

The Rotherham 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

Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused follow-up inspection between 27 and 30 September 2016 to confirm whether The Rotherham NHS Foundation Trust had made improvements to its services since our last comprehensive inspection in February 2015. We also undertook an unannounced inspection on 12 October 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

When we last inspected the trust in February 2015, we rated the service as requires improvement. We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good.

There were fourteen breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and 2014. These were in relation to the safety and suitability of premises, staffing, supporting staff, records, consent to care and treatment, complaints, care and welfare of people who use services, dignity and respect, need for consent, cleanliness and infection control, management of medicines, safeguarding people who use services from abuse and assessing and monitoring the quality of service provision.

The trust sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation. At this inspection, we checked whether these actions had been completed. We inspected the services at the Rotherham General Hospital, community inpatients at Oakwood Community Unit and Breathing Space, children's and adult's community services and community end of life care. We did not inspect dental services provided by the trust as these were rated as good at the previous inspection.

We found that the trust had made considerable improvements. However, there remained areas that required further improvement. The Rotherham NHS Foundation Trust overall rating of requires improvement remains unchanged. At this inspection we found:

- The trust had not taken sufficient action raised in the 2015 inspection to ensure DNACPR forms and mental capacity decisions were documented in line with trust policy, national guidance and legislation. We wrote to the trust immediately following our inspection to ensure that action was taken promptly regarding the DNACPR forms and mental capacity decisions. The trust initiated a number of actions, which we will continue to monitor.
- Staff understanding and application of the Mental Capacity Act 2015 was inconsistent across most of the services inspected.
- There were concerns about the current pharmacy service and the impact on patient care. We wrote to the trust immediately following our inspection to ensure that action was taken promptly regarding the management of discharge medications and service provision. The trust initiated a number of actions, which we will continue to monitor.
- Access to safeguarding supervision was a concern and was in the process of being addressed.
- Staffing levels in the children's ward and maternity had improved since the previous inspection. However, there remained staffing shortages most notably in the Emergency Department, school nursing and medical wards. There was a high use of medical locum staff in some specialties.
- Some policies and guidelines were out of date and there was a backlog of incidents in maternity services that had not been reviewed.
- Audit plans were behind schedule within children's services.
- There were some environmental concerns at the time of inspection; the fire escape on critical care was not appropriate and there were some remaining ligature risks on the children's ward. The trust took immediate action to address these following our inspection.
- Risk registers were in place, but did not always reflect the risks identified on inspection.

Summary of findings

- The hospital reported no cases of hospital acquired MRSA bacteraemia, 16 cases of C.difficile and nine of MSSA bacteraemia between July 2015 and June 2016. The number of cases of C.difficile and MSSA per 10,000 beds has been mostly below (better than) the England average. However, on medical wards, there were some concerns about infection control practices and facilities in the refurbished areas.
- There were areas of notable improvement since the previous inspection. These included safeguarding training and awareness, improvements to the short-break service, access to sexual health records and improvements to training data.
- There had also been improvements in ensuring there were no mixed sex breaches, wherever possible and actions had been implemented to minimise these.
- We saw that patients were assessed using a nutritional screening tool, had access to a range of dietary options and were supported to eat and drink.
- There were no mortality outliers identified at the trust.

We saw several areas of outstanding practice including:

- The trust was piloting a new community model of care called the perfect locality. This multiagency /multidisciplinary team approach focused on implementing measures to avoid hospital admissions and facilitate safe discharge of patients already in hospital.
- BreathingSpace remains the only entirely nurse-led model of care for respiratory inpatients and outpatients in Europe. We found that the culture, care and philosophy of the unit were outstanding.
- The activities coordinator at Oakwood Community Unit had been employed by the trust and had developed a range of activities including arts and craft, bingo, board games and a monthly themed tea party.
- The trust staff had direct access to electronic information held by community services through the SEPIA portal, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines and community services involvement in their care.
- Safeguarding and liaison had a daily meeting with the Emergency Department to identify any safeguarding issues and concerns.

- All patients with mental health needs admitted to the children's ward were reviewed by the CAMHS liaison team/nurse within 24 hours of admission and were followed up after seven days.
- Staff had successfully offered the use of acupins for the relief of nausea, particularly in gynaecology services.

However, there were areas where the trust needs to make improvements.

Importantly, the trust must:

Urgent and emergency care

- Ensure there are sufficient numbers of suitable qualified, competent and skilled staff deployed in the department.
- Ensure all staff are aware of their responsibility to report incidents and ensure learning is shared with all relevant staff.

Medicine

- Continue to take action to ensure there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Ensure all relevant staff have received appropriate training and development. This should include, mental capacity, safeguarding adults and children, resuscitation and dementia awareness.
- Ensure all staff have an annual appraisal.
- Mental capacity assessments and discussions must be clearly documented in patient records.

Critical care

- Ensure risks are assessed, monitored and managed in a timely manner to ensure safety.
- Ensure patients' individual records are held securely on the unit.

Maternity

- Complete the reviews of maternal and neonatal deaths and implement any further identified actions to support safe practice.
- Ensure that identified risks are recognised and recorded on the risk register.
- Ensure that incidents are reviewed and investigated in a timely manner.
- Ensure staff have access to safeguarding supervision and support.

Summary of findings

Children and young people

- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

End of life care

- Ensure all "do not attempt cardio-pulmonary resuscitation" (DNACPR) decisions are always documented in line with national guidance and legislation.
- Ensure there is evidence that patients' capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

Community adults

- Must ensure that there are robust local safe systems in place to keep community staff who are lone working safe, in line with trust policy.
- Must ensure community staff are working in accordance with the Mental Capacity Act code of practice (2005).
- Must ensure that all risks for community services are included on the directorate risk register and where control measures are identified to mitigate risks, managers have assurance that control measure are effectively in place.

Community end of life care

- Ensure that all DNACPR forms are completed appropriately and accurately ensuring that mental capacity assessments are completed for patients where it has been assessed they lack capacity.

Community inpatients

- Ensure that consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005 for patients who lack capacity. The provider must also ensure that staff are trained to enable them to recognise when patients need support to make decisions and, where appropriate, their mental capacity is assessed and recorded.

Community children, young people and families.

- Ensure incidents are appropriately categorised, graded and investigated.
- Ensure that there are sufficient suitably qualified, skilled and experienced staff in the school nursing service to meet the needs of the local population.
- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure that a regular and effective clinical audit schedule is developed.
- Ensure that steps are taken to increase performance against waiting time targets for therapy services and the child development centre.
- Ensure that it improves the number of looked after children assessments carried out within the target timescale.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

Trust-wide

- Ensure there are sufficient numbers of suitable qualified, competent and skilled staff deployed in the pharmacy department.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to The Rotherham NHS Foundation Trust

Rotherham NHS Foundation Trust provides acute and community services to a population of 259,000.

Acute services are provided at Rotherham General Hospital. Community services are provided at Oakwood Community Unit, BreathingSpace and a range of community locations across seven locality areas.

The trust has 450 beds (excluding the community units).

A total of 3954 staff are employed by the trust (at end April 2016). These were:

- 292 (WTE) Medical & Dental
- 1118 (WTE) Nursing/ Midwifery / Health Visiting
- 2118 (WTE) Other

For the 2015/16 financial year, the trust reported a deficit of £8.8m.

We carried out this focused follow-up inspection to confirm whether The Rotherham NHS Foundation Trust had made improvements to its services since our last comprehensive inspection in February 2015. We inspected services focusing on the key questions (safe, effective, caring responsive and well led) that had previously been identified as requires improvement. We also inspected caring where we were looking at the majority of the key questions within a service.

We did not inspect community dental services as these were previously rated as good.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Nurse Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including medical consultants, nurses, midwife, community nurses, health visitor, therapist and expert by experience.

How we carried out this inspection

We carried out this focused follow-up inspection between 27 and 30 September 2016 to confirm whether The Rotherham NHS Foundation Trust had made improvements to its services since our last comprehensive inspection in February 2015. We also undertook an unannounced inspection on 12 October 2016.

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?

When we last inspected the trust in February 2015, we rated the service as requires improvement. We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good.

The trust sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation. At this inspection, we checked whether these actions had been completed.

We inspected the services at the Rotherham General Hospital, community inpatients at Oakwood Community Unit and BreathingSpace, children's and adult's community services and community end of life care. We did not inspect dental services provided by the trust as these were rated as good at the previous inspection.

Summary of findings

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), NHS Improvement, NHS England and the local Healthwatch.

We held a stall at the trust on 21 September 2016 and spoke with patients and relatives. We also received comments cards. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who provided feedback about the trust.

Focus groups were held with a range of staff in the hospital and community, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested.

We talked with patients, families and staff from all the ward areas, community clinics and in patients' homes when visiting with community nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

What people who use the trust's services say

From June 2015 to May 2016, the trust consistently performed better than the England average for the percentage of inpatients who recommended the trust in the Friends and Family Test.

The national maternity survey for 2015, which looked at the experiences of people receiving maternity

services, showed the results for The Rotherham NHS Foundation Trust was about the same as other trusts.

The national inpatient survey from 2016, showed the results for The Rotherham NHS Foundation Trust was better than other trusts regarding operations and procedures and about the same as other trusts for all other results.

Facts and data about this trust

The trust activity for period April 2015 to March 2016 was:

- Inpatient admissions: 55,000
- Outpatients: 250,000
- A&E attendances: 75,000

The health of people in Rotherham is varied compared with the England average. Deprivation is higher than average and about 22.8% (11,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.

For children in Year 6, 23.4% (671) are classified as obese, which is worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was

29.1, which is better than the average for England. This represents 17 stays per year. Levels of breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 28.5% of adults are classified as obese, which is worse than the average for England. The rate of alcohol related harm hospital stays was 673. This represents 1,688 stays per year. The rate of self-harm hospital stays was 161.4, better than the average for England. This represents 406 stays per year. The rate of smoking related deaths was 349, which is worse than the average for England. This represents 497 deaths per year. Estimated levels of adult physical activity are worse than the England average.

Black and minority ethnic residents make up 6.5% of the population, within which the largest group are those identifying as Asian / Asian British (4.1%) of total population.

Rotherham is in the most deprived quintile within the Index of Multiple Deprivation.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>At our previous inspection in February 2015, we told the trust to make improvements to the safety of their urgent and emergency care, medical care, surgery, critical care, maternity and family planning, children and young people and outpatients and diagnostic imaging services at Rotherham General Hospital. We also told the trust to make improvements to their adult, children, young people and families, inpatients and end of life care services in the community. The trust developed an action plan. At this focused follow-up inspection, we made checks to review improvements to these services.</p> <p>Although there had been some improvements since our previous inspection, at this inspection we identified:</p> <ul style="list-style-type: none">• There was a lack of a sufficient pharmacist provision which impacted on the ability to deliver a service.• There remained insufficient doctors and nurses in some areas. These included the Emergency Department, medical specialities such as gastroenterology, and school nurses.• Compliance with mandatory training was below the trust target in some areas, such as the Emergency Department. There had been improvements in overall compliance and recording of compliance.• The rate of safeguarding supervision did not meet national or trust guidance. This was identified on the corporate risk register and staff were in the process of being trained. There was evidence of some referrals being missed within the Emergency Department; this had been recognised and the trust's safeguarding team were providing training and additional support.• There remained some concerns about information governance. This was on the corporate risk register. <p>However, we also found:</p> <ul style="list-style-type: none">• Staffing levels in the children's ward and delivery suite had improved since the previous inspection.• The trust had made significant improvements to the medicines management and environment in the short break service. <p>Duty of Candour</p>	

Summary of findings

- Trust managers were aware of the obligations in relation to the Duty of Candour requirements. The legal Duty of Candour requires the trust to disclose openly events that have led to moderate, major or catastrophic harm to a patient.
- The trust had a 'being open and duty of candour' policy. This included guidance in relation to the implementation of the Duty of Candour and was available to staff.
- The trust's electronic incident reporting system had been adapted so that all moderate and serious harm incidents were automatically sent to senior quality and safety staff to prompt consideration of the Duty of Candour.
- Duty of Candour was included in mandatory training regarding patient safety and incident investigations. External training sessions had been provided to governance leads. The trust were in the process of reviewing the training programme to include e-learning on Duty of Candour for relevant staff.
- We found that most staff were aware of the duty of candour requirements and could explain the principles of being open and transparent with patients, families and carers.
- We reviewed a range of serious incidents; all provided evidence of being open. We saw that Duty of Candour letters were sent, although this was not clearly evident in all investigations reviewed.
- An audit of the incident reporting system to check compliance with the Duty of Candour was reported to the board in July 2016. This showed the duty had been applied in over 95% of instances where moderate to severe harm had occurred. Further audit work was planned and an external audit of duty of candour undertaken by the trust's internal auditors had also been commissioned by the Audit Committee.

Safeguarding

- The trust had appropriate safeguarding policies and procedures in place for both adults and children.
- These were implemented appropriately, except in the Emergency Department where we found evidence of incidents when some referrals were missed. This had been recognised and the trust's safeguarding team were providing training and additional support.
- The trust had a strategic safeguarding group, which reported to the clinical governance committee. The strategic safeguarding group was chaired by the Assistant Chief Nurse for vulnerabilities.
- The executive lead for safeguarding was the Chief Nurse.

Summary of findings

- There was a named nurse for children, named midwife, named nurse for adults and named doctor, in accordance with national requirements. These post holders were supported by four nurse advisors. There was a specialist nurse post for child sexual exploitation; interim cover was in place due to absence.
- The Chief Nurse and the Assistant Chief Nurse attended the local safeguarding boards.
- We found 69% of relevant staff had received level 2 children's safeguarding training and 71% had received level 3 training against a trust target of 80%.
- A total of 69% of staff had received level 2 safeguarding vulnerable adults training
- The rate of safeguarding supervision did not meet national or trust guidance. The recommended frequency of safeguarding supervision for staff holding a child or family caseload was three monthly. During April to June 2016, 30% of community midwives had received supervision. Safeguarding supervision was identified on the corporate risk register and staff were in the process of being trained.
- In February 2015, a Care Quality Commission review of health services in safeguarding and looked after children services in Rotherham was undertaken. An action plan had been implemented and we saw evidence that action had been taken to address the areas highlighted.
- For example, safeguarding and liaison had a daily meeting with the Emergency Department to identify any safeguarding issues and concerns.
- The trust had developed and implemented an action plan following the Kate Lampard review of themes and lessons learnt from NHS investigations into matters relating to Jimmy Saville.

Incidents

- There was one reported never event between 1 July 2015 and 30 June 2016. Never Events are serious incidents that are wholly preventable, where 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 rate of incidents per hundred admissions, reported to the national reporting and learning system, was lower (8.1) than the England average (8.7) between 1 May 2015 to 30 April 2016.
- The most frequent category of incidents was classed as "all other categories."

Summary of findings

- The majority of these were low and no harm. Data from 1 July 2015 to 30 June 2016 showed, from a total of 6250 incidents, 0.2% (10) had resulted in death, 0.1% (7) were classified as severe, 3% (185) were moderate harm, 12.9% (808) were low harm and 83.8% (5240) were classified as no harm.
- We had some concerns, particularly within the community services for children, that incidents which caused harm were classified as 'no harm.'
- There had been three maternal deaths between April 2016 and September 2016. A maternal death review had been held involving two members external to the trust; a consultant obstetrician from another trust and a local supervising authority (LSA) midwifery representative. The trust had taken steps to support safe practice. The trust had also invited the Royal College of Obstetricians and Gynaecologists to undertake an external review of practice. This was in the process of being arranged.
- The trust had a revised incident and serious incident management policy, which had been issued in August 2016. This contained relevant and appropriate guidance for staff.
- The trust used an electronic incident reporting system. Staff were aware of how to use the system, although some unregistered and medical staff, particularly in the Emergency Department, said they would ask nursing staff to report an incident.
- Most staff reported they received feedback when they had reported an incident. This had improved since the previous inspection.
- We reviewed a range of serious incident investigations and found these had been appropriately investigated, recommendations made and the learning disseminated. However, within maternity services, there was a backlog of incidents which were overdue review. This meant that there might have been missed opportunities to learn from incidents and prevent recurrence.
- A weekly serious incident review group had been introduced since the last inspection. This was attended by the Chief Nurse and Medical Director.

Staffing

- Staffing remained a challenge at the trust and was identified on risk registers.

Summary of findings

- There had been an improvement since the previous inspection in nurse and midwifery staffing levels in some areas, such as the children's ward and the delivery suite. However, staffing levels in the Emergency Department, medicine and school nursing remained below planned levels.
- We also had concerns about the pharmacy service, which was 25% below planned staffing levels at the time of inspection. This had led to a reduced pharmacy service for some wards.
- The trust adhered to the ten expectations of the National Quality Board guidance published in 2013. Reports were submitted to the trust board on a regular basis, which gave information on staffing levels and vacancy rates.
- There were twice yearly reviews of nursing and midwifery staffing in accordance with NICE guidance (2014). Within the Emergency Department, nurse actual and expected staffing levels were based on a BEST assessment that was carried out in January 2016. However, these levels were not consistently achieved. The trust was recruiting staff, had appointed a matron for ED and a practice development nurse to support nursing staff.
- The Safer Nursing Care Tool to assess patient acuity and dependency was used in inpatient areas, such as medicine. The review process involved discussion with ward staff and the clinical division managers made a presentation to a panel made up of the Chief Nurse, Finance Director and Director of Workforce.
- The planned midwife to birth ratio was 1:25 and this was achieved. The trust had used the Birthrate plus acuity tool in conjunction with professional judgement and triangulation of care sensitive indicators to determine staffing requirements. The workforce planning tool was planned to be used every two years. It had last been used in 2014; there were plans to undertake this again in 2017. The management team reported that the acuity and demographic profile of the population had not significantly changed since 2014.
- Nursing establishments for community adults nursing teams had been agreed with the local Clinical Commissioning Group (CCG) based on the seven locality model. No acuity tool had been used in this calculation. Staffing levels within each community adult nursing team varied. Five teams were well staffed, however two teams had a high number of vacancies and were struggling to cope with the demands of the caseload.
- The majority of school nurses we spoke with told us that they were still 'stretched to the limit'. Many were looking after two secondary schools and the associated primary schools. This was not in line with Royal College of Nursing staffing guidance.

Summary of findings

In addition, we saw that school nursing staff were carrying high numbers of safeguarding cases (877 children with a child protection plan, 2156 children in need, and 217 looked after children).

- There was no supernumerary shift supervisor on the SCBU as recommended by national guidelines. Staffing levels on critical care did not always meet the levels recommended by national guidance and ensuring supernumerary support by a care coordinator on each shift was not always possible.
- Escalation processes were in place to support safe staffing levels. For example, safe staffing huddles were held every day in the acute hospital and twice weekly in the community to review staffing levels and patient acuity with a view to allocating flexi-staff and bank and agency staff to those areas most in need.
- The trust had brought the nurse bank back 'in house' and there was active recruitment to this.
- Information on planned and actual staffing levels was displayed on the wards and departments.
- The trust had looked to introduce innovative ways of working to support nurse staffing. For example, they had developed and implemented a COMPASS programme for nursing staff. This was a structured rotational programme which included leadership development. They had also started work with another trust and Health Education England regarding the health care practitioner programme. This was a project for band 4 staff held in collaboration with a higher education college. At the time of inspection, a bid had been submitted with another trust to be a pilot site for the nurse associates.
- The trust had a retention and recruitment group which monitored recruitment and retention. A 'sideways' transfer process was being established so that staff could move across the organisation into other specialities.
- The medical staffing mix was similar to the England average.
- There was a high usage of medical locums particularly within medicine. For example, between June 2015 and July 2016, locum usage in gastroenterology had been covered by locums 46% of the time. The trust had put in mitigation, such as working with another trust to provide an on-site gastroenterology service and the out of hours weekend gastrointestinal bleed rota service whilst positions were filled.
- The trust had a monthly operational workforce committee which reviewed workforce plans, recruitment, retention and bank and agency usage.

Medicines

Summary of findings

- We had concerns regarding the pharmacy service provision at The Rotherham NHS Foundation Trust.
- Medicines optimisation and the effective use of pharmacy resource are key priorities in the Carter report. The trust's draft medicines optimisation strategy acknowledged the need to undertake a strategic review of the pharmacy service and as recommended by Carter, there was a high level 'Hospital Pharmacy Transformation Plan'. However, this lacked detail and there was no recorded timeframe for individual project delivery.
- The Chief Pharmacist had identified risks related to current pharmacy staffing including delays in the dispensing service and provision of a reduced clinical service that could "compromise patient safety, care and quality". The Chief Pharmacist also noted that, due to reduced staffing either the KPI's (Key Performance Indicators) for medicines reconciliation on admission or for supply of discharge medicines were missed as these activities called upon the same pool of staff. To try to mitigate risks associated with the vacancies within the pharmacy team, the ward based presence was reviewed on a risk basis which meant some wards (B11, Sitwell and Wharncliffe) received no, or only a limited pharmacy service. However, all areas had access to medicines advice and support.
- Nurses raised concerns about withdrawal of the pharmacy service on all three wards affected. Additionally, a nurse on the children's ward told us that a reduced pharmacy service meant that more charts had to go down to pharmacy, as inhalers could no longer be relabelled on the ward. Both nursing and pharmacy staff reported making frequent trips to pharmacy to collect patients' medicines.
- Pressures on staffing meant that the pharmacy team was less able to deliver training in support of the safe handling of medicines. At our previous inspection, we reported that "the medicines course provided by the paediatric pharmacist was offered only on an ad-hoc basis due to a "lack of pharmacist time". At this inspection, we found training had recommenced in September 2016, as part of an action plan following a medicines incident.
- As noted in our previous report, an unknown number of patients went home without their take home discharge medicines. These were either collected later by relatives or delivered by taxi, giving patients less opportunity to discuss their medicines and any changes before going home. Hospital policy did not allow for the regular use of taxis to deliver medicines. There was no service level agreement in place to help ensure the quality and safety of the service.

Summary of findings

- The trust had completed medicines management audits over three month periods from 2013, with the most recent data for February to May 2016. Whilst overall, these showed improvement in the handling of medicines, none of the wards were rated “Green >95%” for compliance with the trust’s standards for drug charts. Nine of the 24 wards assessed were rated as “Red <74%”. More positively, only one ward was rated red for medicines administration. Similarly, an omitted doses study completed in December 2015 found that although total medicines omissions were lower than the England Average, a higher than average number of doses of critical medicines were omitted (37% of missed doses). This was due for re-audit in July 2016, but the audit results were not available at this inspection.
- The Chief Pharmacist and the Medicines Safety Officer were involved in the review of medicines safety related incidents. Following a review in September 2016, the trust found that two similar medicines incidents reported in January and May 2016 were not correctly identified as ‘Never Events.’ An action plan was developed and an e-mail circulated to raise awareness of never event reporting. However, the Chief Pharmacist acknowledged that there were challenges with sharing learning and embedding new practices, particularly in cascading information to nursing colleagues.
- Some nursing staff in the Emergency Department were unable to give patients pain medication because the standard operating procedure to allow them to do so had expired and had not been updated.
- We asked the trust for an update following our visit. The trust advised us that the division had now signed off the Medicines Optimisation Strategy and it was their intention to recruit four pharmacists and four technicians, to improve pharmacy staffing from 25% to 10% staff reductions based on the current establishment. Additionally, the Chief Pharmacist was being supported by the Director of Workforce on the development of a longer- term workforce strategy. We were advised and provided with evidence that the taxi delivery service had been withdrawn and discharge processes reviewed.

Are services at this trust effective?

At our previous inspection in February 2015, we told the trust to make improvements to the safety of their urgent and emergency care, medical care, critical care, maternity and family planning, children and young people and end of life care services at Rotherham General Hospital. We also told the trust to make

Summary of findings

improvements to their adult, children, young people and families, inpatients and end of life care services in the community. They developed an action plan. At this focused follow-up inspection, we made checks to review improvements to these services.

At this inspection, we found:

- Although the trust had taken action on the issues raised in the 2015 inspection, some of these had not been effective in meeting the requirements. We were concerned that consent to care and treatment, including DNACPR, was not obtained or was not recorded in line with legislation and guidance, including the Mental Capacity Act 2005, for patients who lacked capacity.
- Some policies and guidelines were overdue a review in children's services, end of life services and maternity services. The trust was not using an age-related sepsis six tool.
- Royal College of Emergency Medicine and Trauma Audit and Research Network audit results showed that the Emergency Department was not meeting some standards.
- The service was failing to meet performance targets in the national health child programme. This was highlighted at our previous inspection.
- Within children's community services, there were limited examples of regular or robust audit or outcome monitoring in place to ensure that the service was assured it was providing effective care and treatment. This had been highlighted at our previous inspection.
- Adult outpatient departments that saw children, such as dermatology, ophthalmology, ENT and audiology, had mixed clinic lists and no paediatric trained nurses on duty.

However:

- There was evidence of good multidisciplinary working across many services. For example, the Health Village locality team were the pilot site to test a new model of care involving a system wide approach. This involved a multidisciplinary team.
- Access to psychiatric input for children and young people with a mental health needs (CAMHS patients) using the service had improved since the last inspection.

Evidence based care and treatment

- Policies and guidelines were available on the trust intranet. Most staff were able to locate guidance and further work was underway to improve accessibility.
- Policies were based on NICE and Royal College guidelines. However, compliance with National Institute of Health Care and

Summary of findings

Clinical Excellence (NICE) standards was variable. For example, within children's services action plans to achieve required standards were behind schedule. The service was not using the age-related sepsis six tool, however there were plans to introduce this.

- There was a process in place for reviewing and approving guidelines. However, some policies and guidelines were overdue a review, for example, in children's services, end of life services and maternity services.

Patient outcomes

- The 12-month rolling Hospital Standardised Mortality Ratio (HSMR) for April 2015 to March 2016 was 99.4 and 'as expected' when compared with hospital trusts nationally. This showed an improving trend.
- The 12-month rolling Summary Hospital Mortality Index for April 2015 to March 2016 was 1.03 and was within the expected range.
- There were no active Care Quality Commission mortality outliers for this trust at the time of inspection.
- Within maternity services, the trust had identified a number of poor outcomes since late 2015, which included neonatal deaths, stillbirths and maternal deaths. There was a high rate of births being induced. However, the rate of emergency caesarean sections had improved and was similar to expected when compared with national rates. The rate of normal deliveries was better than the England average.
- Outcomes for patients using the critical care unit were better or similar when compared with similar services.
- The Sentinel Stroke National Audit Programme (SSNAP) in December 2015 scored the trust as a C overall (A being the best and E being the worst). The results in relation to scanning had increased from B to A and no results had decreased for Quarter 2 (July-September 2015) and Quarter 3 (October-December 2015). There was a SSNAP action plan in place..
- The National Diabetes Audit 2015 had mixed results with seven indicators better than the England average and 10 indicators worse than the England average.
- The standardised relative risk of readmission rates at trust level show that most elective specialties had a higher than expected re-admission rate, most non-elective specialities had a lower than expected re-admission rate.
- According to the Trauma Audit and Research Network (TARN) website, the trust data for 2015, showed that out of every 100 patients, there were 0.6 more patients surviving than were expected to.

Summary of findings

- The median time for a patient with a head injury to wait for a CT scan was 1hour 37minutes. The national median time was 55 minutes. This means that most patients waited longer for a scan at this hospital than at others.
- The percentage of patients with a cardiothoracic injury being seen by a consultant was 68.7%. This is better than the national figure of 67.2%.
- TARN data showed that the number of patients being seen by a consultant within 5 minutes of arrival at the department had improved. For trauma patients, this had increased from 38% to 100% and for general patients, from 5% to 6%.
- The department had an action plan in place in response to issues raised by TARN audits. It was reviewed regularly and progress was monitored.
- The Rotherham NHS Foundation Trust performed similarly to the England and Wales average for the two measures included from the National Paediatric Diabetes Audit 2014/15.
- The readmission rates within two days of discharge for paediatrics were better than the England average, but worse for general surgery for patients aged between 1 and 17.
- The multiple readmission rates for asthma for this trust for aged 1 to 17 were better than the England average.
- The SCBU participated in the national neonatal audit programme (NNAP). Results for 2015 showed that 94% of eligible babies were screened on time for retinopathy of prematurity (ROP). However, the proportion of eligible babies receiving any mother's milk available at final discharge was 32%; this was significantly worse than the England average of 60% for this standard.
- The SCBU reported to BadgerNet; this is a national perinatal reporting system. The clinical audit action plan showed data quality and completion of documentation on this system had been audited in March 2016.
- The neonatal service on the SCBU was compliant with all 10 nationally audited neonatal CQUINS outcomes; the neonatal lead consultant oversaw this.
- The End of Life Care Audit – Dying in Hospital 2016, showed the trust scored above or in line with the England average for three out of the five clinical key performance indicators. However, they did not achieve five out of the eight organisational quality indicators. These were around the training in communication skills for staff, collection of feedback from bereaved relatives, the presence of an end of life care facilitator and a lay member on the board with a responsibility for end of life care. The service developed an action plan following the audit. We saw evidence of some of the actions in place during our inspection.

Summary of findings

Multidisciplinary working

- There was evidence of good multidisciplinary working across many services including maternity services and the emergency department. Within the emergency department, a number of different teams attended the department to see patients with conditions such as dementia, mental health needs, substance misuse or requiring a bed on a ward.
- Daily multidisciplinary ward rounds took place on the critical care unit led by a consultant intensivist where patients' conditions were discussed and treatment plans were agreed by the team.
- We saw good examples of multidisciplinary team working within the community teams. The Health Village locality team were the pilot site to test a new model of care involving a system wide approach. This involved a multidisciplinary team of GPs, a community physician, community matrons, district nursing, mental health professionals, therapists, social care workers and the voluntary sector. All agencies were co-located in the same building in order to promote integrated working. A multidisciplinary team meeting was held every week. Staff told us communication between professional groups had improved as a result of the pilot.
- Community matrons worked closely with GPs to care for patients with long term conditions in their own homes in order to prevent hospital admissions.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We were concerned that DNACPR decisions were not always obtained or documented in line with national guidance and legislation, for example the Human Rights Act and Equality Act.
- Staff we spoke with on the wards demonstrated some awareness of mental capacity, however, they did not complete capacity assessments. They told us they would speak to the nurse in charge or the safeguarding team if they had concerns about a patient's capacity.
- Following our inspection in 2015, the trust developed an action plan, but we found some of the actions related to DNACPR had not been completed. For example, changes had been made to medical documentation to prompt staff to consider mental capacity and DNACPR status daily. In the records we reviewed where a DNACPR form was in place, staff had not completed these prompts.
- DNACPRs were not completed fully in 32 out of 48 cases across acute and community services. We reviewed 30 DNACPR forms during the announced inspection across nine hospital wards

Summary of findings

(medical and surgical) and found that 20 of the forms had not been completed in line with the trust policy. Of these 20 forms, five DNACPR decisions had not been discussed with the patient. It was clear on two of these forms that the patient had the capacity to make the decision.

- Twelve of the 20 DNACPR forms stated the patient did not have capacity to make the decision. However, there was no evidence on the form or in the patient record that staff had completed a capacity assessment on the patient.
- DNACPR forms and mental capacity assessments were appropriately completed at BreathingSpace and in the community settings.
- However, we also reviewed 12 DNACPR forms at Oakwood Community Unit during the announced and unannounced inspection. In all 12 patients it was identified that they did not have capacity to understand the decision made for DNACPR. In 11 of the forms and medical records there was evidence that discussion had taken place with family members regarding the DNACPR decision, although one had documented they had discussed the decision partially. In ten of the records, no assessment for mental capacity had been completed.
- We raised our concerns with the trust at the time of the inspection. The trust informed us of action they would take to improve compliance.
- On our unannounced inspection, we reviewed seven DNACPR forms and found that five of the forms had been completed in line with trust policy and national guidance.

Are services at this trust caring?

At our previous inspection in February 2015, we rated services as good for caring. As part of this inspection, we checked caring in urgent and emergency services, medical care, maternity and gynaecology, children and young people's services in the hospital and the community, community inpatients and community end of life care. We found:

- Feedback from patients and relatives was positive about the care they received.
- National survey results indicated that patients felt involved in decisions about care and received emotional support.
- We saw numerous examples of compassionate care being provided throughout the inspection.
- We saw examples of outstanding compassionate care within the community inpatient facilities. All staff were very responsive to the psychological needs, not only of patients but also those close to them.

Summary of findings

Compassionate care

- All indicators in the CQC inpatient survey for 2015, showed the trust was about the same as other trusts. All scores had either slightly increased (improved) or stayed the same from the 2014 results.
- CQC's Survey of Women's Experiences of Maternity Services 2015, showed results similar to other trusts for 15 out of 16 indicators; the other indicator was better than other trusts (skin to skin contact with baby shortly after the birth).
- The National Cancer Patient Experience Survey for 2015 found the trust scored better than expected for four questions and within expectations for all other questions.
- Results from the 2014 A&E survey showed that the trust scored about the same as other similar trusts when patients were asked if they felt they were treated with respect and dignity in the department.
- Friends and family test data from June 2015 to May 2016 showed the percentage of people recommending the trust was consistently above the England average of 96%.
- Friends and Family maternity test results from June 2015 to May 2016 showed the percentage of people recommending the hospital was consistently above the England average.
- The patient-led assessments of care (PLACE) results for 2015 showed that scores for privacy, dignity and wellbeing at the trust had decreased since 2014 to 76%, which was below the England average of 86%.
- We saw examples of outstanding compassionate care within the community inpatient facilities. All staff were very responsive to the psychological needs, not only of patients but also those close to them. We saw that numerous activities were arranged to prevent social isolation including themed monthly tea parties, bingo, board games, singing, art and crafts.
- We observed a number of staff and patient or carer interactions during our inspection. We observed consistently caring and compassionate staff.

Understanding and involvement of patients and those close to them

- CQC's Survey of Women's Experiences of Maternity Services 2015, showed results similar to other trusts for questions relating to involvement in decisions about care.
- According to the 2014 A&E Survey, the department scored about the same as other trusts for questions relating to understanding and involvement apart from being informed of danger signals to look for after going home. The trust performed worse than other trusts for this question.

Summary of findings

- The trust scored about the same as other trusts in the inpatient survey (2015) for being involved as much as they wanted to be in decisions about their care and treatment and for being given enough information on their condition and treatment.

Emotional support

- The trust scored about the same as other trusts in the inpatient survey (2015) for receiving **enough emotional support**, from hospital staff, if needed.
- The National Cancer Patient Experience Survey for 2015 found 62% of patients were given enough support from health or social services after treatment; this was better than the national average of 45%.
- Bereavement support was offered to all women who had experienced a pregnancy loss. This included women who suffered early pregnancy loss on the gynaecology ward. Memory boxes were offered to women who experienced pregnancy loss. This included a handmade knitted blanket, that was described as 'angel wings.'

Are services at this trust responsive?

At our previous inspection in February 2015, we told the trust to make improvements to the responsiveness of their urgent and emergency services, medical care, surgery, maternity and gynaecology and children and young people's services. We also told the trust to make improvements to their children, young people and families, inpatients and end of life care services in the community. They developed an action plan. At this focused follow-up inspection, we made checks to review improvements to these services.

At this inspection, we found:

- The trust had taken action on the issues raised in the 2015 inspection. For example, the management of medical outliers was in line with trust policy, there had been no mixed sex accommodation breaches and access and flow had improved in fracture clinic.
- The trust's surgical referral to treatment performance was better than the England average between June 2015 and May 2016.
- Referral to treatment time for medical specialties had been better than the England average until November 2015. Since then it had fluctuated between being better and worse than the England average.
- Cancelled operations had been lower than the national average for the last two years.

Summary of findings

- There had been improvements since the last inspection to the access and flow within the maternity unit.
- The trust had consulted widely with the local population and other stakeholders to plan services for the future, including in the building of the new Emergency Care Centre.
- There were systems in place to support patients with additional needs, such as interpreters.

However:

- The trust had not met waiting time targets within urgent and emergency care between May 2015 and June 2016, including the median time to treatment target, the 95% four hour target, the re-attendance target and the ambulance handover standard.
- There were long waits for treatment following first appointments in speech and language therapy. This had been highlighted at our previous inspection.
- The children's, young people and families service was not meeting the needs of looked after children and there were delays in child protection information being available to staff.

Service planning and delivery to meet the needs of local people

- The trust provided acute and community services. Community services became part of the trust in 2011.
- The trust engaged with internal and external stakeholders, patients, governors, members, partners and staff to plan services. The local clinical commissioning groups commissioned services within the trust.
- The trust had worked in partnership with key stakeholders, including the voluntary sector and social care, to develop and pilot a new model of care involving a system wide approach.
- The trust had consulted widely with the local population and other stakeholders to plan services for the future, including in the building of the new Emergency Care Centre as part of the Urgent and Emergency Care Transformation Programme.
- Since the last inspection, there had been significant improvements to the service delivery, for example, of inpatient children's services. For example, the children's assessment unit and ward had closed beds in order to meet the nationally recommended staff to patient ratios. This meant patients experienced better care and treatment from staff, particularly nursing staff.

Meeting people's individual needs

Summary of findings

- There was a system, on the electronic patient record, to identify patients with learning disability needs, which flagged if patients were known to the system.
- The trust had a lead nurse for learning disability. Staff spoke positively about the support provided.
- Staff told us they talked to patients and families about the pathway of care and took into account the patients' ability to make decisions and their view about their capabilities and individual needs in relation to discharge. Staff provided examples of reasonable adjustments made for patients with learning disabilities, such as allowing additional time.
- There was no formal auditing in place of the care received by patients with learning disabilities.
- The trust provided an interpreting service to support the communication needs of people who are non-English speakers, people for whom English is a second language, and people who are deaf.
- Spoken translation services were available by telephone and face to face translation. Document translation was also available. Most staff were aware of these services and gave examples of when they had been used. However, staff in some medical ward areas were unclear regarding the use of the interpreters.
- Interpreter bookings could be made either by telephone or online 24 hours/day. The fulfilment rate for interpretation service requests was reported as 99% at the time of inspection.
- We saw a wide range of information leaflets were available to patients on all of the wards. However, patient information was not routinely provided in a range of languages, for example, in children's community services.
- The trust had a multi-faith chaplaincy team that offered spiritual care to patients and their carers. There was ongoing recruitment to the team to enable a 24 hour service to be sustained.

Dementia

- There was a flagging system, on the electronic patient record, to identify patients living with dementia. This was monitored by the trust's dementia lead nurse.
- Staff were aware of the trust's lead nurse for dementia and of the dementia inpatient care pathway. This included prompts for staff to initiate a 'this is me' document to ensure person centred care. We saw these were completed appropriately.
- A dementia strategy was in place for 2014 -2017.
- The trust had introduced open visiting hours for the primary carer of patients with dementia and gave them the opportunity

Summary of findings

to visit 24 hours a day and stay with the person they care for. A 'Forget Me Not Carers Passport' (which removed restrictions on visiting hours and enabled assistance for families from the carer's resilience service) was in use in some areas and being rolled out to other wards.

- There were ward link nurses for dementia, who received additional training, to help support staff meet the needs of individuals living with dementia.
- We observed nurses giving patients very clear information in a way they could understand.
- We saw areas of the trust, such as AMU, Ward A2 and A5 were dementia friendly with coloured bays, day clocks, dementia friendly signage and toilets.

Access and flow

- The trust had not met waiting time targets within urgent and emergency care between May 2015 and June 2016, including the median time to treatment target, the 95% four hour target, the re-attendance target and the ambulance handover standard.
- The trust's surgical referral to treatment performance was better than the England average between June 2015 and May 2016.
- Referral to treatment time for medical specialties had been better than the England average until November 2015. Since then it had fluctuated between being better and worse than the England average.
- Cancelled operations had been lower than the national average for the last two years. The percentage of patients whose operation was cancelled and then were not treated within 28 days had been consistently been lower (better) than the national average for the last two years.
- Bed occupancy had been consistently above the England average throughout 2015/16.
- There were long waits for treatment following first appointments in speech and language therapy. This had been highlighted at our previous inspection.
- Concerns with the waiting list management system in 2015 had been addressed. However, the trust had identified further concerns with the waiting list management system in 2016 and declared another serious incident in relation to 13,195 patients that may have needed a follow up appointment or investigation who were not visible on a waiting list. The management team explained this had occurred due to staff entering the wrong outcome following a clinic. A full

Summary of findings

investigation had taken place, no patient harm had occurred as a result of the incident and staff had undergone further training. The management team recorded the incident on the division's risk register and we saw evidence of a review of the risk and the mitigation and controls that were in place.

- There had been improvements since the last inspection to the access and flow within the maternity unit. At the previous inspection, we found that there was a high number of women who remained in the maternity unit for 'social services reasons.' This had been addressed and there had been no delayed discharges for these reasons since August 2015.
- The surgical and gynaecology ward frequently had medical patients outlying on the wards.
- For gynaecology patients admitted to hospital, referral to treatment within 18 weeks was 80% in June 2016. This was below the 92% standard.
- The looked after children service had a target to carry out health assessment within 20 days of referrals being made. At the time there was 0% compliance with this target. Staff told us that delays in referrals were impacting on the target. The service was working with the local council to address this issue and a task and finish group had been set up to address the issues.

Learning from complaints and concerns

- The trust had an up to date policy for the management of compliments, comments, concerns and complaints. The trust complaints policy required complaints to be acknowledged within three working days and responses to complaints to be made with 25 working days or 40 working days, if the complaint was complex. It was noted that the timeframe of 25 days differed from the 30 days used by the trust patient experience team. This had also been identified in an internal audit.
- At our previous inspection in 2015, there had been a backlog in responding to complaints.
- In January 2015, we found that 33% of complaints were dealt with within 25 days, against a trust target of 95%. At this inspection, whilst we found that the position had improved and in July 2016, 58% of responses were provided within the revised 30 day timeframe, there was further work to do. An improvement plan remained in place.
- During the inspection, we reviewed five complaint responses and found these to be clear and appropriate to the complaints raised. We noted there was delay in the response being sent to

Summary of findings

one complainant due to number of reviews required to ensure the response was appropriate. The trust acknowledged the quality of the responses was an area of development and this had been identified through the quality assurance stage.

- The patient experience team had undertaken a survey of satisfaction with the complaints process. Between August 2015 and July 2016, a total of 306 questionnaires were sent out with 40 (13%) returned. This showed 52% found the complaints process helpful and were satisfied or very satisfied, however 28% were not satisfied.
- Patients were offered meetings to discuss their complaint. Recordings of the meetings were also offered to complainants.
- The Board received a monthly quality report, which included the number of complaints received. A quarterly complaints report was provided to the Clinical Governance Committee.
- The Complaints, Claims & Incidents Review (CCI) Group a sub-group of the Clinical Governance Committee met monthly to identify thematic learning. Complaints were also monitored at performance meetings.
- We saw evidence of lessons learned and changes to practice as a result of complaints.
- Complaints were a standing item on divisional governance meetings agendas, but were not always discussed.
- An internal audit on the identification, reporting, management and learning from complaints had been undertaken in July 2016 and found reasonable assurance.

Are services at this trust well-led?

At our previous inspection in February 2015, we told the trust to make improvements to well-led in urgent and emergency care, medical care, critical care, maternity and gynaecology and children and young people's services. We also told the trust to make improvements to their adult, children, young people and families, inpatients and end of life care services in the community. They developed an action plan. At this focused follow-up inspection, we made checks to review improvements to these services.

At this inspection, we rated the overall key question of well-led for The Rotherham NHS Foundation Trust based on the findings at this inspection. We rated well-led as requires improvement because:

- We were not assured of the effectiveness of the governance arrangements that were in place
- We had some concern that some divisional and consequently the corporate risk register did not include some of the key risks identified at inspection.

Requires improvement



Summary of findings

- Staff engagement remained both a challenge and a key priority for the trust's executive team. It was recognised this was a key factor in improving the quality of services. However, engagement was still limited in some areas and staff, particularly in some community services, felt disconnected.
- Although there had been improvements since the previous inspection in February 2015, there was insufficient progress in some areas, such as Mental Capacity Act implementation and the standard of DNACPRs.
- Further development of work around workforce, race and equality standards (WRES) was needed. The trust recognised this.

However:

- There was a clear vision for the future of integrated medical services, which was a part of the 'Community Perfect Locality' project.
- The rate of staff appraisal had significantly improved from the inspection in 2015.
- We saw evidence of improvements made in many of the areas highlighted at the previous inspection.

Leadership of the trust

- The trust board had maintained some stability since our previous inspection. The Chief Executive had been in post for over two years. There had been a period of interim medical leadership, however, a permanent Medical Director had been appointed in July 2015. Staff confirmed during the inspection that they felt there was now a more stable leadership team in place.
- The trust had a unitary board with attendance from the directors of clinical services at board meetings. A trust board development programme was in place. The trust was led through five clinical divisions. A division of Emergency Care had been established since our previous inspection. This was in recognition of the leadership required as part of the transformation to the Emergency Care Centre in 2017.
- Each division was led by a General Manager with the support of a Divisional Director and Head of Nursing.
- The leadership teams in the divisions were not all aware of the services' own self-assessment ratings provided to us prior to our inspection. The ratings had been completed by the trust executive team based on the services quarterly self-assessment of compliance.

Summary of findings

- The NHS staff survey (2015) found recognition and being valued by managers and the organisation, support from immediate line managers and the percentage reporting good communication between senior management and staff were all worse the national average.
- The rate of staff appraisal had significantly improved. At March 2016, 78.4% of staff had received an annual appraisal against a trust target of 90%; this had increased from 63.9% the previous year and 22.1% the year before.
- The staff sickness absence rate had reduced, but was above the England average at around 4.3%.
- The GMC 2015 survey showed that all measures were as expected. We found senior doctors were not always resident on site to support junior doctors and advanced nurse practitioners out of hours. A Hospital at Night team was being introduced which should address this.
- There was evidence of good engagement with external stakeholders including the local Clinical Commissioning Group.

Vision and strategy

- The trust had a clear vision and strategic objectives. At the time of the inspection, a consultation was occurring with staff as part of refreshing the values. As part of this, steps had been undertaken by the executive team to engage with staff, including meetings, stands, questionnaires and values week. However, we found some staff were not aware of this.
- A five-year clinical strategy was being revised led by the Medical Director. It was anticipated this would be ready for approval in late 2016.
- The trust was actively engaged in the sustainability and transformation plan (STP) for the region.
- The Board of Directors was supported by a Clinical Transformation Group which was formed in January 2016. This was overseeing assessments and developments of likely future service configurations including the impact of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP).
- Service business plans for 2016/17 were in place within the divisions. However, there was inconsistency across the services regarding the quality of the plans. For example, in medicine the business plan included clear service vision and key priorities; in children's services the business plan lacked detail and key priorities were not clearly defined. Trust directors recognised the planning process needed to improve and were working to achieve this.

Summary of findings

- Community end of life services were not meeting their five-year strategy targets.
- There was a clear vision for the future of integrated medical services, which was a part of the 'Community Perfect Locality' project. It was based around local teams from health and social care working together in the community to provide care closer to, or at home and patients who require hospital care spending no longer than required in hospital. A pilot of the integrated locality model commenced in the Health Village locality in July 2016 and it was anticipated that roll out of an integrated community locality model would be introduced by the end of 2017.

Governance, risk management and quality measurement

- There was a Board Assurance Framework (BAF) in place which was reviewed quarterly by the Board. We reviewed the BAF from July 2016 and saw this detailed the risks, detailed priorities and key deliverables and identified the lead Executive Directors. The BAF was linked to the strategic objectives.
- There was a committee structure to provide assurance to the Board. Eight operational committees provided assurance to six Board committees. The key assurance committees included the Quality Assurance Committee, Audit Committee, Finance and Performance Committee and the Strategic Workforce Committee.
- All operational committees reported to the Trust Management Committee. Reports, for example, business cases for investment, were reviewed by the Trust Management Committee prior to their presentation to the Board of Directors for approval to ensure the appropriate consultation and involvement from all senior managers.
- We reviewed the corporate risk register which detailed the highest risks to the trust. This was reported to the Board quarterly and documented the actual risk, control measures, target risk ratings and the relevant assurance committee for each risk.
- In response to the CQC inspection in February 2015, an action plan had been developed and progress against the actions had been monitored by the Board. We saw evidence of considerable improvements made in many of the areas highlighted at the previous inspection. However, however there was still insufficient progress in some areas, such as Mental Capacity Act implementation and the quality and consistency of DNACPRs.
- A weekly serious incident panel had been introduced in March 2016. This was attended by a clinical member of the executive team and reported to the clinical governance committee.

Summary of findings

- A weekly harm meeting was also in place, which reviewed incidents and complaints from the previous week.
- Divisional clinical governance meetings were in place and standardised agendas were in use to ensure consistency. The Clinical Directors and Heads of Nursing were members of the trust's Clinical Governance Committee, which provided assurance to the Trust Management Committee.
- Each clinical division of the trust had a governance lead; these posts had been introduced in March 2015 to support the clinical governance agenda.
- We were not assured that the key risks were captured on the divisional risk registers and would not therefore be escalated to the corporate risk register. For example, although action was being taken to investigate and review the incidents of maternal deaths to enable learning and support safe practice, this was not identified on risk registers. A backlog of incidents, with 94 overdue a review and investigation at the time of the inspection in maternity services, was also not recorded on a risk register.
- Senior managers and directors recognised the need to strengthen clinical engagement in the governance agenda. A review of ward to board governance arrangements was planned.
- Senior managers and clinical leaders had attended an externally-led training session on risk management and the use of risk registers in the NHS in June 2016.
- Cost improvement programmes and business cases were reviewed by the Quality Assurance Committee to be assured of any quality impact.
- Each division had an integrated performance report. Divisional performance meetings were held monthly with a panel of the trust executives. These reviewed the quality, finance, governance and workforce performance.

Culture within the trust

- The 2015 NHS staff survey had 20 findings worse than the national average, eight positive findings and four in line with the national average. However, the findings had stayed the same or improved, with the exception of one finding, from the 2014 survey.
- The percentage of staff reporting most recent experience of harassment, bullying or abuse was worse than the national average and had deteriorated, with a statistically significant negative change, from the 2014 staff survey results.
- However, most staff we spoke with reported an increasingly open culture. In most areas, staff told us the culture had improved, although some staff did report otherwise.

Summary of findings

- Trust managers were aware of the obligations in relation to the Duty of Candour requirements. The legal Duty of Candour requires the trust to disclose openly events that have led to moderate, major or catastrophic harm to a patient.
- Training had been provided to governance leads. A review of training regarding Duty of Candour was planned.
- An audit of the incident reporting system to check compliance with the Duty of Candour was reported to the board in July 2016. This showed the duty had been applied in over 95% of instances where moderate to severe harm had occurred. Further audit work was planned and an external audit undertaken by the trust's internal auditors of duty of candour compliance had also been commissioned by the Audit Committee.

Equalities and Diversity – including Workforce Race Equality Standard

- There was an Equality and Diversity steering group that had been established in 2014.
- The trust recognised further development around workforce, race and equality standards (WRES) was needed. The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation.
- The WRES report and strategy went to the board in July 2016. This identified that the overall BME representation in the workforce had decreased slightly to 6.7%. It also identified there was a gap in representation of BME staff at band 7 and above for non-clinical staff, although the trust had 22% BME representation at a clinical very senior manager level. There had been an increase in the reporting of harassment from BME staff groups and the relative likelihood of BME staff being managed through a disciplinary process had decreased to 1.3. It was recognised the trust had no BME representation at board level (voting members only) and although BME representation was low in the trust, the population of Rotherham was 91.9% white British, which was significantly higher in comparison to the figure across England of 79.8%.
- Further analysis was planned to identify appropriate actions. This was to be overseen by the Equality and Diversity Steering Group.
- There was no established BME group at the trust.

Fit and Proper Persons

Summary of findings

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had procedures in place for the Fit and Proper Person that were discussed by the Trust Board in October 2014.
- The procedures covered all executive and non-executive directors and all directors.
- We reviewed the personnel files of all the executive directors and six non-executive directors. We were satisfied that all the relevant checks and information was available to meet the FPPR.
- There was an annual declaration of ongoing compliance and clear procedures and checks for new applicants.

Public engagement

- There was a patient experience strategy developed in 2014, although it was recognised this needed to be updated. It was due for a review in 2017.
- A patient experience team, comprising of five staff, was in place whose remit included all elements of patient experience including complaints and bereavement. Managers recognised this was small team for the size of their portfolio.
- There was evidence of some public engagement. For example, the trust had consulted with the public and local stakeholders about the building and configuration of the new ED, the school nursing service had attended a local youth forum that discussed adolescent mental health services and staff on the discharge lounge (transfer of care team) actively sought patient feedback by ringing six patients a week (three simple discharges and three complex). They collated the feedback and acted upon it.
- A trust public engagement meeting was organised in June 2016, but was not attended by any members of the public.
- A patient story was presented at each Board meeting.

Staff engagement

- Staff engagement remained both a challenge and a key priority for the trust's executive team. It was recognised this was a key factor in improving the quality of services. However, engagement was still limited in some areas. For example, consultants had been invited to a consultation event on developing the clinical strategy, but there had been limited participation and there was limited attendance by Clinical Directors at clinical governance committees.

Summary of findings

- The trust used Listening into Action (LiA) to aid engagement with staff. There was a dedicated lead for LiA. We saw this was used and had resulted in changes such as the redesign of domestic services to free up nurses time.
- The NHS staff survey (2015) found the trust's engagement score of 3.64 was below (worse than) average (3.79) when compared with trusts of a similar type. However, the engagement score had increased from 3.55 in 2014.
- The staff survey results had been reviewed. We saw that there had been scrutiny of areas of concern and reflection on how to engage staff in addressing and feeding back progress. Action plans were developed including the use of listening into action.
- The trust governors met regularly with the Chief Executive and Chair of the trust and felt engaged with the trust.
- The trust had established 'Proud' awards to recognise good practice. The Chairman visited each 'Proud' award winner in their work location.
- There was a system of cascade for a trust team brief. Staff could contact the Chief Executive directly using a 'Dear Louise' email address and there was a weekly Chief Executive message circulated to all staff.
- Board assurance visits had been introduced. These were undertaken every month including in the community and formally reported.

Innovation, improvement and sustainability

- A pilot of the integrated locality model commenced in the Health Village locality in July 2016 as part of the vision to provide care closer to home.
- A Sepia portal had been developed and was being rolled out at the trust. This enabled staff across community services and hospital teams to access patient information from the various electronic systems in use at the trust and supported communication between teams.
- Staff had been trained and used acupins to reduce nausea and vomiting and reduce length of stay in hospital.
- Events such as a 'Day to Celebrate' were organised to share innovation and improvements being led by nurses, midwives and allied health professionals.
- The trust had introduced 'Pride Makers' who modelled the trust values and behaviours.
- The Rotherham NHS Foundation Trust was one of seven hospitals that was part of the 'working together' partnership to share best practice and improve patient care. This became an acute care collaborative vanguard project in November 2015.

Overview of ratings

Our ratings for Rotherham General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	N/A	N/A	Good	N/A	N/A
Critical care	Good	Good	N/A	N/A	Requires improvement	N/A
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	N/A	Requires improvement	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	Good	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Our ratings for The Rotherham NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	Requires improvement	N/A

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Requires improvement	N/A	N/A	Requires improvement	N/A
Community health services for children, young people and families	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community health inpatient services	Good	Good	Outstanding 	Good	Good	Good
Community End of Life Care services	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. We previously inspected The Rotherham NHS Foundation Trust in February 2015 and rated it as requires improvement overall. At this inspection, we rated services that had previously been rated as requires improvement.
3. At this inspection, we rated the overall key question of well-led for The Rotherham NHS Foundation Trust based on the findings of this inspection.
4. We did not review the other overall ratings for the trust as the inspection was focused on specific areas only.

Outstanding practice and areas for improvement

Outstanding practice

- The trust was piloting a new community model of care called the perfect locality. This multi-agency/multidisciplinary team approach focused on implementing measures to avoid hospital admissions and facilitate safe discharge of patients already in hospital.
- BreathingSpace remains the only entirely nurse-led model of care for respiratory in and outpatients in Europe. We found that the culture, care and philosophy of the unit was outstanding.
- The activities coordinator at Oakwood Community Unit had been employed by the trust and had developed a range of activities including arts and craft, bingo, board games and a monthly themed tea party.
- The trust staff had direct access to electronic information held by community services through the SEPIA portal, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines and community services involvement in their care.
- Safeguarding and liaison had a daily meeting with the Emergency Department to identify any safeguarding issues and concerns.
- All patients with mental health needs admitted to the children's ward were reviewed by the CAMHS liaison team/nurse within 24 hours of admission and were followed up after seven days.
- Staff had successfully offered the use of acupins for the relief of nausea, particularly in gynaecology services.

Areas for improvement

Action the trust MUST take to improve Urgent and emergency care

- Ensure there are sufficient numbers of suitable qualified, competent and skilled staff deployed in the department.
- Ensure all staff are aware of their responsibility to report incidents and ensure learning is shared with all relevant staff.

Medicine

- Continue to take action to ensure there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Ensure all relevant staff have received appropriate training and development. This should include, mental capacity, safeguarding adults and children, resuscitation and dementia awareness.
- Ensure all staff have an annual appraisal.
- Mental capacity assessments and discussions must be clearly documented in patient records.

Critical care

- Ensure risks are assessed, monitored and managed in a timely manner to ensure safety.

- Ensure patients' individual records are held securely on the unit.

Maternity

- Complete the reviews of maternal and neonatal deaths and implement any further identified actions to support safe practice.
- Ensure that identified risks recognised and recorded on the risk register.
- Ensure that incidents are reviewed and investigated in a timely manner.
- Ensure staff have access to safeguarding supervision and support.

Services for children and young people

- Ensure the policies and procedures for the management of the children's and young people's service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure children and young people's service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

End of life care

Outstanding practice and areas for improvement

- Ensure all “do not attempt cardio-pulmonary resuscitation” (DNACPR) decisions are always documented in line with national guidance and legislation.
- Ensure there is evidence that patients’ capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

Community adults

- Must ensure that there are robust local safe systems in place to keep community staff who are lone working safe, in line with trust policy.
- Must ensure community staff are working in accordance with the Mental Capacity Act code of practice (2005).
- Must ensure that all risks for community services are included on the directorate risk register and where control measures are identified to mitigate risks, managers have assurance that control measure are effectively in place.

Community end of life care

- Ensure that all DNACPR forms are completed appropriately and accurately ensuring that mental capacity assessments are completed for patients where it has been assessed they lack capacity.

Community inpatients

- Ensure that consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005 for patients who lack capacity. The provider must also ensure that staff are

trained to enable them to recognise when patients need support to make decisions and, where appropriate, their mental capacity is assessed and recorded.

Community children, young people and families.

- Ensure incidents are appropriately categorised, graded and investigated.
- Ensure that there are sufficient suitably qualified, skilled and experienced staff in the school nursing service to meet the needs of the local population.
- Ensure the policies and procedures for the management of the children’s and young people’s service are up-to-date, regularly reviewed, document controlled and readily accessible to staff.
- Ensure that a regular and effective clinical audit schedule is developed.
- Ensure that steps are taken to increase performance against waiting time targets for therapy services and the child development centre.
- Ensure that it improves the number of looked after children assessments carried out within the target timescale.
- Ensure children and young people’s service risk register reflect current risks, contains appropriate mitigating actions, is monitored and reviewed at appropriate intervals and acted upon.

Trust-wide

- Ensure there are sufficient numbers of suitable qualified, competent and skilled staff deployed in the pharmacy department.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

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

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Need for consent

How the regulation was not being met:

DNACPRs were not completed fully in 32 out of 48 cases across acute and community services. Documentation to prompt staff to consider mental capacity and DNACPR status daily was not completed.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

How the regulation was not being met:

There was a backlog of incident reports overdue a review or investigation within maternity services. Serious incidents and never events regarding medicines were not identified in a timely manner to enable learning.

There were policies and procedures, including for the management of the children's and young people's service, overdue for review.

Risk registers in children's services, maternity services and critical care did not reflect current risks, did not contain appropriate mitigating actions, and were not reviewed at appropriate intervals and always acted upon.

This section is primarily information for the provider

Requirement notices

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014

Staffing

How the regulation was not being met:

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff in the Emergency Department, medical wards and specialities and pharmacy.