# Sherwood Forest Hospitals NHS Foundation Trust

## Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust | Requires improvement |
| Are services at this trust safe? | Good |
| Are services at this trust well-led? | Requires improvement |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected Sherwood Forest Hospitals NHS Foundation Trust on 18, 19 & 20 July 2016. This was a focused unannounced follow up inspection to check progress against our findings from our last inspection of June 2015. We inspected:

- Emergency and Urgent Care Services at Kings Mill Hospital and Newark Hospital looking only at the safety of these services.
- Medical Services at Kings Mill Hospital, Newark Hospital and Mansfield Community Hospital looking only at the safety and effectiveness of these services.
- Maternity Services at Kings Mill Hospital and Newark Hospital looking only at the safety of these services.
- Outpatient (but not diagnostic) Services at Kings Mill Hospital and Newark Hospital looking only at the safety of these services.

We rated the safety of emergency and urgent care services, medical services, maternity services and outpatient services as good. We rated the effectiveness of medical services as requiring improvement.

Our key findings were as follows:

- The trust had systems in place for incident reporting, investigating and monitoring. Lessons learnt were shared with staff to prevent similar incidents happening again.
- The wards and clinical areas were visibly clean and there were systems to monitor and manage the risk of the spread of infection.
- There were systems, processes and standard operating procedures in place to ensure records, medicines management and maintenance of equipment was given sufficient priority. Emergency resuscitation equipment was checked daily. However, oxygen cylinders were not stored in accordance with Health and Safety Executive (HSE) guidance at Mansfield Community Hospital. At Newark Hospital 73 out of 183 pieces of equipment used by the outpatient services were recorded as not having received a scheduled annual check. However some of the items had been reported missing but not removed from the check list and most of the remainder were items issued to patients but not returned. The maintenance organisation was working with Respiratory Specialist nurses to manage these items within the community. Also at Newark Hospital on medical wards there was no standardised system for highlighting when equipment was clean and ready for use.
- Whilst we saw high numbers of nursing staff vacancies on medical wards and high use of bank and agency staff, levels of staffing and skill mix of staff was managed appropriately and recruitment was underway.
- Nursing staff levels and skill mix in the emergency department and minor injuries unit were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. However, when all the patient beds in the resuscitation area of the emergency department were fully occupied nursing staff levels were insufficient.
- Patients received the correct treatment in a timely manner. There were well embedded systems in place to recognise a deteriorating patient and we saw evidence of patients being assessed, monitored and managed for a variety of potential risks. Staff knowledge of sepsis and the ability to identify a patient who was at risk of developing sepsis was improving with high numbers of staff completing the sepsis training.
- When something went wrong, patients received a sincere and timely apology and were told about any actions taken to improve processes to prevent the same thing happening again.
- Since our last inspection, the outpatient service had made significant improvements in reviewing patient outcomes and reducing the number of overdue appointments.
- The inspection team had concerns regarding staffing and booking arrangements for ophthalmology outpatient clinics. Ophthalmology had the largest numbers of incidents reported and the largest numbers of patients overdue for an appointment. Staff raised concerns regarding the conduct of medical staff in ophthalmology clinics.
- We found patients' care and treatment was planned and delivered in line with current evidence based

# Summary of findings

guidance, standards, best practice and legislation and outcomes for medical patients were mostly within expectations when compared with similar services. However, there was minimal data collected on patient outcomes for medical services at Newark hospital and Mansfield Community Hospital which meant care could not be benchmarked against other providers.

- Patients' symptoms of pain were suitably managed and staff were mostly proactive in assessing the patient's nutrition and hydration needs.
- There were systems to assess, monitor and mitigate risks to patients as well as systems to monitor and improve the quality and safety of services. Now the systems and processes are in place the trust needs to ensure they are fully sustained and part of the organisational culture.

We saw several areas of outstanding practice including:

- Since our last inspection in June 2015 the trust had demonstrated significant improvements in the management of the deteriorating patient and the treatment of sepsis. Across medical care services staff identified and responded appropriately to changing risks to deteriorating patients. Where patients had met the trust criteria for sepsis screening, patients were screened appropriately.
- The 'EGO' pathway which had been implemented for those patients admitted with a minor orthopaedic injury who also had comorbidities that were medical care related.

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

Importantly, the trust must:

- Ensure staff understand the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards in relation to their roles and responsibilities.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Sherwood Forest Hospitals NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust was formed in 2001 and achieved foundation status in 2007. Sherwood Forest Hospitals is the main acute hospital trust for the local population, providing care for people across north and mid Nottinghamshire, as well as parts of Derbyshire and Lincolnshire. The trust employs 4,140 members of staff working across the hospital sites.

There are three registered locations. Kings Mill Hospital in Sutton in Ashfield is the main acute hospital site. It provides over 550 inpatient beds (more than half in single occupancy rooms), 13 operating theatres and a 24 hour emergency department. Each year there are more than 76,000 inpatient admissions and 30,000 day case patients; 102,000 patients attend the emergency department, around 3,000 babies are delivered and more than 270,000 people attend outpatient and therapy appointments in the King's Treatment Centre.

Newark Hospital provides a range of treatments, including consultant-led outpatient services, planned inpatient care, day-case surgery, endoscopy, diagnostic and therapy services and a 24 hour minor injuries unit. There are two medical wards and a GP led rehabilitation unit.

Mansfield Community Hospital provides three medical wards with a total of 64 beds, largely for rehabilitation.

Sherwood Forest Hospitals is registered to provide the following Regulated Activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Surgical procedures
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Termination of pregnancies
- Nursing care
- Family planning services

The trust serves a population of 418,000 across Nottinghamshire, as well as parts of Derbyshire and Lincolnshire. Kings Mill Hospital is located in Ashfield District which was ranked in the fifth (most deprived) quintile in the English Indices of Deprivation in 2010. Mansfield Community Hospital is located in Mansfield District which was also ranked in the fifth quintile. Newark Hospital is located in Newark and Sherwood District, which is in the middle quintile. Other bordering districts – Gedling, Bassetlaw and Bolsover – were ranked in the second, fourth and fifth quintiles respectively.

Total operating income for 2015-16: £297m

Total operating expenses for 2015-16: £352m before impairment adjustments

This was a focussed unannounced follow up inspection to check progress against our findings from our last inspection of June 2015. We inspected:

- Emergency and Urgent Care Services at Kings Mill Hospital and Newark Hospital looking only at the safety of these services.
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## Our inspection team

Our inspection team was led by:

**Head of Hospital Inspections:** Carolyn Jenkinson, Care Quality Commission

**Inspection Manager :** Helen Vine, Care Quality Commission

# Summary of findings

The team included CQC inspectors, inspection managers, clinical fellows, a paramedic operations officer, nurse practitioner, a geriatrician, a junior doctor, a head of nursing and midwifery, an associate director, a non-executive director, a director of nursing and a mental health act reviewer.

## How we carried out this inspection

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Before visiting, we reviewed a range of information we held including information from clinical commissioning group, NHS England, NHS Improvement, Health Education England and the local Healthwatch.

We carried out an unannounced inspection from 18 – 20 July 2016. We inspected three of the trust's locations; Kings Mill Hospital, Newark Hospital and Mansfield Community Hospital.

We talked with patients, their carers and staff from support services, ward areas and outpatient areas. We also reviewed patient records.

## What people who use the trust's services say

Friends and family test recommended scores for Sherwood Forest Hospitals were consistently higher than the England average and greater than 96% for the period April 2015 to April 2016.

In the most recent adult inpatient survey the trust performs about the same as other trusts for all measures.

## Facts and data about this trust

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# Summary of findings

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# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|
| **Are services at this trust safe?**<br>We rated safe as good because:<br>• At our last inspection we raised a number of safety concerns including a lack of learning from incidents, a lack of mitigation of environmental risks and a failure to assess and respond appropriately to deteriorating patients. We took enforcement action against this trust, requiring them to make significant improvements in the health care they provided.At this inspection we found there were systems to assess, monitor and mitigate risks to patients<br>**Duty of Candour**<br>• At our last inspection some executives were unable to demonstrate a clear understanding of what the Duty of Candour was. Systems at the time of the inspection did not ensure patients and their representatives always received an apology. Systems did not ensure that all qualifying incidents had the Duty of Candour applied as they should. During this inspection staff we spoke with had a variable understanding about duty of candour. Junior staff talked of being open and transparent with the public. Senior medical and nursing staff had a full understanding and gave examples of where duty of candour had been applied appropriately.<br>• The Duty of Candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust had been 100% compliant with Duty of Candour requirements since 16 January 2016. This was verified by the electronic incident reporting system which included a duty of candour module indicated 93% compliance for all qualifying incidents up to May 2016 with 7% of incidents requiring specialist psychologist advice.<br>• Each Division appointed a Clinical Lead for Duty of Candour for every incident with moderate or greater harm. The Governance Support Unit (GSU) provided support to this clinical lead to ensure compliance with the requirements and appropriate contacts with the patient and their family. Where a complaint had been received relating to an incident, the trust told us the GSU ensured colleagues in the patient experience team were | Good  |

informed. However, the patient experience team told us they did not always have an opportunity to review duty of candour letters which could create challenges for staff maintaining a single point of contact process for families and patients.

**Safeguarding**

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children.
- The trust had a safeguarding lead and staff knew who they were. At our last inspection the trust were not compliant with NICE safeguarding guidance in respect of staff being trained to level three in safeguarding children. Only 58% of non-medical staff had been trained for the period 2014 – 2015. At this inspection we found the majority of staff working in the emergency department, minor injuries unit and maternity services had received safeguarding level three training where appropriate.
- The trust had a policy and guidance available for staff on female genital mutilation (FGM) as well as links on the trust intranet to information relevant for the mandatory reporting duty. Female genital mutilation/cutting is defined as the partial or total removal of the female external genitalia for non-medical reasons.

**Incidents**

- At our last inspection we found a lack of learning from incidents. We also found ineffective monitoring to make sure required actions following incident investigations were implemented. At this inspection we found an incident reporting policy and procedure was available to all staff.Incidents were reported through the trust's electronic reporting system. Without exception all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- Between June 2015 and May 2016 the trust reported 41 serious incidents. These are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant they warrant using additional resources to mount a comprehensive response.
- The trust reported 6,503 incidents to the national reporting and learning system (NRLS), of which 5,349 resulted in no harm to the patient between June 2015 and May 2016. The NRLS is a central database of patient safety incidents. The rate of incidents per 100 admissions was 7.8 which is better than the England average of 8.8.

# Summary of findings

- At 1 January 2016 the trust had 44 open serious incident investigations some of which were more than six months overdue for reporting. By 17 May 2016 there were only six investigations open of which three were overdue.
- Learning from incidents was shared at the patient safety quality board (PSQG), as well as via a Learning Matters Brief for all staff. Minutes of the board quality committee from May 2016 recognised an increased focus at the trust on learning from incidents and on the delivery of action plans. The committee however, agreed there was more work to be done around assuring implementation of recommendations from investigations.

**Environment and Equipment**

- We found at our last inspection that ligature risk assessments had not taken place and ligature risks were visible in the emergency department. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bed frames, window and door frames, ceiling fittings, handles, hinges and door closures. We found this had been addressed.
- A ligature point risk assessment had been carried out in November 2015 and had identified that non-collapsible curtain rails were present in the majors part of the department. The work to replace these with collapsible rails was due to be completed by the end of July 2016. Ligature cutters were available throughout the department and staff told us they knew where to find them.
- A risk assessment with mitigating actions was in place for mental health patients at risk of harming themselves. Staff showed us the flowchart, managing self-harm, and described instances when they had used it. Following our last inspection the trust had conducted a review of all blinds in relation to ligature risks. Subsequently weekly checks of blinds had been carried out by housekeeping staff.

**Assessing and responding to patient risk**

- At our last inspection in June 2015 we raised concerns about the management of patients with sepsis. In August 2015, following an inspection of medical care (including older people's care), we served an urgent Notice of Decision to impose conditions on the trust's registration under Section 31 (1) (2) (a) of the Health and Social Care Act 2008. Followed a

review of reporting and evidence we lifted this condition in May 2016. During our July 2016 inspection we saw evidence the trust were consistently assessing and responding to patient risk in relation to sepsis.

- The trust had established a deteriorating patient group (DPG) to expand on improvements they had achieved with the sepsis working group. We reviewed the minutes of the DPG meeting for June 2016.The trust continued to report on compliance with the sepsis care pathway despite the lifting of the requirement by CQC. It was recorded that the trust continued to meet the requirements of their commissioning for quality and innovation framework (CQUIN).
- As of 31 March 2016 compliance with sepsis training was; consultant 99%, nursing staff 90% and junior doctors 100%.
- The trust had one mortality outlier for fluid and electrolyte disorders. CQC use the term 'outlier' to describe a service that lies outside the expected range of performance. A concerning trend is not, of itself, evidence of poor quality. CQC's expert panel had approved the trust's proposed action plans and considered them to be an appropriate means of addressing concerns that were identified by the trust's review of the alert.
- We found at our last visit in June 2015 women waking up from an operation were cared for by midwives who were not trained. Midwives no longer provided care for these women on the birthing unit immediately after a general or local anaesthetic. Women were recovered by the anaesthetist and operating department practitioner (ODP) and remained in theatre until they could breathe on their own. Midwives then took over the woman's care and transferred her to their room on the birthing unit.

**Staffing**

- Nursing staff levels were displayed in all the clinical areas we visited and actual staffing levels mostly met planned staffing levels. Where there were gaps in nursing staffing bank and agency staff had been requested. We observed the presence of bank and agency staff on most ward areas.
- Whilst junior doctors told us there were lots of agency nurses employed at the trust they told us there were enough nurses available to provide safe care. However, concerns around staffing levels and high agency use were raised by most nursing and medical staff we spoke with.

# Summary of findings

- When all patient beds in the resuscitation area of the emergency department were fully occupied nursing staffing levels were insufficient. A business case had been submitted to increase staffing in this area by one whole time equivalent qualified nurse.
- The chief nurse personally visited any nursing staff who had resigned in order to understand why they were leaving the trust.
- The majority of outpatient clinics had sufficient nursing staff to ensure they ran smoothly and on time. However, we were concerned about staffing levels in the ophthalmology clinic where staff said there were not enough nurses to meet demand. We saw staff were busy and they told us they had to work more than their contracted hours.
- There were high medical vacancies in the health care of the elderly team and the diabetes team; 46% and 12% respectively of the total number of budgeted posts. There were plans in place to address vacancies and where recruitment processes were underway we saw evidence that posts were being filled.
- Junior doctors told us there was a heavy reliance on locum doctors at middle grade, especially at weekends, who sometimes did not have access to systems. This meant these doctors were not able to be as efficient and relied more heavily on junior doctors for some activities.

**Mental Capacity, Mental Health Act 1983 and Deprivation of Liberty Safeguards**

- In January 2016 the Care Quality Commission found that the trust were not appropriately registered for the assessment or medical treatment of persons detained under the Mental Health Act 1983. We wrote to the trust asking them to register in order to avoid being in breach of Section 10 of the Health and Social care Act 2008. This meant that patients could have been treated and detained at the trust unlawfully. The trust submitted an application to register for this Regulated Activity in February 2016, however we wrote to them requesting further information which at the time of the inspection we had not received. Following the inspection the trust submitted the required information and their registration for this Regulated Activity was confirmed.
- Executive leaders at the trust did not clearly understand their responsibilities within the Mental Health Act Code of Practice 2015, chapter 37 in relation to hospital managers and their functions. This meant that patients detained under the act may be being detained unlawfully.

# Summary of findings

- During a recent detention of a patient under Section 5 (2) of the Mental Health Act 1983 the patient's rights had not been read to them at the time of their detention as required under the Act.
- At our inspection in June 2015 we found staff did not always understand the practical application of the Mental Capacity Act. At our inspection in July 2016 some staff were able to explain the practical application of the Act however, we remained concerned that a number of staff did not understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities.
- There were processes in place to apply for authorisation if a patient had been identified as being deprived of their liberty. Most staff we spoke with understood this process. However, there were significant delays in the supervisory authority sending out best interest assessors to authorise and report of Deprivations of Liberty. For one patient a standard authorisation was granted on 13 July 2016 and expired on 17 July 2016 when the assessments were completed 17 May 2016.A further extension had been granted on 19 July 2016. This meant that although it is not the fault of the trust there were patients who were deprived of their liberty without authorisation. We escalated this concern and the chief nurse told us it would be added to the corporate risk register and had been discussed at the local safeguarding adults board.
- Since the inspection in June 2015 the trust had rolled out a mental health awareness training programme for frontline staff. At the time of our inspection in July 2016 90% of staff had received this training so as to be able to cascade it to other staff. From 1 April 2016 mental health awareness training was included in the trust's mandatory induction programme.
- Consultants told us their understanding of safeguarding, Deprivation of Liberty Safeguards (DoLs) and mental capacity had all improved with the mandatory training they had received. At the time of our inspection 84% of medical staff had completed this training.
- We found some confusion amongst nursing staff about what was valid consent.
- At our last inspection we raised concerns about the safety of patients who might self-harm or those with a mental health condition who were admitted to the hospital or being treated in the emergency department and minor injuries unit. Following our inspection the trust delivered a mental health awareness training programme across all staff with 90% having completed at the time of this inspection. From 1 April 2016 this training became a mandatory part of induction training for staff.

# Summary of findings

- The trust had recently introduced a system where the senior manager on call was always made aware of any incidents relating to self-harm or mental health as well as any detained patients who were admitted. This meant they were able to ensure staff were supported to take appropriate and safe action in relation to these patients.

**Are services at this trust well-led?**

**Requires improvement** 

We rated well led as requiring improvement because:

- At our last inspection we rated the trust's leadership as inadequate. We took enforcement action against this trust, requiring them to make significant improvements in the health care they provided. At this inspection we found there were systems to assess, monitor and mitigate risks to patients as well as systems to monitor and improve the quality and safety of services. Now the systems and processes are in place the trust needs to ensure they are fully sustained and part of the organisational culture.

**Vision and strategy**

- At our last inspection we found staff did not talk about the trust's vision and strategy and when asked about it had very little knowledge. Staff now talked about the future in a more positive light.
- There was no new vision and strategy for the trust, but staff were no longer focused purely on the special measures term. From our discussions with staff, and our observations of care and treatment, staff were focused on delivering better care to their patients.
- There was a plan for the trust to merge with another local NHS acute trust. Staff from both organisations were beginning to work more closely together. Some staff told us they felt anxious about potential changes resulting from the merger where as others welcomed the opportunities it would bring. Many of the concerns centred on operational worries such as would they have to travel further to get to work and how would they manage their child care. The leadership team had a communications plan which aimed to address these concerns.

**Governance, risk management and quality measurement**

- Following our last inspection we took enforcement action against this trust requiring them to make significant improvement in the quality of health care they provided. These

improvements included ensuring systems to assess, monitor and mitigate risks to patients were improved and systems to monitor and improve the quality and safety of services were operated effectively.

- At our last inspection when we discussed risk management and governance with a number of senior managers and directors there was lack of clarity about exact escalation and reporting systems. At our last inspection we saw examples of the board receiving conflicting and inaccurate evidence of assurance. During this inspection we were assured that the new governance, risk and assurance systems were much more effective. Senior managers and a non-executive director were clear about escalation and reporting systems and told us they felt more assured and confident they were sighted on risks and quality. Minutes of the board quality committee for April 2016 recorded commissioners were assured that there was challenge and understanding of quality at executive level in the trust. The senior leaders were aware that there was still room for further improvement to ensure the processes were fully embedded across the organisation.
- At our last inspection, we found a lack of evidence to suggest senior staff understood where the weaknesses in the trust's governance arrangements were. During this inspection we found a marked difference; there was a recognition that improvements were needed and we found evidence that improvements were being brought about.
- The trust had a comprehensive quality improvement plan (QIP) which had been created after our last inspection. There were ten areas for improvement; each led by an executive director. Every month there was a four week cycle of confirming and challenging progress against the action plans. At the start of the plan there had been 287 action points. At the time of our inspection 197 of those actions have been completed and embedded. Staff told us the QIP had made a huge difference and structures were now in place to confirm and challenge improvement. The board were aware of and assured about risks and quality.
- The trust had a new business assurance framework (BAF) which was to be presented to the board on 18 July 2016 for use from August 2016 onwards.
- At the time of the inspection a new Chair had just been appointed and had not yet chaired a board meeting. We reviewed minutes of board meetings since our last inspection. There was evidence of a greater degree of challenge by the board but this could be strengthened further.

# Summary of findings

- The interim leadership team had reviewed the governance committee structure, reduced the number of committees and defined the terms of reference for those that remained so there were clear aims and objectives as well as appropriate membership, which had led to improved attendance and clearer accountability. An important committee in this structure was the Patient Safety Quality Board (PSQG), jointly chaired by the chief nurse and the medical director. The PSQB reported to the Board level Quality Committee. This committee was chaired by a non-executive director
- A risk committee met monthly and reviewed all significant risks, escalating those with a score of 15 or above to the corporate risk register where appropriate. The committee would invite individual service or speciality representatives to the meeting to review their divisional risk registers. This ensured that the relevant team had ownership and responsibility for risks in their area. Minutes for the June 2016 PSQB meeting indicated 82% of specialities had an updated risk register. The minutes stated that engagement in risk management had increased.
- Each division in the trust had a clinical governance consultant lead and a nurse clinical governance coordinator. Divisions held monthly clinical governance committee meetings.
- Whilst governance arrangements had been reviewed and strengthened these had only been in place for less than six months at the time of our inspection and so it was too early to determine their sustainability and long term effectiveness.
- A new patient safety culture team had been introduced to support staff at service level to make improvements. They were able to use a toolkit to enable teams to recognise the need to do something differently. The trust had established a consultant lead for quality improvement with three dedicated sessions as well as adding dedicated governance time to work plans for all consultants.
- The chief nurse had led a review of the ward quality accreditation tool and the revised tool was in place at the time of our inspection. We saw records which demonstrated improvements had been identified and actions implemented and monitored to follow these up.
- Non-executive directors partnered with a senior clinician and completed monthly or bi-monthly senior leadership walk arounds in clinical areas using a visit proforma. The results of these visits were collated and reported on at the board's quality committee. However, the results were not routinely fed back to staff in the clinical area visited.

- We reviewed three complaints and the trust annual complaints report. The complaints had been dealt with according to trust policy. However, action plans had not always been thoroughly completed.
- We talked with staff in the patient advice and liaison service who told us they did not see any information about themes and trends in complaints. They also advised they were not aware of themes and trends around incidents which would be relevant to their work.

**Leadership of the trust**

- The executive team had changed since our last inspection. The Chair of the trust had recently completed their term of office and the Chair of another local acute NHS hospital trust had been appointed. An interim chief executive had been in post for seven months. The team of six executive directors all held substantive appointments with the exception of the chief operating officer who was an interim appointment and had been in post for seven months. The remainder of the team had been in post for periods ranging from three years to seven months. There were seven non-executive directors who had been in post for between six months and three years.
- All staff spoke highly of the interim executive team and felt they had brought about improvements in the organisation. This was a high performing team achieving a great deal in a short space of time. As the team had only been in place for six months they needed more time to demonstrate the longer term sustainability of improvements.
- Without exception consultants were positive about the leadership of the medical director and chief nurse.
- All nursing staff were positive about the leadership of the chief nurse who met with ward sisters weekly. They had been given bespoke training and guidance and knew what the expectations of them were. The chief nurse had devolved responsibilities for budgets and staffing to ward level whilst continuing to offer operational support to nursing leaders. The chief nurse had worked hard to empower the ward sisters and helped them to recognise the key role they played within the trust. Nursing staff spoke extremely highly of the support offered by the chief nurse.
- We met with a staff partnership representative. Feedback indicated there had been significant improvements in leadership throughout the trust since our last inspection. The feedback given reflected our direct observations as well as our discussions with staff.

**Culture within the trust**

# Summary of findings

- During the inspection we spoke with many members of staff and without exception staff told us they understood why their last inspection report had resulted in a lot of change at the trust. This was a marked difference from the findings of our last inspection and was indicative that there had been a shift in the culture at the trust.
- The General Medical Council (GMC) national training scheme survey for 2015 was largely positive with 11 out of 14 indicators within expected range and only three negative. These related to induction, clinical supervision and feedback.
- Thirty consultants attended a focus group we ran during inspection. They told us there was more opportunity to discuss issues than before, sharing of learning was across the trust, governance had been strengthened and there had been significant improvements in safety and quality over the previous 12 months.
- The same group of consultants told us there was increased energy reflected around the hospital with better team work, cross departmental working and improved relationships.
- Staff reported good team working within their areas of work at all levels.

**Fit and Proper Persons**

- At our last inspection we took enforcement action against the trust because they did not have proper processes in place to make robust assessments required by the Fit and Proper Persons Regulation (FPPR) requirements.
- As part of this inspection we reviewed the files of three directors and three non-executive directors and found they met the requirements of the Fit and Proper Persons Regulation (FPPR). The trust also had a comprehensive FPPR policy which was appropriately applied.

**Public engagement**

- The trust's patient experience strategy was due for revision in January 2017. The current strategy had been in place since January 2014 and had not been amended during the three year period. This meant the strategy had not considered more recent possibilities for patient engagement especially technological advances.
- Minutes of the May 2016 quality committee meeting recognised low response rates to the friends and family test (FFT) and indicated actions to address this including a business case for the provision of electronic hand held devices and volunteer support to complete responses.

- During our inspection the trust had begun a text messaging pilot for patient feedback in the emergency department.
- There was a detailed stakeholder communication and engagement plan in relation to the planned merger of the trust with another local NHS acute trust.

**Staff engagement**

- In February 2016 the trust board approved an employee engagement strategy for 2016. The stated purpose was "To enable our staff to deliver great patient care, affect positive cultural change and drive improvement."
- Sickness absence rates rose sharply in January 2016. However, they remained at less than 1% above the England average.
- The chief nurse had introduced a monthly bulletin for nursing staff containing information about national developments as well as local updates. They had also introduced awards for wards where the most progress had been made around improvement work and for individual staff.

**Innovation, improvement and sustainability**

- Whilst consultant staff were positive about the imminent merger with another local acute trust they also expressed concerns that recent positive advances in culture could be lost. One consultant also expressed concerns that their quality and safety focus could be lost with the merger. They were, however, confident that improvements in clinical safety and quality had been embedded and would survive the change in leadership as a result of the merger.
- Staff at all levels expressed concern about the potential lack of senior leadership stability for the immediate future. The departure of the current interim executive team prior to a merger with a local NHS acute trust meant there was a period of instability and further change. Many staff were worried that the identity of the trust and its role as a smaller district general hospital would be lost in the merger. Some were also worried that the improvements made under the interim leadership team might be at risk, although many staff told us the improvements were well embedded and supported by all staff who were committed to continuing to provide a high quality safe service for patients.
- The leadership team were very aware of the risks that the improvements and changes that had occurred at the trust might not be sustained in the long term.
- Our inspection was focussed and we did not look at all services in the hospital. Whilst the trust had made significant

# Summary of findings

improvements in a short space of time under the leadership of the interim executive team, this team had not had the opportunity to demonstrate those improvements were sustainable over a longer period of time.

# Outstanding practice and areas for improvement

## Outstanding practice

- Since our last inspection in June 2015 the trust had demonstrated significant improvements in the management of the deteriorating patient and the treatment of sepsis. Across medical care services staff identified and responded appropriately to changing risks to deteriorating patients. Where patients had met the trust criteria for sepsis screening, patients were screened appropriately.
- The 'EGO' pathway which had been implemented for those patients admitted with a minor orthopaedic injury who also had comorbidities that were medical care related.

## Areas for improvement

### Action the trust MUST take to improve

- The trust must ensure that staff understand the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards in relation to their roles and responsibilities.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>**Regulation 11(1) (4)**<br><br>Care and treatment of service users must only be provided with the consent of the relevant person<br><br>**How the regulation was not being met:**<br><br>Staff did not always understand the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards in relation to their roles and responsibilities. |