diagnosis. From April to June 2015 there had been 94 new referrals and 23 re-referred patients. 100% of these were seen within 24 hours. This was a small increase from 2014- 2015 where 98% were seen within 24 hours.

- There was an end of life steering group, which had a high profile at the hospital. We found that membership of this group could be increased to allow the mortuary team, frailty team and bereavement services to take part.
- The trust was in the lower 20% of deaths that occurred in hospital in England. This reflected a stance of discharging patients who were near the end of life. A CCG report of 2015 noted in 2009 that 53.7 % of patients died in hospital; this reduced to 49% in 2013. This was lower than the national average.
- The same report noted that 84% of pts known to the community palliative care team died in their preferred place of care.
- The hospital teams were not able to record how many patients died in their preferred location, until the EPACCS system was amended later in the year.

Meeting people's individual needs

- Personalised care plans were used to tailor care for patients at the end of life. Staff told us families write in the care plan and their needs were responded to 'immediately'. We saw one situation out of 25 care records we looked in where this had not been the case.
- There were 'comfort care packs which contained toiletries and other items; staff gave the bags to family and carers to use if they were staying overnight with patients.
- We visited the chapel and saw mainly Christian symbols; this reflected the local population. There was a 'memory and prayer tree' provided for relatives or patients to write messages on 'leaves' and stick them on the tree.
- On the acute medical unit there was a single room used for end of life patients. The room had been decorated in soft colours and had a dimmer switch for the lights. There was a profiling bed in use, which meant the patient could be in a comfortable sitting position without needing to move from the bed to the chair. Work was in progress to relocate the room to a quieter area on the ward as families said they found the area noisy.
- A doctor on the acute medical unit told us he had been hesitant and unsure about further treatment for a patient. He used the individualised care plan to help him make decisions in the interest of the patient.
- The mortuary staff told us that the coroner offered a 'digital' post mortem to families, including Muslim families, if it was appropriate. An MRI scan would be performed, however, if cause of death could not be ascertained a standard post mortem would take place at the hospital.
- We found a general lack of awareness of advanced care planning on most wards. If patients brought in a preferred place of care folder form the community, hospital staff thought it was not relevant, as it was a 'community document'. On the respiratory ward, a senior nurse thought the individual care plan was an advanced care plan. The same nurse told us patients were actively dying on their ward before the individualised care plan was brought into use. A doctor on the same ward told us identification of dying patients was difficult and patients become too ill to be transferred to their preferred place of care.
- A senior ward nurse on ward 33 told us they did not understand the concept of advance care planning; they thought this could only be done in the community.
- A consultant told us it was often too late to have care planning discussion with patients by the time it was recognised they were dying.
- When it was recognised patients were dying and they were to be 'fast tracked,' patients were asked about their preferred place of care, but there was no specific tool or prompt for staff to do this.
- The frailty team told us they were not involved with advance care planning; there were five band seven nurses who were suitably skilled to do so.

Access and flow

- Staff liaised with the discharge sister who was part of the end of life care team. She was responsible for coordinating rapid discharges. She made referral to the supportive care at home team, and ordered equipment such as hospital beds and pressure relieving mattresses. She told us discharge could be arranged within two hours.
- Senior staff told us there had been discharge delays for end of life patients in the past. Work had taken place with the clinical support unit of the CCG to speed up funding decisions.

End of life care

- During our inspection, we found that three patients on the respiratory ward had become too poorly to be transferred. We found that better planning would have prevented this situation.
- On the coronary care ward we saw in medical notes that a fast track form should have been completed on the 13th of July and plans for rapid discharge commenced. When we were on the ward on the16th July, this had not yet been done. We asked the senior nurse about this and they were unable to explain why the delay had occurred.

Learning from complaints and concerns

- We found there was a strong ethos of learning from complaints. The SPCT told us this had improved since the current chief executive came into post. We heard of two patient 'stories' being heard at clinical governance meetings as a way of learning from complaints.
- An example of learning occurred on ward 19 where a complaint was received about the lack of mouth care for an end of life patient. The ward manager arranged for a learning session with the end of life team. We were told improvements had taken place and been sustained.
- There had been a complaint about care from a family which was sent to the CQC. It related to the acute medical unit. A patient had been discharged in an unkempt condition, without dressings on pressure ulcers and was not sent home with any medication. A safeguarding investigation verified the families concerns. An action plan had been put in place on the ward to prevent a reoccurrence.

Are end of life care services well-led?

Good

We rated end of life care services at Barnsley hospital as good for well-led.

We found there was strong clinical leadership provided by the associate director of cancer services and the deputy director of nursing. There was high visibility of senior staff and end of life care was high on the agenda of the trust. Following a review of board responsibilities, the medical director had been recently appointed as the lead for end of life care. There was also a non-executive director responsible for end of life care at board level. There were clinical leaders for both hospital and community team who worked closely together; both were members of the end of life steering group. We found an open and friendly staff culture at Barnsley hospital. There was a close community environment.

From a review by the CCG in March 2015, five key recommendations were developed and some had been achieved by the time of our inspection in July. There was a strategy group led by the district wide end of life care lead and a steering group that worked to ensure a seamless transition for the patient from hospital to the community. Care pathways and assessment tools were shared by the hospital and community teams as a way of ensuring this happened.

There was a clear governance structure from ward and clinical business unit to the board. Staff we spoke with were clear about incident reporting and how this was used to make improvements in care. Staff were open about reporting risks or incidents and there was a philosophy of learning from incidents and complaints. We found three occasions where staff told us they had been encouraged to develop and acquire new skills.

Staff we spoke with told us they were unaware of plans to develop or roll out a preferred place of care tool or advance care planning. Staff told us their line managers and senior managers were approachable and supportive. We found the trust engaged with the local community through a news magazine

The end of life service was forward thinking. The palliative care team were working with the IT department to develop video links to MDT meetings on other hospital sites in order to share learning. There were developments underway for a telehealth pilot to link in with GPs and care home staff in order to prevent unnecessary admission for end of life patients.

Vision and strategy for this service

- Following a review of board responsibilities the medical director had been recently appointed as the lead for end of life care . There was also a non-executive director responsible for end of life care at board level.
- We were shown the CCG's end of life care strategy for 2015- 2017 which the trust had provided input to. There had been a review by the CCG in March 2015 and five key recommendations were developed: they included the

development of a clinical steering group (this had been achieved), the creation and monitoring of clinical standards, further education and training for clinicians, and a review and implementation of EPaCCS.

- There was a strategy group led by the district wide end of life care lead where the aim was to influence the strategic direction of end of life care services for the area. The group aimed to deliver better outcomes for patients at the end of life in line with national, regional and local end of life strategy. There was also a steering group that worked to ensure a seamless transition for the patient from hospital to the community. Care pathways and assessment tools were shared by the hospital and community teams as a way of ensuring this happened. There was an opportunity to widen membership of the steering group to include the pathology team, frailty team and bereavement team.
- We were shown board minutes from April 2015 which showed a matter for escalation included the "last days of life and lack of seven day palliative care service". The board were made aware that further support was needed to expand the programme, a business case for which was being developed.
- The frailty team told us there were plans to develop a new frailty unit, a new general manager had been appointed to oversee this development. The vision was for a 10-bedded short stay unit to take direct admissions from care homes and GP's so frail patients near the end of life could avoid admission to the emergency department.

Governance, risk management and quality measurement

- There was a clear governance structure from ward and clinical business unit to the board. Staff we spoke with were clear about incident reporting and how this was used to make improvements in care.
- The SPCT participated in morbidity and mortality meetings as a learning opportunity.
- We were told funding for the AMBER care bundle was due to expire in September 2105 and a business case had been submitted to the CCG, which would mitigate the risk of not having a specified staff member to deliver this training. We were concerned however, there were no plans to roll out AMBER care bundle training to the surgical wards. This would mean that patients and families in that area might not get the opportunity to continue with treatment in the hope of a recovery, while talking openly about their wishes and plans in place if they did not recover.
- We spoke with three staff from the end of life team and the discharge sister. We were concerned they told us there were no plans to develop or roll out a preferred place of care tool. They told us advance care planning did not take place a Barnsley hospital but they were hopeful that the new medical director would be able to influence this.
- We were shown minutes from the quality and governance committee meeting of March 2015, where end of life issues were documented. There was evidence of the effectiveness of individualised care plans. There were also notes about decisions taken to discharge patient very near the end of life where there was a risk they would die in the ambulance.

Leadership of service

- Most staff we spoke with told us their line managers and senior managers were approachable and supportive.
- We found there was strong clinical leadership provided by the associate director of cancer services and the deputy director of nursing. There was high visibility of senior staff and end of life care was high on the agenda of the trust.
- Mortuary staff told us the chief executive had carried out an unannounced visit to mortuary and had introduced themselves and told staff they could get in touch if they needed to.
- There were clinical leaders for both hospital and community team who worked closely together; both were members of the end of life steering group.
- Ward staff told us the SPCT and end of life team were very supportive. Ward nurse knew the SPCT and end of life team by name and were able to give us examples of their involvement in patient care.
- Doctors told us that most consultants were visible and supportive.
- We found that there was a strong nursing 'voice' related to end of life care at board level, but there could be more medical leadership to support this and to enable change to take place.

Culture within the service

- We found an open and friendly staff culture at Barnsley hospital. There was a close community environment.

End of life care

- Staff were open about reporting risks or incidents and there was a philosophy of learning from incidents and complaints.
- We found three occasions where staff told us they had been encouraged to develop and acquire new skills. We spoke with porters and were impressed that and had set goals and objectives for themselves which were in line with those of their manager. One of the porters had attended a leadership course and had been encouraged to further his career at the hospital.
- Leaders told us they had acquired funding to develop the role of healthcare assistants. Competency workbooks were being developed and there were plans to implement the Care Certificate. This would involve having national minimum training standards and would set out the learning outcomes, and standards of behaviour expected of a healthcare assistant or support worker.
- During our inspection, three junior doctors told us it was difficult to challenge consultants regarding the 'ceiling of care' for end of life patients. Other doctors told us consultants were open to discussion.

Public engagement

- The trust participated in an annual national bereavement survey known as 'VOICES' as part of the national care of the dying audit. In April 2015 the trust used a modified version of this to undertake a further questionnaire of bereaved relatives. This latest survey indicated that out of 88 deaths in the hospital, 30 relatives responded and indicated that the care of their loved one was very good. Managers told us the survey would be repeated again this year. Some trusts do not participate in VOICES surveys due to sensitive nature of surveying bereaved families.
- Minutes of the end of life care steering group of March 2015 noted a patient and carer survey had been carried out as part of the national care of the dying audit. There had been 31 responses received, the themes were due to be looked at and shared across the hospital.

Innovation, improvement and sustainability

- The SPCT told us they were working with the IT department to develop video links to MDT meetings on other hospital sites in order to share learning.
- There were developments underway for a telehealth pilot to link in with GPs and care home staff to have three way conversations. It was anticipated this would reduce the number of unnecessary admissions to hospital for end of life patients in care homes. The team were uncertain when this work would be finalised.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

Outpatients and diagnostic imaging were managed under a single clinical business unit and comprised two main areas:

The outpatient service which was split into a number of departments / specialities such as, ear, nose and throat (ENT), women's health, surgical, medical, dietetics, maxillary-facial, fracture, dermatology, cardiology, diabetes and endocrinology and phlebotomy. The ophthalmology service was provided and operated by another trust. Outpatients also included pathology services that provided routine diagnostic services for Blood Sciences, Blood Transfusion and Microbiology and Cellular Pathology (Histology) and

The diagnostic imaging service which was also split into a number of departments and provided an extensive range of techniques, including plain film x-ray, ultrasound, CT scanning, MRI scanning, nuclear medicine scans, fluoroscopy, angiography and mammography.

Each department or speciality ran a wide range of clinics; some nurse-led, some led by allied healthcare professionals and some by doctors.

Between July 2013 and June 2014, Barnsley Hospital NHS Foundation Trust outpatient department saw 267,664 patients. The majority of appointments were arranged via a 'choose and book' system.

Some outpatient pathology and radiology services were delivered in partnership with other trusts under service level agreements.

We inspected the imaging departments, the main outpatients, and the ophthalmology, ear, nose and throat (ENT), women's health, surgical, medical, dietetics, maxillary-facial, fracture, dermatology, cardiology, diabetes and endocrinology, and phlebotomy clinics. During the inspection, we spoke with 41 patients and family members and 58 members of staff, including volunteers. Staff we spoke with included senior managers, nurses, doctors, scientists, radiographers, healthcare assistants and administrative staff. We observed the radiology, laboratory and outpatient environments, checked equipment and looked at patient information. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Outpatients and diagnostic imaging

Summary of findings

Barnsley Hospital NHS Foundation Trust outpatients and imaging departments was judged as good overall. The safe, caring and well-led domains were rated as good with the responsiveness domain found to be requiring improvement. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Within the departments, patients received safe care and staff were aware of the actions they should take in case of a major incident. Incidents were reported, investigated appropriately and lessons learned were shared with all staff. The cleanliness and hygiene in the departments was within acceptable standards, however, there were some areas in need of re-decoration and a lack of appropriate seating for patients with different needs in some areas.

Staff were aware of the various policies designed to protect vulnerable adults and children and we saw good examples of actions taken to address identified concerns.Patients were protected from receiving unsafe treatment as medical records were available 99% of the time and electronic records of diagnostic results, x-ray images and reports and correspondence were also available. The records we looked at were in good order and entries were legible; however, some areas of record keeping practice required improvement.

Workload within outpatients was predictable due to the scheduling of clinics and availability of clinic lists in advance and nurse staffing levels were based on the number of clinics and expected number of patients. There were some vacant radiologist and radiographer posts; however, there were mitigations in place to ensure gaps in service were covered.

Care and treatment in outpatients and diagnostic imaging was evidence-based and performance targets consistently met. The staff working in outpatients and diagnostic imaging departments were competent, received an annual appraisal and there was evidence of multidisciplinary working across teams and local networks. Nursing, imaging, and medical staff understood their roles and responsibility regarding consent and the application of the Mental Capacity Act.

Staff undertook regular audits in imaging and pathology departments regarding quality assurance to check practice against national standards and action plans were put in place to make improvements when necessary. We found that some imaging reports contained mistakes due to the voice recognition system that generated the reports. We were told that no formal audit was in place to monitor these errors, but that clinicians highlighted errors in reports within their discrepancy audits. Outpatient clinics ran every weekday, occasionally at weekends and on Thursday evenings. Imaging services for inpatients were available seven days a week.

During the inspection, we saw and were told by patients that staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey. Patients told us they were given all of the information they needed, were given sufficient time and were encouraged to ask questions to ensure understanding. Patients were able to make informed decisions about the treatment they received and there were services in place to emotionally support patients and their families.

Confidentiality was maintained in all of the areas we visited.

Areas of good practice included mechanisms to ensure that services were able to meet the individual needs of patients such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems in place to record concerns and complaints, review these and take action to improve patients' experience.

Staff were focussed on delivering the best possible experience for all of their patients.

Staff and managers had a vision for the future of the departments and were aware of the risks and challenges. Managers at all levels were active, available and approachable to staff. Staff felt supported and were able to develop to improve their practice. Regular meetings took place where all staff participated and were confident to talk about ideas and sharing of good

news as well as anticipated problems. There was an open and supportive culture where lessons were learnt and practice changes resulting from incidents and complaints were discussed.

The department was supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments. Staff were centred on delivering a good patient experience, they said that they felt proud to work for the trust and that they provided a good service to patients.

After moving to the new electronic patient record system in October 2014, the trust had identified in June 2015 that 23,557 patients were being held on a review list and who may not have been provided with follow up appointments. Immediate validation of the list reduced this to 7,980 patients overdue an appointment to end August 2015. Due to the change in processing the trust was carrying a backlog of about 2,000 outpatient outcomes per month; these were all reconciled by the end of each month. A further 9,613 patients appeared to have an open patient pathway, however these patients were discovered to have multiple pathways opened in error and the duplicates were removed from the system early into the validation process. Work was underway to ensure all relevant patients were offered a review appointment by 30th November with all patients seen by 31 January 2016; however, this was rated as a red risk by the trust, which indicated the potential patient safety risk associated with missed appointments. It was unknown at the time of inspection whether any harm had occurred to patients as a result of this situation, however, there was a risk that there may have been delayed treatment or diagnosis.

There were relatively high rates of cancelled clinic appointments and patients who did not attend their appointments.

Are outpatient and diagnostic imaging services safe?

Good

We rated the safety of outpatient and imaging services as good.

Within the departments, patients received safe care and staff were aware of the actions they should take in case of a major incident. Incidents were reported, investigated appropriately and lessons learned were shared with all staff and the cleanliness and hygiene in the departments was within acceptable standards.

Staff were aware of the various policies designed to protect vulnerable adults and children and we saw good examples of actions taken to address identified concerns. Medical records were available 99% of the time and electronic records of diagnostic results, x-ray images and reports and correspondence were also available. The records we looked at were generally in good order and entries were legible; however, some areas of record keeping practice required improvement.

Nursing staff numbers were thought to be sufficient and staff were able to work flexibly to meet the different demands of clinics and patients. There were some vacant radiologist and radiographer posts; however, there were mitigations in place to ensure gaps in service were covered.

Incidents

- Staff were aware of how to report incidents using the electronic incident reporting system and how to escalate incidents to their line manager, or Radiological Protection Supervisor (RPS) as necessary.
- Laboratory services used an electronic Quality Management IT system to help manage quality, safety and risk effectively. This system recorded any errors or issues within the department that needed corrective action. Types of issues recorded included those to do with equipment, labelling, near misses and comments from multidisciplinary team members. Details of the issues were entered onto the system and a named member of staff was allocated to investigate and recommend action.
- Across outpatients and diagnostic imaging departments there were 249 incidents reported to the National

Reporting and Learning System (NRLS) between 1 June 2014 and 31 May 2015. Of these, one incident was reported as severe harm and one was reported as moderate harm. The remaining incidents were reported as no or low harm, 92% and 7% respectively. The most frequently reported incident categories were relating to treatment or procedure (24%), documentation (22%) and clinical assessment (19%).

- There had been one never event in 2014/15 within outpatients and diagnostic imaging services (Never Events are serious incidents that are largely preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.).
- The never event occurred when a doctor commenced an invasive radiological procedure at the wrong site. This was recognised almost immediately and the procedure was halted. The procedure was then carried out correctly with no harm to the patient. The incident was fully investigated using root cause analysis methodology, lessons were learnt and appropriate actions taken to prevent similar incidents occurring again.
- Outpatient and radiology staff we spoke with told us that any incidents were discussed informally at departmental meetings. Staff gave examples of receiving feedback following incidents via these meetings. For example, learning from a splash incident in radiology had led to the introduction of Luer lock syringes for certain procedures. Following a wrong site examination, an extra check had been put in place when supervising the practice of student radiographers to reduce the risk of this happening again.
- Radiology staff were aware of the need to report radiation incidents under IR(ME)R and routinely informed their RPS and Radiology Protection Advisor (RPA) if an incident occurred. In the case of equipment related incidents staff were aware of the need to also report to the HSE.
- Patient safety information was shared through a weekly bulletin with all staff.

Duty of Candour

- Most staff we spoke with were aware of the need to communicate with patients and or relatives, to ensure they were informed of the outcomes of investigation into incidents of moderate harm or above. This was in line with duty of candour principles and regulation. All staff described an open and honest culture.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and we saw evidence that waiting areas, clinic rooms and equipment were cleaned regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use and imaging equipment was cleaned and checked regularly.
- Patients felt the departments were clean, tidy and safe.
- We observed staff complying with "bare below the elbow" in clinical areas and hand hygiene policy. Soap dispensers and hand gel were readily available for staff, patients, visitors and the public to use. Dispensers were clean and well stocked.
- Hand hygiene champions were in place in some areas.
- Monthly hand hygiene and cleanliness audits were undertaken and showed high levels of compliance. 100% compliance was achieved by all areas audited in March / April 2015.
- Patients in fracture clinic told us they had observed the staff washing their hands often.
- The manager of the dietetics service told us that the infection prevention and control (IPC) team had been requested to look at their environment and practices. This review had resulted in some deep cleaning of carpets and replacement of others, as well as the development of cleaning schedules for each room. Since the review by the IPC team, the dieticians had taken responsibility for the cleaning of their rooms and equipment themselves to ensure expected standards were maintained.
- A recent IPC audit in radiology had identified the need for improved cleaning of toys in the children's area. Individual members of staff had been identified to be responsible for standards of cleaning in different areas to ensure all areas were cleaned to an acceptable standard.

Environment and equipment

- A Patient-led assessment of the care environment (PLACE) audit (March 2015) in the breast unit had given the area a "qualified pass" with some areas for improvement noted. It was unclear from the audit report whether there was a formal action plan in place

and who was responsible for the required actions. It appeared from our observation that some of the issues identified, such as resuscitation trolley blocking fire exit and storage of dirty linen had been addressed.

- The main outpatient department was on the first floor accessed directly by an escalator and stairs. There was a check in reception desk and automated check in machines to allow patients to book in for their appointments. Patients were called through to specific clinic waiting areas via an electronic message board with audio prompts.
- Patients we spoke with told us that at times there was a queue around the escalator, which they felt was unsafe, sometimes the check in machines did not work properly, for example, their appointment did not display and there may be only one person on the desk. Fracture clinic reception was situated in the x-ray department next to the main x-ray, which made it difficult to locate. Staff on x-ray reception told us the two reception desks sometimes caused confusion and frustration for patients as they would queue in the wrong place and then have to queue again. Staff had erected new signage to help alleviate this problem.
- There was sufficient seating available in waiting areas and there was a play area for children in the main outpatient department.
- Ophthalmology staff told us clinical space was insufficient and they felt the department was "bursting at the seams."
- The children's outpatient area was well decorated and engaging for children. A separate children's play area was also included in the main outpatient area and was welcoming and engaging.
- Televisions or radios were on and playing in outpatient waiting areas for entertainment.
- In Nuclear Medicine, staff explained that one dual head gamma camera was eight years old and due for replacement. There were also plans in place for a single photon emission computed tomography (SPECT CT) camera, but space within the department was limited. There was a business plan in place to fund the replacement of equipment.
- There was easy access to emergency resuscitation equipment in all outpatient and radiology areas. These were checked every day to ensure they were in good working order. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis. Drawer locks were in place.
- The ear, nose and throat department (ENT) shared a resuscitation trolley with the ophthalmology department. The trolley held additional equipment for ENT patients with a tracheostomy. The ENT department had appropriate equipment and oxygen available on the department to commence immediate resuscitation if needed, until the crash trolley arrived.
- Within the ENT department, there were good systems in place to decontaminate instruments after use and to ensure traceability. Traceability stickers were entered into patients' notes following procedures. Similar processes were seen in dermatology however, traceability records were not entered into patients' records but recorded in a book that was kept within the department. This meant that if a patient was injured because of a faulty piece of equipment, there was a risk that it may take longer to trace the instrument as this information would not be present in the medical record. The audiology department had access to two sound proofed rooms for testing.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protected patients against unnecessary exposure to harmful radiation. Staff wore dosimeters (an instrument for measuring the amount of radiation absorbed by somebody) to ensure that they were not exposed to high levels of radiation.
- There was clear and appropriate signage regarding hazards in the imaging department.
- Waiting and clinical areas were clean and there were radiation-warning signs in areas used for diagnostic imaging.

Medicines

- Limited medicines were kept in outpatients areas. Small supplies of regularly prescribed medicines were stored in locked cupboards and fridge temperature was regularly recorded.
- Sedatives and local anaesthetics were used for patients undergoing interventional radiology procedures. These were stored and checked appropriately. The nurse in charge on duty kept keys to medicine cupboards. When there was no nurse on duty the keys were kept in a locked cabinet in Theatre recovery. To ensure security of

drugs, keys to the radiology medicine cupboard needed to be signed for when removed from the theatre cupboard. Controlled drugs were checked on a daily basis with a full drug stock check carried out monthly.
- There was a dedicated outpatient pharmacy where patients could collect medicines prescribed at their consultation.

Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images.
- Staff had some concerns regarding the lack of a single electronic records system and difficulties in using the newly implemented electronic patient records system.
- Administration staff were frustrated by IT issues and difficulties in replacing IT equipment. They felt that the move to a paper light system was not progressing as well as it should and that this would benefit from a project lead to take this forward.
- Staff reported that records were usually available in a timely manner for clinic appointments. Historically there had been issues with records not being available for clinic but this had improved in recent months. The trust's latest medical record audit (20-24 April 2015) showed that 99% of patient medical records were available at the time of their outpatient appointment. There were no issues regarding unavailability of records during the inspection.
- Staff in some areas told us that the volunteer service was invaluable in helping them to collect and organise records ahead of clinic appointments.
- Records were stored securely away from waiting patients.
- In dietetics, we saw patient records being stored separately from the main medical record. These were not reconciled with the main patient records until after a patient had been discharged from the service. We were concerned this could pose a risk for patients if they attended appointments with other services or were admitted without a full medical record being available.
- Diagnostic imaging and reports were stored electronically and available to clinicians via PACS (Picture Archiving and Communications System).
- The diabetic eye screening service had a stand-alone administration system that was reported to work well.
- We reviewed 10 samples of records in ENT and surgical outpatients and found that the notes were in good order and entries were legible. However, in all of the records we looked at either the printed name of the doctor or the GMC number of doctor was missing. Patient contact numbers were also missing from records.
- A world health organisation (WHO) safer steps to surgery checklist was used in imaging for interventional procedures such as lung biopsies, however, there was no evidence that use or completeness of this record was audited.

Safeguarding

- Staff we spoke with were aware of their responsibilities to safeguard adults and children and knew who to contact in the event of concern.
- We saw evidence of comprehensive children's safeguarding procedures. Nursing and medical staff to elicit level of concern and to determine what action needed to be taken regarding the missed appointments reviewed the records of children who did not attend for appointments. There was a flow chart for staff to follow if they had a concern about a child, which prompted contact with other services such as health visitors, GPs or school nurse.
- Information for staff regarding safeguarding processes and protocols was readily available and we saw this displayed on notice boards.
- We were concerned that the record keeping practice in dietetics was a children's safeguarding risk. Delayed reconciliation of records could result in the breakdown of communication regarding a child's well-being to other members of the multidisciplinary team.
- Staff were aware of their responsibilities in relation to adult safeguarding and knew how to raise concerns or make an alert. Receptionists in x-ray gave the example of how they had raised safeguarding alerts directly with the local authority regarding repeatedly missed appointments by patients from nursing and residential homes.
- All areas within outpatients were above 90% compliance with Adult Safeguarding training.
- All areas within outpatients were above 90% compliance with Children's Safeguarding training with the exception of outpatients' administration and radiology who were at 77.8% and 75.7% respectively.

Mandatory training

Outpatients and diagnostic imaging

- All of the staff we spoke with told us they received on going mandatory training and were aware of how to access this.
- Most of the staff we spoke with told us that their training was up to date and others told us training sessions were booked for them to attend.
- The trust mandatory training programme was composed of nine elements and the target was 90% compliance with all subjects. The outpatient clinical business unit report showed there was very good compliance with training targets across all areas achieving 90% compliance or above, with very few exceptions. The exceptions mainly related to the ENT department and were due to long-term sickness of staff.
- We saw differing practices within different outpatient areas. Some areas reported allocating time for staff in their rota to complete mandatory training, whilst other areas expected staff to complete this outside of their work schedule.
- The radiology department had a dedicated trainer from within their staffing to provide manual handling training. Staff reported that due to staffing pressures manual handling training was delayed as the department trainer needed to be released from their role to deliver this and needed to be able to deliver sessions to a few staff at once.
- Staff were concerned regarding some IT issues when completing e-learning modules and completed courses not registering on the system. This had led to a number of staff having to repeat training.

Assessing and responding to patient risk

- Within the outpatient clinics, staff were able to describe the action they would take if a patient's condition deteriorated and they were aware of how to raise an alarm to summon the crash (medical emergency) team.
- We did not see evidence of a centralised call bell service in some clinic consultation rooms. Staff said they would open the door and call for help if the situation arose. Some areas had purchased staff alarms to raise an alarm in the event of any emergency.
- During the inspection, we witnessed a fire alarm in the outpatient's area. Staff responded quickly to the risk by closing doors and started evacuating patients. There were some delays in coordinating the situation and porters arriving to evacuate a patient in a wheel chair. The trust told us they had a process in place to debrief following the incident and take actions for improved response should this situation happen again. The debrief was due to take place following the inspection.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances were managed and minimised. The new superintendent and department manager advised us that there had been a recent review of all policies and that 60% of the policies had been updated and uploaded onto the intranet for staff to access. The updating of the remaining 40% was on-going and this was a priority for the superintendent to work through. We observed that there was a record in the department for staff to sign when they had read the updated policies. However, a large number of staff had not read the policies and updated their records.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations (IR(ME)R).
- There were named certified radiation protection supervisors (RPS) to give advice when needed and to ensure patient safety at all times. We were informed the radiation protection advisor (RPA) was based at Sheffield Teaching Hospital Trust and they were available to provide regular adivice and support to the local RPS.
- All of the radiologists working within nuclear medicine held an Administration of Radioactive Substances Advisory Committee (ARSAC) certificate. They were available for consultation and advice relating to radiation protection and development, implementation, monitoring and review of policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations.
- Risk assessments that looked at patient safety, environment and staff safety were undertaken in all areas annually, and when new risks were identified. Identified risks had mitigations in place to reduce potential risks to a minimum.
- In accordance with radiation protection requirements and the identified risks to an unborn foetus, women patients were asked if they might be pregnant before exposing them to X-ray.
- Early warning scores were to monitor and manage patient risk when they were undergoing interventional procedures.

Outpatients and diagnostic imaging

- CQC IR(ME)R information forwarded to the inspection team showed that the Radiology Department reported and investigated incidents appropriately. Mistakes were identified and learnt from and actions were taken to reduce the risk of similar errors occurring in the future.

Nursing and allied health professional staffing

- There was a registered nurse in charge of each clinic, and a mix of registered nurses and healthcare assistants available to provide care to patients. Senior staff we spoke with were happy that they had appropriate levels of staff on duty in their areas. Staffing levels in the outpatient clinics were determined based on the number and type of clinics running each week and the number of patients attending.
- Senior staff did describe periods of high sickness levels of nursing staff within some outpatient departments. However, they were working closely with human resources and understood the reasons for this. Overall sickness levels for the outpatients departments for the last 12 months was 4.2% which was similar to trust wide performance and against a target of 4%.
- Clinical nurse specialists (CNS) were available in many of the clinics we visited. However, they shared a different management structure to the outpatient clinic staff. Staff told us that this arrangement some caused administrative issues and they were not always present at outpatient departmental meetings.
- The imaging departments had a number of radiographer vacancies at both junior and senior levels and staff were feeling the pressure of shortages. There had been a recent recruitment programme and appointments had been made to start in the near future. Staff were kept up to date regarding recruitment and appointments. Agency staff and substantive staff working extra hours when needed were covering gaps in service. Recruitment was on-going to a lead sonographer (diagnostic ultrasound radiographer) post.
- Radiology secretaries were concerned about cover for typing of reports due to the loss of a post. Staff recognised that the current two posts were enough to cover workload but there were concerns regarding cover in case of sickness and annual leave. When both staff had been absent, at the same time, workload had backed up until their return and turnaround time was increased. Managers told us there was a departmental procedure to secure locum/temporary cover, if possible, for absences lasting more than 48 hours to ensure that safe reporting times are maintained.
- In blood sciences, scientific staff undertook routine and urgent work between 9am and 8pm and two scientists undertook urgent work during the night on a rota basis, providing a 24 hour seven day service.

Medical staffing

- The individual care groups were responsible for identifying and managing the medical staffing for the outpatients clinics. Medical staff were allocated to individual clinics.
- Consultants from another local trust covered the Ophthalmology service.
- In radiology, staff were concerned about consultant shortages. There were 10 whole time equivalent (WTE) budgeted posts. At the time of our inspection, there were 6.5 WTE in post. Further cover was supplied by another local trust (0.8 WTE) under a service level agreement. The remainder of the short fall was being covered via outsourcing to the trust's telemedicine partner.
- One radiologist covered Musculoskeletal (MSk) investigations with a locum providing support until a second radiologist was trained up for this work.
- Support with reporting images was available from an out of hours tele-radiology services 8pm until 8am, consultant overtime, out of hours reporting from a visiting Consultant, and some CT scans were outsourced for reporting when backlogs developed.
- Staff told us that only two Radiologists carried out interventional procedures and if necessary complex interventional procedures were transferred to another hospital.
- Two radiologists from Doncaster trust provided the radiological breast service under a service level agreement two days and two evenings a week. It was recognised there was increasing demand for this service, which could affect the future service provision.

Major incident awareness and training

- Staff we spoke with were aware of their role during a major incident and all staff showed a willingness to assist if such an incident was to take place.

Outpatients and diagnostic imaging

- Staff in radiology were aware of disaster recovery plans and had experience of implementing contingency plans to maintain business continuity.
- There was adequate IT cover for technical breakdowns both in normal working hours and at weekends and at night.
- A major incident policy folder was readily accessible to all staff with information about what to do and who to contact in the case of a major emergency.
- Comprehensive business continuity plans were in place to make sure that each specific department was able to continue to provide the best and safest service in the case of a major incident. These also covered staffing shortages, electronic system failures and equipment breakdowns.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Effectiveness of the outpatient and diagnostic imaging service was inspected but not rated. Care and treatment in outpatients and diagnostic imaging was evidence-based and performance targets consistently met. The staff working in outpatients and diagnostic imaging departments were competent, received an annual appraisal and there was evidence of multidisciplinary working across teams and local networks. Nursing, imaging, and medical staff understood their roles and responsibility regarding consent and the application of the Mental Capacity Act.

Staff undertook regular audits in imaging and pathology departments regarding quality assurance to check practice against national standards and action plans were put in place to make improvements when necessary. We found that some imaging reports contained mistakes due to the voice recognition system that generated the reports. No formal audit was in place to monitor the errors, but clinicians highlighted errors in reports within their discrepancy audits.

Outpatient clinics ran every weekday, occasionally at weekends and on Thursday evenings. Imaging services for inpatients were available seven days a week.

Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) and other guidance that affected their practice. New guidance was disseminated to staff via team meetings and briefings.
- Heads of nursing gathered nursing metrics around patient privacy, environment, communication and infection control. This data was used to monitor standards and influence on-going care. Audit results showed good compliance with the standards set.
- The Microbiology department had Clinical Pathology Accreditation (CPA) and was working towards United Kingdom Accreditation Service (UKAS) accreditation. The accreditation schemes provide assurance that the requirements for quality, competenceand proficiency testing are met. The laboratories had undertaken all actions identified by the UKAS visiting team and were awaiting formal acknowledgement of achievement.
- The trust had a radiation safety policy in accordance with national guidance and legislation (Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000). There were nominated radiation protection supervisors (RPS) to lead on the development, implementation and monitoring of compliance.
- The 2014 annual RPA's report showed that internal audits of compliance with radiation regulations showed good compliance. This included compliance with local and national diagnostic reference levels. Diagnostic reference levels (DRLs) are used as an aid to optimisation in medical exposures.
- Staff were seen wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- The imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- Pain relief medication was not generally administered in the outpatients department, but the doctors in clinic could prescribe medication for any patient needing pain relief.
- Patients could buy pain-relieving medication and obtain their prescriptions at the onsite outpatient pharmacy.

Outpatients and diagnostic imaging

- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures, which could highlight patients suffering pain.
- Inpatients received pain relief on the ward prior to arriving in the department and those attending outpatients who were on medication were asked to bring their normal medication with them. Radiologists could prescribe additional pain relief for administration during procedures such as biopsies when required.
- Nurses in radiology used a pain score for patients undergoing interventional procedures and were able to administer pain-relieving medications as prescribed by the doctor.

Patient outcomes

- There were quality assurance systems and processes in place in the laboratories and in imaging services to ensure local and national standards were met and results were as timely and accurate as possible.
- The radiology team leaders carried out monthly audits of images from all imaging departments and a monthly discrepancy meeting was held with staff to learn from the findings and improve quality. The sonography lead undertook a quarterly audit of five scans from each practitioner and prepared an anonymous report of outcomes to share learning with all staff. If a team leader identified that individual members of staff repeated mistakes, this was addressed on a one-to-one basis.
- Technical assistants in the radiology department quality assured image plates to ensure artefacts (marks or imperfections) did not appear on images.
- We found that some imaging reports contained mistakes due to the voice recognition system that generated the reports. We were told that reports were proof read and authorised before sending out, however, some reports were sent out with minor errors due to the system's inability to correct mistakes without repeating the process form the start of the dictation. We were told that no formal audit was in place to monitor these errors, but that clinicians highlighted errors in reports within their discrepancy audits. Outsourced reporting of scan images overnight and at weekends was generally turned around in 60 minutes in line with the service level agreement.
- In May 2015 95% of CT reports were completed within 14 days of examination, 98% of MRI reports and 88% of plain film reports were also completed within this timescale. The number of images that remained unreported at 21 days was 2% CT, 1% MRI and 3% plain film for the same period. The radiology manager closely monitored plain film reporting and as maximum tolerance threshold was reached additional films were sent for outsourced reporting.
- The laboratories kept a scorecard of performance against targets for timeliness of blood and histology results. From April to June 2015 there were very few occasions when the 90% minimum targets were not met and an improving picture was seen across the quarter with achievement exceeding 95% for most tests.
- Target turnaround times for Accident and Emergency (A&E) blood tests were one hour. The laboratories recorded meeting this target for all tests except INR (blood clotting test) between March and June 2015. The performance for INR reporting was 86% completed within one hour in June 2015.
- Patient Reported Outcome Measures were collected and reported nationally in line with Department of Health requirements.
- Secretaries for surgical outpatients achieved a three-day turnaround time for clinic letters and were working towards new target of two days.
- The laboratories had a comprehensive rolling programme of quality assurance audits.

Competent staff

- Staff we spoke with had undergone appraisals and we saw evidence that confirmed 92% of staff in outpatients had received an appraisal in the previous year (as of April 2015). Senior clinical staff told us it was stressful and time consuming to have all appraisals completed, between 1 October and 30 June each year, in line with the trust's requirement. Staff we spoke with felt that appraisals were worthwhile and facilitated personal development. Many staff we spoke with confirmed that they had received support from the trust to undergo further training and professional qualifications. For example, staff working in retinal screening either had achieved or were working towards the City and Guilds diploma in Diabetic Eye Screening.
- Staff told us they felt comfortable and confident in the skills of their colleagues.
- There was a mentorship process in place for newly qualified staff in the radiology department and staff were assigned to a senior radiographer for local induction and support.

Outpatients and diagnostic imaging

- Staff within the radiology department were given opportunities for development in their role and other roles within the department. Training booklets and competency frameworks were in use in radiology and requests for training courses were usually granted. Training needs were met on an individual basis within the department and if staff needed more experience or supervision before undertaking roles alone this was accommodated.
- Darkroom technicians had received training as technical assistants and radiology assistants as their roles had evolved. The technical assistants were provided with training from AGFA, the company who provided the PACs system, when needed.
- Healthcare assistants in radiology told us it was sometimes difficult to access additional training, such as first aid, which they felt would be helpful in their role.
- Radiology had processes in place to ensure the competence of locums working within the department.
- Clinical supervision was available for nursing staff and records were kept of discussions.
- Patients visiting the phlebotomy service commented that the staff were very efficient and competent.
- Nurses within a number of areas in outpatients had been able to develop as advanced nurse practitioners. For example, the radiology nurses had been trained to undertake hysterosalpingogram x-ray tests that examine the inside of the uterus and fallopian tubes.

Multidisciplinary working

- There was evidence of multidisciplinary team (MDT) working in the outpatients and imaging departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments, such as radiology and community staff, when this was in the interest of patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys, such as GPs and nursing homes.
- A range of clinical and non-clinical staff worked within the outpatients department. Staff were observed working in partnership with people from other teams and disciplines, including radiographers, nurses, booking staff and consultants.
- Radiologists supported MDT meetings within clinical specialities as needed.
- Staff reported good working relationships within MDTs. Staff in Urology spoke highly of the support offered by Radiology and the turnaround times of the Histopathology service.

Seven-day services

- Most outpatient services were provided during the day, Monday to Friday.
- Radiology was open from 7.45am until 8.15pm on weekdays and 8am until 4pm on weekends. Ultrasound scans were also provided on weekend mornings. There was 24 hour, seven day a week provision of x-ray services for emergencies.
- Radiology had also provided “waiting list initiative” clinics when needed to reduce the waiting time for CT investigations.
- Microbiology and blood sciences ran a routine service until 8pm with scientific staff covering overnight, for urgent testing, on a rota basis. There was also an out of hours' consultant service for urgent issues.
- Outpatient nursing staff told us that they had previously provided weekend clinics in times of increased demand.
- The Diabetic Eye Screening service confirmed that there was an occasional Saturday clinic in place, as well as later evening working on a Thursday to meet the needs of working patients.

Access to information

- All staff had access to information relating to policies, procedures, NICE guidance and e-learning via the trust intranet.
- Staff were able to access patient information, such as imaging records and reports, medical records and physiotherapy records through electronic records.
- Radiology images could be viewed on wards and departments through the Image Exchange Portal. Images could also be viewed remotely by consultants for reporting purposes or for second opinion and were often sent to Doncaster or Sheffield hospitals for consultants who provided services at Barnsley. Where reports were available, these were automatically attached to the relevant images and could be viewed in this way.
- The hospital had introduced a new records management system that included the ability to track notes using barcodes and microchips attached to the records. This was operational in some areas, but not fully rolled out across the trust.

Outpatients and diagnostic imaging

- All diagnostic test results were available to staff electronically via the ICE electronic record system.
- The trust's latest medical record audit (20-24 April 2015) showed that 1% of patient medical records were unavailable at the time of their outpatient appointment. The trust explained that, in the event of the full medical record not being available, the Medical Records team were informed and would create a temporary set of case notes, containing patient identification labels and front sheet, copies of relevant clinic and ward discharge letters, and any available paper results. All temporary sets of records were logged and checks were made regularly to trace the original records. When the original records were located, the paperwork was reconciled.
- Diagnostic Imaging departments outsourced reporting of out of hours urgent CT scanning to a private provider. There was a service level agreement in place, which included quality assurance processes. Reporting times for their reports were 60 minutes for general scans and 30 minutes for suspected stroke patients.
- Patients were given a pro-forma sheet with details of their consultation and this was used to book any follow up appointment at the main outpatient reception.
- Secretaries generated typed letters of consultations for GPs within three working days and there were no issues reported regarding achievement of this. A new target of two working days had been introduced and secretaries were working towards this. Achievement of the target was monitored as part of "Commissioning for Quality and Innovation" (CQUIN). We were told that that this target was not always achieved but it was possible to arrange cross working and use of overtime or agency staff when needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training regarding consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was incorporated into adult safeguarding training. Compliance with training was 95% as of April 2015.
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients. We saw good examples of separate consent forms for adults, children, and adults who were unable to consent to treatment.
- Formal written consent was obtained for appropriate interventional and intrusive procedures in all outpatient and imaging areas.
- Most staff we spoke with told us they were aware of the MCA and DoLS and knew how to seek advice where they had concerns. Staff told us they would request support from the medical staff to assist in assessing a patient's mental capacity.
- Nursing, Imaging, and Medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do this. Consent was obtained verbally in the majority of outpatient and imaging procedures. Consent for interventional radiology was obtained in writing on the ward prior to patients attending the imaging department. Patient consent was confirmed before carrying out any interventional procedure in Radiology.
- Staff were able to clearly articulate examples when they had encountered confused patients and had had to defer investigations as patients had withheld consent. They understood the principles of the MCA and a patient's right to refuse treatment.

Are outpatient and diagnostic imaging services caring?

Good

We rated the caring aspect within outpatient and diagnostic services as being good

During the inspection, we saw and were told by patients that staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey. Patients told us they were given all of the information they needed, were given sufficient time and were encouraged to ask questions to ensure understanding. Staff were observed to be friendly and communicate well with patients

People were treated respectfully and their privacy and dignity was maintained at all times through the actions of staff. Confidentiality was maintained in all of the areas we visited.

There were services in place to emotionally support patients and their families. Patients were kept up to date and involved in discussing and planning their treatment and were able to make informed decisions about the treatment they received.

Outpatients and diagnostic imaging

Staff treated patients with kindness and we were told that "nothing is too much trouble", patients were happy with the care provided and told us that they would recommend the services to loved ones.

Compassionate care

- We observed that staff were courteous when caring for patients and were seen responding to patient's individual needs in a timely manner.
- Care was provided in individual consulting rooms; we noted that doors were shut to ensure privacy.
- The departments had a welcoming environment and were conducive to maintaining privacy and dignity. There were curtained bed areas in clinic rooms and doors had "in use" signs.
- Staff expressed concern that there was only one changing room in the CT area as this could hold up flow through the department. Although some patients could take a long time to get changed in to x-ray gowns, staff made a determined effort to not rush patients changing.
- Chaperones were available and notices were in place advising patients to ask for a chaperone if they wanted one.
- Administration staff in X-ray had introduced a privacy board at reception to help maintain patient privacy and confidentiality.
- Patients' confidentiality was compromised in the main outpatient reception area where an automated check in system was in use. If patients failed to log out of the system then their details were displayed on screen for around 10 seconds before the system reset. The positioning of these machines meant that this information was easily visible to people entering on the ground floor and stepping off the escalator into the main outpatient reception.
- The departments used patient feedback cards and from the results we saw patients were happy with their experience.
- All of the patients and relatives we spoke with were happy with the service they received in outpatients, stating that the staff were caring, kind, professional and communicated well.
- Patients told us staff were dedicated and they would be happy to use the services again.

Understanding and involvement of patients and those close to them

- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment and on some occasions those close to patients were encouraged or enabled to support patients.
- Staff were good at explaining what was happening in a way the patients could understand and they were seen to check patients' understanding.
- Patients told us they were given all the information they needed and they were involved in their treatment and care. Those close to them said that they were kept informed and involved by nursing and medical staff.
- All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- We saw staff inform patients if clinics were running late. Staff apologised and explained why appointments were delayed.

Emotional support

- We saw evidence of changes being made to services to meet the emotional needs of patients. This included moving the location of a room where patients could sit after receiving bad news away from the reception area.
- The specialist nurse in the dermatology service was available to be with patients when bad news was being delivered and to offer follow up support and advice.
- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, they were give the time to ask questions.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated outpatient and diagnostic services as requires improvement for responsive.

Following the move to a new IT system, the trust had identified a large backlog of 23,557 patients who may not have been provided with follow up appointments, an additional 5,542 patients who may not have had the outcome of their care recorded and a further 9,613 patients who had an open patient pathway. These figures had subsequently been reduced to 7,980 patients who may need a follow up appointment, 2,000 unrecorded

outcomes and 1,274 open patient pathways. Processes had been put in place to identify and contact the relevant patients and a helpline was to be opened to be able to respond to patients who needed to be seen for follow up.

The did not attend (DNA) rates were above the England average.

There were systems in place to ensure that services were able to meet the individual needs of patients such as those people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems in place to record concerns and complaints, review these and take action to improve patients' experience.

Staff were focussed on delivering the best possible experience for all of their patients.

Service planning and delivery to meet the needs of local people

- We were told that a task and finish group had recently been established to undertake a transformation project looking into areas such as clinic capacity and slot allocation, with a view to considering alternative ways of working within the outpatient areas.
- Some outpatient services were provided in conjunction with other NHS providers. The laboratories had joint working arrangements with Rotherham NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. Small volume and speciality tests were performed at Rotherham and breastwork went to Sheffield while larger volume routine and GP work was undertaken at Barnsley. Urgent work for A&E patients was carried out at all sites.
- Ophthalmology services were provided in conjunction with The Rotherham NHS Foundation Trust. Staff felt that this worked well overall however, they did highlight some issues this regarding booking of appointments, as some of the systems in use did not link in across the NHS organisations.
- Visiting consultants from Doncaster provided the breast care service.
- ENT staff told us of plans involving the MDT to improve achievement against the 31 and 62 day cancer treatment targets.
- The Diabetic Eye Screening service ran a specific new patient clinic to allow extra time in consultations. It also ran occasional Saturday clinics to meet demand when necessary.
- Some areas within outpatients needed some maintenance and redecoration. The access stairwell to Dermatology outpatients was in a poor state of repair, with damage to flooring and window frames and needing redecoration. In audiology, some chairs in this area had been mended with tape. The waiting area in the maxillary – facial department was reported as too warm and too small by patients and it was observed to be in need of redecoration.

Access and flow

- Between July 2013 and June 2014, the outpatient department saw 267,664 patients.
- The majority of patients accessed outpatient appointments through GP referral and by using choose and book.
- Following the move to a new IT system, the trust had identified a large backlog of 23,557 patients who may not have been provided with follow up appointments, an additional 5,542 patients who may not have had the outcome of their care recorded and a further 9,613 patients who had an open patient pathway. These figures had subsequently been reduced to 7,980 patients who may need a follow up appointment, 2,000 unrecorded outcomes and 1,274 open patient pathways. Processes had been put in place to identify and contact the relevant patients and a helpline was to be opened to be able to respond to patients who needed to be seen for follow up.
- Some services were utilising community based care and GP led initiatives to reduce the number of patients who may need to attend hospital. Examples of this included the use of cameras for diabetic eye screening in GP practices and a tele-dermatology project.
- Access to audiology was by direct referral, including self-referral, and the department was maintaining a two week waiting time to testing and a two week waiting time from testing to fitting.
- Patients could access emergency clinics for eyes or ENT problems every day.
- Phlebotomy clinics were accessed by appointment as well as by patients who attended from outpatients and GPs who were only notified on the day.

Outpatients and diagnostic imaging

- Department of Health guidelines state that 95% patients should start consultant-led treatment within 18 weeks of referral. The rate for this trust was consistently 97% of patients seen within 18 weeks of referral, for patients not admitted. This had been consistently better than the standard and better than the England average since April 2013.
- The average referral-to-treatment times for patients with incomplete episodes of care ranged from 93% to 96% since June 2014. This had been consistently better than the standard of 92% and better than the England average since April 2013.
- The percentage of patients (with all cancers) waiting less than 31 days and 62 days from urgent GP referral to first definitive treatment was better than the England averages. Between Quarter (Q)1 2013/2014 and Q2 2014/2015 the percentage of people waiting less than 31days ranged between 99% and 100%. The percentage of people waiting less than 62 ranged between 88% and 94%, during the same time period.
- The trust had a similar performance to the England average in the percentage of people seen by a specialist within 2 weeks. Between Q1 2013/2014 and Q2 2014/2015 the percentage ranged between 93% and 96% and increased to 98% at Q3 2014/2015.
- The trust's 'new to review' rate (the ratio of new appointments to follow-up) had been higher than the England average since February 2014; however, this was showing an improving trend. December 2015 figures showed Barnsley hospital's new to follow up rate at 2.45 against an England average of 2.28.
- Radiology provided plain x-ray services for routinely booked appointments, A&E and urgent GP referrals. Urgent GP referrals were usually seen the same day or at the latest the following day.
- The trust had a high proportion of people waiting six or more weeks for diagnostic tests September 2013 to October 2014, when compared to the England average. However, at the time of the inspection all patients were being seen within the six-week target.
- Radiology had provided some weekend waiting list initiative clinics to reduce waiting times to less than 6 weeks and this was being maintained during "business as usual" activities.
- There was a six week waiting list for cardiac stress tests.
- Did not attend (DNA) for an appointment rates were higher than the England average for adults and within range for paediatrics. Staff told us that a new Access policy was now in place to provide a more structured approach to removing patients from clinic lists where they had failed to attend.At the time of the inspection areas such as dietetics, secretaries rang parents to remind them of children's' appointments if they had any concerns an appointment may be missed. If appointments were missed on three occasions a letter was sent to the GP, advising the patient had been removed from the list. The trust was also operating a texting reminder service to help reduce the DNA rate.
- Information supplied by the trust, indicated that in the region of 1% of clinics were cancelled. The reasons given for this were; appointments made in error, medical staff on annual leave or otherwise unavailable and patients booked outside the "choose and book" system.
- Some support was available for patients in using the electronic check in and we witnessed this working well. We observed that at times the system did not locate patient appointments and those patients had to attend the reception desk. The receptionists found the appointments when they accessed the system themselves.
- When we visited, patients did not appear to be left waiting for any considerable time and were seen promptly. Patients told us that they were seen quickly and efficiently in the fracture clinic. Patients in the eye clinic told us emergency patients were seen very quickly but routine appointments may have up to an hour's wait. The longest waiting time during our visit was 45 minutes in the eye clinic. Cardiology patients all had waits of less than 15 minutes.
- Staff we spoke with explained that delays were sometimes a problem in clinics, but that these were often unavoidable due to the unpredictable nature of the patients' consultation and the duties of clinical staff.
- The trust collected some data on the average time patients waited to be seen in clinic when they attended for their appointment; however, did not specifically report on the number of patients waiting more than 30 minutes. The trust was able to demonstrate an average wait time of 27 minutes over the last six weeks during this period.
- We saw the information department sisters collected regarding longest waiting times, the most frequent

reasons given for delays were: double booking of appointments, patients needing longer than allotted time, and the complexity of cases and we were told that this information was escalated to senior staff.
- We did not see evidence that this information was acted upon although a manager told us that changes were being made to appointment booking times to even out distribution of new and follow up patients which should improve waiting times as there would be a more even spread of more and less complex consultations.
- When delays occurred, all staff told us that they made patients in the waiting area aware of any delays in person; staff would apologise for the delay and would provide an estimate of the waiting time.
- Due to the unpredictable numbers of patients, attending phlebotomy, there could be long queues that moved slowly due to the booking in system. However, patients told us that once booked in waits were usually in the region of 10-20 minutes. Long-term patients visiting phlebotomy could arrange with staff to come back later if there was a long queue.
- Laboratory staff aimed to ensure blood results were available for emergency department patients within an hour to facilitate flow through the emergency department.

Meeting people's individual needs

- We found that staff in outpatients and radiology were attentive to delivering a positive patient experience for all patients and were focused on meeting the needs of patients with complex needs and communicated with patients directly as far as possible rather than relying on relatives or carers.
- Staff were able to describe how they cared for patients with memory impairments and learning disabilities. They gave practical examples of how these patients' needs could be accommodated in the departments and who they could contact for further advice and support. Staff told us how they involved family and carers as much as possible with the care of patients suffering from dementia and learning disabilities to alleviate as much anxiety and distress for the patient as possible.
- We saw evidence of the 'butterfly' dementia scheme in use.
- A carer told us that they often brought vulnerable adults for outpatient appointments and the staff in the department were friendly and made patients feel at ease.
- The diabetic screening service proactively involved the Learning Disability nurse to facilitate appointments, reasonable adjustments if needed and compliance with regular screening for patients with a learning disability. The service generally allowed longer appointments for patients with a learning disability but also for all new patients to ensure adequate time for giving of new information and questions and to reinforce the importance of annual screening.
- Translation services were available for patients to request, and the trust had accessible translation services. Staff knew how to follow to secure the services of translators (including British Sign Language) and how to obtain foreign language patient leaflets if needed.
- Patients visiting the phlebotomy service told us staff were flexible with appointment times and "nothing is too much trouble".
- We saw a range of information leaflets were available across the departments.
- We saw that staff name badges, signage for eye clinic, diabetic eye screening and ophthalmology used a black on yellow background for people with visual impairment.
- This option was also available on the automated check in machines.
- Some outpatient areas supported the use of loop system for people with hearing impairment.
- Staff were able to explain how they would support bariatric patients and bariatric couches were available in clinics.
- Signage around the hospital was in the main good with some areas that needed improving such as signage to dermatology.
- Children and young people were seen in some adult outpatient clinics such as ophthalmology and surgery. This was recognised by staff as not being ideal but felt that capacity did not allow for bespoke clinics. There were toys available to distract children while waiting.
- Some services offered separate paediatric clinics and services such as the diabetic screening service offered appointments to fit around school and college times.
- Nurses were available to welcome and chaperone patients who requested or required assistance.
- A snack trolley with soft drinks and snacks was brought around the main outpatient department in the morning and afternoon to allow waiting patients to purchase food and soft drinks.

- Departments, in the main, were able to accommodate patients in wheelchairs or who needed specialist equipment. However, the seating arrangement in the phlebotomy area made it difficult for patients with limited mobility to move between the rows to easily access a seat.
- We observed that only one height of chair was offered throughout the outpatient areas we visited, with no obvious seating available for bariatric patients. Patients commented that the chairs in the main department were all the same size and height and not suitable for all patients
- Within some imaging departments, waiting facilities were limited and the lack of waiting room for one of the scanners meant that inpatients and outpatients had to wait in the same area. Staff were concerned that this affected privacy and dignity of inpatients who would be wearing nightwear or gowns and may have numerous drips and drains in place. Access to the CT scanner was also through the main waiting area and staff felt that this could be frightening for other patients, particularly children, when trauma or ITU patients were wheeled through. There was a curtained area for patients on a trolley but this was only big enough for one patient.

Learning from complaints and concerns

- Since 1 April 2015, outpatients and radiology had received one formal complaint and one complaint had been re-opened. Sixty-eight informal concerns had been received with the main areas of concern reported to be; communication with the patient, waiting times and delay, appointments cancelled without patients being aware, and appointment information.
- Patients could feedback complaints and concerns in a number of ways, including formally, via PALS, and by completing patient feedback cards. Posters were displayed to explain how to raise concerns.
- All the staff we spoke with showed a willingness to pro-actively respond to patient feedback to try to resolve concerns as soon as they became aware of them. Staff were aware of PALS and the formal complaint process if they were unable to resolve a patient's concerns.
- Feedback and actions needed following complaints investigations were discussed at team meetings. Administration staff told us feedback regarding complaints was received from the patient safety panel and governance meeting. We saw evidence that complaints were considered and discussed in governance meetings.
- As staff attitude and behaviour was often a part of formal complaints, the trust offered customer care training to staff three times a year. The training was not mandatory but was identified as a training need through the evaluation of values and behaviours discussed during the appraisal process.
- We were given practical examples of how patient feedback via concerns was used, including relocating reception areas and providing a drinks and snack trolley in outpatient areas at times of peak delays.
- In breast clinic, we saw evidence of changes made to a clinic room following patient feedback. Alterations had been made to make a room look like a bedroom. This provided a private, comfortable area for fitting prosthesis.

Are outpatient and diagnostic imaging services well-led?

Good

We rated outpatient and imaging departments as good for well-led.

Staff and managers had a vision for the future of the departments and were aware of the risks and challenges. Managers at all levels were active, available and approachable to staff. Staff felt supported and were able to develop to improve their practice. Regular meetings took place where all staff participated and were confident to talk about ideas and sharing of good news as well as anticipated problems. There was an open and supportive culture where lessons were learnt and practice changes resulting from incidents and complaints were discussed.

The department was supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments. Staff were centred on delivering a good patient experience, they said that they felt proud to work for the trust and that they provided a good service to patients.

Vision and strategy for this service

- All the staff we spoke with were able to articulate the trust's vision and values and were observed to demonstrate engagement with the vision through their behaviours. Staff were extremely proud to work at Barnsley hospital and were focussed on delivering the best patient experience they could.
- Staff we spoke with were not aware of the overarching strategy for outpatient departments but they were clear on the goals and aspirations of their own departments.
- The clinical business unit for outpatients and diagnostic services had a clear strategy which outlined opportunities for development and risks to current service delivery. Each department within the clinical business unit was clear about its own areas for development and risk and had mitigated for risks wherever possible.

Governance, risk management and quality measurement

- All staff we spoke with were aware of the governance arrangements in place and who to report risks to. We saw from minutes of meetings that risks, complaints, incidents and litigations were discussed and actions shared through the monthly clinical business unit meetings.
- Governance arrangements facilitated the identification and management of issues such as the outpatient backlog of appointments and ensured risks were logged on the appropriate risk register, and action plans were in place to provide mitigation and resolution. The governance arrangements ensured the board was aware of risks and was able to monitor progress against action plans.
- The radiology risk register was also discussed at the monthly clinical management team meeting and at the radiology team brief. We observed the team brief and saw staff being requested to assist with the mitigation of two new risks. One new risk in radiology was a recurrent technical glitch in the transfer of images on PACS to the main server during the night. Staff were asked to note the identifier numbers of images where problems occurred for the attention of the technical assistants to rectify. This was an interim measure until the IT service had managed to identify and repair the system fault. The other risk was to do with the air conditioning in the MRI area which had recently stopped working. Staff knew to report any air conditioning issues immediately to estates, especially out of hours, and to highlight the urgency of repair needed. This risk had been escalated with the estates department and the scanner provider company were to provide some training to estates staff. The low likelihood of this happening again was reflected in the risk assessment score. Radiology had processes in place to ensure quality assurance and governance of outsourced work.
- The blood sciences laboratory manager told us the biochemistry, haematology and microbiology laboratories had been recently inspected by Clinical Pathology Accreditation (CPA) and had achieved full compliance. CPA assesses and declares the competence of medical laboratories. This provided independent assurance that the accredited laboratory services were meeting current standards for quality and risk management. Barnsley NHS Foundation Trust was the first English trust to undertake CPA accreditation.
- The Laboratories were awaiting formal confirmation of UKAS accreditation following an inspection and actions taken to address the non-conformances identified.
- Quality management was well-developed within pathology, for example audits, incident reporting and performance monitoring. Monthly meetings were held with staff and feedback was given regarding any issues identified and any actions to be taken to improve performance. For example due to past errors caused by poor labelling there was now a process in place which meant that each sample and request had to be labelled with at least three positive identifiers or samples were returned to the requester to complete the labels correctly.

Leadership of service

- Staff we spoke with were overall very positive about the management of outpatient services. It was felt that the present management structure was clear and supportive at local level.
- All the staff we spoke with reported that the senior executive team communicated well and that relevant information was disseminated to staff via email and bulletins.
- Radiology staff spoke highly of the clinical leadership and reported that they could see improvements in the department as a result of the new management arrangements
- The manger and clinical leads worked well together regarding any service developments.

- We observed the monthly team brief in the main radiology area and with the admin team. Key messages were clearly given and staff were given the opportunity to ask questions. In addition to the trust brief, the radiology manager and clinical and training leads gave updates on relevant issues within the department such as progress with recruitment, financial position, open and new risks added to the department risk register, replacement / procurement of new equipment, training compliance and feedback from relevant audits such as the IPC audit. Staff were signposted to further information such as the performance report which was to be displayed in the main department. All staff were being reminded to ensure their email accounts were active as this was to be used as frequent method of communication with all staff. Concerns and compliments were also shared.
- We found that managers encouraged staff to participate in on-going learning and professional development and were open to ideas and suggestions for improvement. We spoke with staff that had benefitted from investment in their development and they had recently successfully achieved promotion because of this.
- Staff told us there were good flexible working arrangements in place, teamwork was very good and they felt listened to.
- The radiology nurses had recently been realigned with the surgical business unit and the planned interventions unit. The nurses had been receiving 1-1s under old structure and this would continue with new matron. The nurses felt the new arrangement would be beneficial in terms of professional support and give opportunity for further development of skill.

Culture within the service

- Most staff we spoke with were proud of their service and the trust. All the staff were very positive about their role and the support in place for staff.
- Staff told us it was a great place to work and felt supported by their colleagues. Staff told us they were proud to work at Barnsley and had come to work there due to the good reputation as a place to work.
- Staff were extremely motivated and centred on providing a good patient experience.
- Staff we spoke to explained that they would be confident in challenging the views of other staff members if required. However, we heard some examples where nursing staff appeared to have been reluctant to directly challenge the views of medical consultants. In these cases, actions were taken to ensure that patient care was not affected, but there appeared to be limited efforts to discuss these issues directly with the consultants involved.
- Senior staff worked closely with human resources to understand and manage sickness-absence.
- There was a well-established culture of learning and development and there were many examples which demonstrated valuing staff, where staff had been retained through learning and development and retraining where needed.
- The radiology department in particular had retrained a number of staff in new roles, and successfully developed staff into more senior positions as well as assisted ancillary staff to access radiographer training.
- The radiology department supported radiographer students and had a well-established support and training process in place. Staff in the department had also successfully bid for monies to support students in training with the purchase of text books and furniture for the seminar room.

Public engagement

- We heard examples of services engaging with the public, such as in using stalls in the main hospital reception and visiting local businesses to present talks on medical issues.
- We saw efforts that had been made to tailor notice boards to provide information to the public on topical health issues. For example the clinical nurse specialist in the breast clinic displayed posters and information during breast cancer awareness week. ENT staff displayed seasonal health promotion topics. We saw that patients were involved in organising and collating patient information in the Breast Clinic.
- The dermatology specialist nurse and consultant held a public event during the summer of 2014 and intended to repeat it in 2015 where they set up a stall in the town centre for anyone to walk in and have skin lesions examined. The staff also provided summer skin care advice and wrote to GPs advising that referral was needed on behalf of people who had concerning lesions identified. The event had been advertised in advance in the local press and had been very well attended.

- The specialist nurse had also supported the campaign for access to mammography for women over 70 years of age.
- Volunteers provided tea and coffee for outpatient department patients.

Staff engagement

- Most of the staff we spoke with felt engaged with the organisation and were able to share feedback and suggestions to improve services. We heard examples of where junior staff had made suggestions and these had been acted on to improve services.
- The organisation and services we inspected were very supportive of staff development.
- Nursing staff were aware of revalidation and that road shows were going to be held to provide information to them regarding meeting the requirements of the NMC for revalidation. A presentation had also been developed for lead nurses to deliver to staff in their own area.
- Staff in radiology felt able to raise issues and give ideas for improvement to their managers at any time. Staff were observed engaging with their manager through questions and answers during the team briefing session.
- Staff told us that they enjoyed working for the trust and we interviewed several people who had been employed for 20 years or more. Staff were proud of the service they provided and felt they worked in highly skilled teams. Several staff told us that they would be happy for members of their family to be cared for by staff in the department.

Innovation, improvement and sustainability

- We saw and heard of good examples of innovation from staff.
- The uro-gynaecology nurse specialist had introduced "Percutaneous tibial nerve stimulation for overactive bladder" following a successful business case to the trust which demonstrated it not only improved symptoms for patients but also cost saving for the trust. Audit data from 2014 demonstrated improved outcomes for women.
- The Dermatology service described a tele-dermatology project they were providing in conjunction with the local Clinical Commissioning Group whereby some GP practices could send in pictures of patient problems and receive an electronic treatment plan within 3 days. The service had also recently been approved to provide private cosmetic procedures (such as Botox) and was seeking to use these as a revenue generator for the trust.
- We saw that staff in Breast Clinic had developed a simple tool for patients to remind them to take their medication. The staff had developed a card, covered in a picture of brightly coloured tablets that could be hung from a door handle at their home such as a kitchen cupboard. This had been shared at an internal nursing conference and staff in other areas of the trust were using for their patients.

Outstanding practice and areas for improvement

Outstanding practice

- A Midwife had won the prestigious 2015 Royal College of Midwifery's (RCM) Philips AVENT National Award for Innovation in Midwifery. They created a secure staff social networking site called 'Ward-book' which was used by midwifery staff at the hospital to communicate important messages across the department. Each week the Head of Midwifery wrote a departmental update which gave staff the opportunity to feedback in real-time and this was posted on the system. The Ward-book was used as a virtual notice board. It helped communication between managers and staff and helped improve the outcomes for patient care.
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- Pharmacy robots had been introduced at the trust in July 2014. This has reduced errors and increased staff capacity.

Areas for improvement

Action the hospital MUST take to improve

- ensure all patients attending the emergency department, have an initial assessment undertaken by a suitably qualified healthcare professional in accordance with national guidance.
- ensure that children attending the hospital are cared for by nursing staff who have the qualifications, competence, skill and experience to do so safely.
- ensure oxygen is prescribed in line with national guidance.
- ensure that medicines reconciliation is completed in 24hrs and meets local and NICE guidance.
- ensure compliance with the five steps for safer surgery.
- ensure suitable patients are offered laparoscopic colorectal surgery in accordance with NICE guidance.
- address the backlog of outpatient follow-ups.

Action the hospital SHOULD take to improve

- review processes to enable staff to receive mandatory training on a regular basis.
- confirm guidance to staff, based on best practice, as to the recording of verbal consent by patients in the clinical record.
- review sign language interpretation availability for patients whose main or only means of communication is British Sign Language (BSL).
- monitor the consistent use of the sepsis screening tool and timely completion of the interventions on the sepsis pathway.
- review the out of hours medical staffing provision within medicine.
- work with local services to reduce the number of medical outliers and medically fit patients in hospital to improve patient flow and reduce bed occupancy.
- work with medical consultants to implement a robust system of timely mortality review.
- work with ward staff to improve the understanding of the specific requirements associate with Duty of Candour.

Outstanding practice and areas for improvement

- undertake regular infection prevention and control ward audits.
- improve the quality of medical record keeping and include this in the audit programme.
- monitor and reduce the number of out of hours bed moves.
- undertake a review of historic serious incidents and recommendations made to ensure learning is carried forward in to current areas of clinical practice
- provide appropriate access to IT systems for appropriate staff, including temporary staff.
- ensure medicines are stored at the correct temperature.
- review medical note taking including prescription documentation.
- review infection prevention and control practices within surgical areas including clinical stock rotation, environmental cleanliness and the changing rooms within main theatres environment
- ensure there are sufficient numbers of staff with suitable qualifications, competence, skill and experience to provide care to patients within trauma and orthopaedics.
- continue to take action to ensure the urology service meets patient need.
- improve compliance with national emergency laparotomy audit.
- undertake a full assessment of the area currently used for lucentis and its environmental and engineering suitability for service provision in the current facility.
- consider the amount of sessions for ward rounds for surgeons.
- consider undertaking a review of waiting facilities within theatre reception area.
- store records in line with data protection requirements.
- meet the government targets for antenatal screening between 10 and 12 weeks gestation relating to foetal abnormality.

- consider monitoring of waiting times in the CAU.
- support incident reporting and ensure timely response to investigations and clear lines of communication to staff in order that lessons are learnt in a transparent manner.
- consider improving the environment in the POPD waiting area.
- review the safe storage of patient records in the children's outpatients department.

- take action so advanced care planning and preferred place of care are considered by the MDT in a timely way in order that patients wishes at end of life can be met.

- quality assure radiology reports generated by voice recognition.
- take action to improve cancellation and DNA rates.
- take action regarding the visibility of patient information on their electronic check in screens.
- review the seating arrangements in the phlebotomy department and main outpatients' areas to provide seating for patients with differing needs.
- review the facilities and waiting areas for inpatients to improve the maintenance of privacy and dignity.
- review processes for reporting of x-ray films and CT scans to ensure acceptable and consistent reporting times are achieved.
- include the quality of record keeping in medical records and the use of WHO checklists in its audit programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitable qualified, competent, skilled and experienced persons must be deployed. There were insufficient numbers of nurses competent in the care of children deployed in the Emergency Department and the children's clinical areas.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care must be provided in a safe way. The registered person must assess the risks to health and safety of service users of receiving the care or treatment and ensure the proper use of medicines. Patients not entering the emergency department by ambulance did not have an initial assessment undertaken by a suitably qualified healthcare professional in accordance with national guidance. Medicines reconciliation was not completed within 24hrs to meet local and NICE guidance. Oxygen was not prescribed. Patients were not offered laparoscopic colorectal surgery in accordance with NICE guidance. The five safer steps to safer surgery were not embedded in practice. There was a backlog of outpatient's follow-up appointments and patients referred for treatment.