South Tees Hospitals NHS Foundation Trust

Inspection report

The James Cook University Hospital
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Date of inspection visit: 8th, 9th, 10th and 17th November 2022 and 10th January 2023
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Ratings

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

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Overall summary

South Tees NHS Foundation Trust provides acute and community health services to a population of around 1.5 million people living in Middlesbrough, Northallerton and surrounding areas. There are two main hospital sites, The James Cook University Hospital, a regional major trauma centre and tertiary hospital offering a wide range of specialist services, and Friarage Hospital, a busy acute hospital serving a mainly rural population of 135,000. The trust also operates from several primary care hospitals and community locations.

The trust provides urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children and young people's services, end of life and outpatient services alongside a range of community services delivered in people's homes and local community settings.

Our findings

We carried out this unannounced inspection of four of the acute services provided by this trust to check that the trust had made improvements since our last inspection in February 2022. We looked at all key lines of enquiry in the core services we inspected. We checked that the trust had taken action to comply with the Warning Notice we served under Section 29A of the Health and Social Care Act following the last inspection which told the trust to make significant improvements in the quality of healthcare provided.

We inspected urgent and emergency care and critical care services at The James Cook University Hospital, and medical wards (including services for older people) and surgery at both The James Cook University Hospital and Friarage Hospital. We also inspected the well-led key question for the trust overall.

We did not inspect end of life care, maternity, gynaecology, services for children and young people, outpatients, diagnostics, or community services at this trust during this inspection. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Our rating of services improved. We rated them as good because:

Overall, we rated safe, effective, caring, responsive and well led as good. The trust had made significant improvement since the last CQC inspection and throughout the pandemic, particularly in critical care.

We rated emergency and urgent care services as good. We rated safe, effective, caring and well-led as good. We rated responsive as requires improvement.

We rated medical care as requires improvement. We rated safe and effective as requires improvement and rated caring responsive and well-led as good at both hospitals.

We rated surgery as good overall at both hospital sites. We rated safe, effective, caring, responsive and well-led as good at both hospital sites.

We rated critical care as good overall and in all domains. The safe domain had improved significantly since our last inspection.

In rating the trust, we took into account the current ratings of the five services we did not inspect at this time.

What we found

Leaders had the skills and abilities to run the service. They understood the priorities and issues that the trust faced and had plans in place for these. They were visible and approachable in the trust and were well known to staff. They supported staff to develop their skills and take on more senior roles.

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

Leaders operated largely effective governance processes, throughout the service and with partner organisations, although there was more to do to strengthen this. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Our findings

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified risks had actions taken to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders and staff actively and openly engaged with patients and those closest to them, staff and the public to plan and manage services. They acknowledged that wider engagement with equality groups, the public and local organisations was needed. They collaborated with partner organisations to help improve services for patients.

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

However:

In medical care, there was not always enough nursing staff to care for patients and keep them safe.

In the emergency and urgent care service, there was no clear flagging system for risks associated with patients experiencing mental health crisis and people could not always access the service when they needed it and could experience long delays waiting for treatment.

The trust faced ongoing challenges with access and flow in the emergency department, which meant that they could not ensure people were able to access the department and receive the right care promptly. Despite these pressures, staff worked hard to keep patients safe.

Whilst the trust provided mandatory training in key skills, medical staff compliance was below the trust target.

Substances hazardous to health were not always stored securely in areas where there were vulnerable people.

How we carried out the inspection

The team that carried out the inspection included two inspection managers, 11 inspectors, one assistant inspector and an inspection planner. In addition, there was an executive reviewer plus three specialist advisors experienced in executive leadership of NHS trusts, including the CQC national professional advisor for ambulance services. The inspection team was overseen by Sarah Dronsfield, Deputy Director of Operations.

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

Outstanding practice

We found the following outstanding practice:

- To nurture a culture of compassionate leadership, the trust had developed a leadership, improvement and safety academy (LISA). This included human factors and civility training and education, leadership development with additional specific support as needed, and one to one externally mentored coaching support. The trust had presented nationally on the improvements made by putting civility first, including nationally significant improvements in their national staff survey data.

Our findings

- The introduction of the frailty team pilot in January 2022 had helped to play a role in addressing access and flow challenges within the emergency department, with 54% of patients reviewed by the team avoiding admission to hospital.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 10 legal requirements. This action related to three services.

Trust-wide

- The trust must implement effective systems and processes to ensure all medical staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. (Regulation 17(1)(2)(a)(b)).
- The trust should ensure staff always complete and record capacity assessments, best interest decisions and consent to care and treatment fully and in line with legislation and guidelines at James Cook University Hospital. (Regulation 13(1)(2)(5)).
- The trust must ensure substances hazardous to health are always stored securely, in accordance with Control of Substances Hazardous to Health Regulations 2002 and trust policy. (Regulation 12(1)(2)(a)(b)).

Emergency and urgent care services

- The service must ensure that all staff complete mandatory training and safeguarding training to meet the trust's set standard of 85%. (Regulation 12 (2) (c)).

Medical care

- The trust must implement effective systems and processes to ensure all medical staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. (Regulation 17(1)(2)(a)(b)).
- The trust must ensure robust control of infection risk, including but not limited to staff compliance with trust policy regarding use of personal protective equipment (PPE). (Regulation 12(1)(2)(h)).
- The trust must ensure substances hazardous to health are always stored securely, in accordance with Control of Substances Hazardous to Health Regulations 2002 and trust policy. (Regulation 12(1)(2)(a)(b)).
- The trust must ensure staff assess risks to patients, act on them and keep comprehensive, contemporaneous care records. (Regulation 12(1)(2)(a)(b) and Regulation 17(1)(2)(a)(b)(c)).
- The trust must continue to monitor nurse staffing and consider ways to ensure optimal nurse staffing levels are achieved. (Reg 18(1)(2)(a)(b)(c)).

Our findings

- The trust must ensure staff use systems and processes to safely prescribe, administer and record medicines, in accordance with trust policy. (Regulation 12(1)(2)(g)).
- The trust must ensure staff record mental capacity assessments and best interests decisions, in accordance with legislation and trust policy. (Regulation 13(1)(2)(5)).

Surgery

- The trust must ensure that pain relief is given to patients when they need it and there are no delays to prescribed pain relief being administered. (Regulation 12(2)(g)).

Critical Care

- The service must ensure and check that chemicals subject to COSHH rules are secured and stored in locked cupboards.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that every effort is made to ensure that information governance mandatory training reaches the trust target of 95%.
- The trust should ensure that yearly 'pen' tests for information security are conducted in line with schedule and actions appropriately implemented.
- The trust should complete its work on and publish a mental health strategy in consultation with appropriate stakeholders.

Emergency and urgent care services

- The trust should ensure that all patients have access to call bells.
- The trust should ensure that medical staff compliance with Mental Capacity Act training meets the trust target.
- The trust should ensure a more robust flagging system for risks associated with patients experiencing mental health crisis attending the department is in place.

Medical care

- The trust should consider ways to improve consistent use of labelling systems for cleaned clinical equipment at James Cook University Hospital.
- The trust should consider ways to improve provision of clinical supervision for nursing staff at Friarage Hospital.
- The trust should consider ways to improve compliance with trust complaint policy timeframes at both hospitals.

Surgery

- The trust should ensure there are enough staff to care for patients and keep them safe at James Cook University Hospital.
- The trust should ensure that all staff cleaning records and schedules are up to date and cleaning products are locked in cupboards as required at Friarage Hospital.

Our findings

- The trust should ensure staff training meets trust target for safeguarding.
- The trust should ensure staff always complete capacity assessments, best interest decisions and consent to care and treatment fully and in line with legislation and guidelines at James Cook University Hospital.

Critical care

- The service should improve compliance figures for medical staff to complete relevant safeguarding training.
- The service should work to increase the level of specialist pharmacy provision in critical care in line with GPICS recommendations.
- The service should ensure that registered nurses follow the correct IPC procedures when reconstituting medicines.
- The service should ensure that a minimum of 50% of registered nursing staff have a post registration award in critical care nursing in line with GPICS recommendations.
- Patients discharged from the critical care unit should have access to an intensive care follow up programme.
- The service should review its waiting and overnight provision and facilities for families and visitors to the unit to ensure it is meeting current need.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues that the trust faced and had plans in place for these. They were visible and approachable in the trust and were well known to staff. They supported staff to develop their skills and take on more senior roles.

At our previous inspection of the well-led key question for the trust overall in July 2019 we rated well led as requires improvement. This was because there was a lack of effective leadership capacity, a deterioration in staff engagement, and medical leadership in particular was not functioning well.

At this inspection we found a strong and focused executive leadership team, a re-engagement of staff and improved culture. The trust explained it had moved from a top down to a distributed leadership model. It had one of the most improved scores in the NHS staff survey in the country for the last two years, and an overhaul of the medical leadership model meant the organisation was more effectively clinically led. The trust had moved to a clinical collaboratives model, with 10 self-selected collaboratives feeding into a clinical policy group, which in turn fed directly to board. This maintained a prominent clinical voice while providing a stronger structure than at our previous inspection.

Plans for succession were in place for all key posts, and frontline staff working in wards and clinical areas spoke very positively about the visibility of senior leaders, with several having spoken to executive leaders on a number of occasions. In the core services inspected, we found that morale was not perfect, but significantly improved. In every observed interaction, staff were kind to each other, and their patients.

Local leadership at core service had improved. For example, in critical care and surgery we found leadership to be much improved despite significant challenges to the service during the pandemic.

Our findings

The chief pharmacist and pharmacy service was well embedded within the trust. A review of leadership within the department had been completed and new roles had been developed to further improve and strengthen the team. There was clear pharmacy workforce strategy and succession planning was in place. Pharmacy leadership could demonstrate how staff views were embraced and how this joined up working had led to service improvements.

The chief executive joined the trust in 2019 in an interim post, taking up the permanent position in 2020. They were supported by a managing director who joined the trust in 2020. The chief nurse, chief medical officer and chief finance officer had all been appointed to their posts since our last inspection in 2019 by the current chief executive. All directors were in substantive roles, and the current team had remained largely stable since our last inspection.

The chairman was in a joint role held with North Tees and Hartlepool NHS Foundation Trust, and had held this role since September 2021, having previously held a post as a professor of medicine at Imperial College London. Since our last inspection, four non-executive directors had been replaced due to planned moves. All had been replaced by new substantive non-executive directors, and the trust also had two newly appointed associate non-executive directors.

The board was functioning as a unitary board, and all members of the executive and non-executive teams were clear about their risks, priorities, and direction of travel. This was reflected in board meeting minutes. There was a structured board development programme for 2022/2023 aligned to the trust's strategic objectives, and board members also participated in board walkrounds including community sites.

Newer board members spoke positively about their full induction. All were allocated a more experienced mentor. Board to board away days with North Tees and Hartlepool NHS Foundation Trust were well received and we heard consistently across the course of our inspection that working together had continued to progress, and further closer collaboration was planned. Since our inspection, the trusts have agreed to a group model.

The board included two people from ethnic minority groups. The board had recruited one non-voting board director from an ethnic minority group in 2021/22 and, in September 2022, had recruited a voting non-executive director. The trust told us they were considering ways of improving board diversity, including recruiting to associate non-director roles, but acknowledged there was more work to do.

Fit and Proper Persons Requirement

We found that the trust's policy for fit and proper persons requirement was in date and met the requirements of the regulation. A copy was stored in each personnel file. We saw all files reviewed contained DBS certificates, issued within the previous three years. This was an improvement on our previous inspection when this was not routinely done. Both executive and non-executive directors completed annual self-declaration forms including directorships and conflicts of interest. A register of interests for all directors was displayed on the trust website. This page was last updated in April 2022.

We reviewed three director files including a mixture of non-executive and executive posts. We found they were consistent, well organised and contained an up to date front sheet ensuring all required information had been captured.

A paper presented in November 2022 provided assurance to the board that annual ongoing fitness checks had been completed.

Vision and Strategy

Our findings

The trust had developed a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At our last inspection of the well led domain, we found the trust was in the process of refreshing its strategy to align with the developing integrated care system. At this inspection, an overarching two year plan was in place. Leaders told us this was intentionally short, to enable them to remain responsive to the changing priorities and relationships in the developing local system. Work had started on the next iteration, in collaboration with staff and partners.

Strategic objectives for 2022/2023 had been discussed and signed off at board in September 2022.

The trust strategic plan included their mission, values and behaviours. These were clear, displayed around the trust and understood if not freely articulated by staff at core service level.

Underpinning the strategy were a number of other plans and strategies (clinical, quality and safety, digital, estates, people, financial, research and innovation, nursing and midwifery and communication and engagement). These were comprehensive and informed the trust strategic plan effectively. Progress against these plans and strategies was monitored by subcommittees in conjunction with the overall strategic plan.

The trust also had an improvement plan for 2022/2023 which supported the strategy documentation. A mid-point review examined the clinical strategy, how this was being delivered within the 10 clinical collaboratives, and how this linked with the trust's enabling strategies and assurance frameworks.

Each clinical collaborative had its own vision and objectives, produced in consultation with staff, and we saw that these fed neatly into the wider trust vision and strategy.

The trust did not have a mental health strategy and had identified this as a gap, and there was a plan in place to develop a strategy in collaboration with partners, staff and patients. The trust had appointed a person to the role of mental health lead for the organisation.

The trusts medicines strategy, vision and objectives were developed collaboratively between the pharmacy team as well as in consultation with the multidisciplinary team. The key medicines themes were in line with the overarching trust strategy and there was a clear assurance framework with key deliverables.

Culture

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

At our last inspection, we found that many staff told us about a 'top down' directive culture, and we saw declining staff survey results. Staff told us that morale and good will was waning and there was a lack of engagement with clinical staff.

During this inspection, we found a marked and clear change in direction, with staff working in core services we inspected now on the whole feeling supported and proud to work for the organisation and their team. Since our last visit, the majority of the executive team had changed, and the new team explained how they had made culture, alongside patient safety, their top priority to urgently address. The chief executive talked passionately about restoring

trust in leadership and investing a significant amount of time in personally visiting 104 departments and areas to listen to teams and using this feedback to begin to effect change. Executive and non-executive directors talked about the journey and distance travelled in terms of changing culture, and that they had come a long way, but there was more still to do.

The 2020 staff survey showed the trust as having the most improved scores in the country, and we saw evidence that this was celebrated and shared with staff. The 2021 survey saw another significant increase in the numbers of colleagues who felt patient care was the organisation's top priority and would recommend the organisation as a place to work. Question 21a 'care of patients / service users is my organisation's top priority' rose from 58.7% in 2019, to 74.4% in 2020, to 76% in 2021 against a national average of 75.5% that year. Question 21c 'I would recommend my organisation as a place to work' rose from 44.5% in 2019 to 59.2% in 2020 and 59.5% in 2021, above the national average of 58.4%. The trust had discussed these results at board and there was a 'staff survey action plan on a page' in place, monitored by the people committee.

The trust had four freedom to speak up (FTSU) guardians, who had a total of 75 hours per week protected time to carry out this role. This was a significant improvement on our last inspection when there were two guardians with no protected time. They met bi-monthly with the chief nurse and nominated non-executive to discuss any themes, trends and concerns. A FTSU report was received by the people committee and board quarterly. The freedom to speak up: raising concerns policy was newly reviewed and ratified.

FTSU guardians' work was supported by a network of 26 FTSU champions. The guardians spoke at staff induction days to introduce their work, and there were plans to incorporate FTSU into the trust's mandatory training by March 2023.

Staff could report any freedom to speak up concerns via a standalone confidential system, email, phone, or letter, and choose to be identified or remain anonymous. Reports to board showed a total of 106 concerns raised in 2021/2022, with quarterly totals consistently around the national average of 26 per quarter. Top themes were leadership and management, generally linked to incivility or poor communication, health and safety, patient safety and staffing / workload.

The FTSU team had used the national guardian's office self-reflection tool to audit their practices and this was presented to the people committee in September 2022. There were no significant risks identified, and an action plan formulated to address the other areas of concern. Areas of good practice included the model of access and the diversity of the team.

The FTSU team had recognised that people from ethnic minority groups were less likely to share their concerns using this route and had enrolled in a national pilot with the national guardian's office entitled 'supporting an inclusive speak up culture for black and minority ethnic people.'

The trust had a guardian for safer working (GFSW) who was supported by 1.5WTE administrator posts. Their role was to support junior doctors and ensure they were represented and concerns heard. There had been no fines issued to the trust in the last year, and no themes identified from exception reports. We heard examples of concerns brought to them, such as access to overnight phlebotomy cover, which had been addressed to the satisfaction of junior medical staff. They chaired the junior doctors forum, but were in the process of completing a standard operating procedure to move to a more independent chair. They were working nationally with NHS England on workforce planning. We saw that their report was discussed at board quarterly.

Our findings

The trust had six staff networks in place to support staff. The BAME, faith and LGBT+ networks had been operating since 2019, joined by the menopause and childless not by choice networks in 2021 and disability and long term health conditions networks in 2022. The equality, diversity and inclusion (EDI) workforce steering group received quarterly updates from the networks and items for escalation were a standing agenda item.

The trust had an equality in employment policy which was appropriate, ratified and in date. There were clear equality, diversity and inclusion (EDI) strategic objectives and actions and progress against these were monitored at the EDI workforce steering group and reported quarterly to the people committee. The annual EDI report was presented into both the EDI workforce steering group and people committee.

The workforce race equality standard (WRES) became mandatory for all NHS trusts in 2015 and trusts are required to show progress against 9 workforce indicators. The trust had improved in 5 of the 9 metrics in the last 12 months. There was an executive and non-executive lead for EDI. The trust was making good progress on EDI, having increased the number of staff from ethnic minority groups in the workforce, but there was more still to do, for example, there were gaps in representation of people from ethnic minority groups at grade 8a and above. A WRES action plan had clear dates for delivery and identified leads and was monitored through the people committee.

The trust's workforce disability equality standard data (WDES) was positive, with seven of the ten metrics showing improvement over the previous year. In 2021 the trust achieved a bronze better health at work award, achieved the menopause accreditation standard, and increased disability self-declaration rates.

A gender pay gap report published the annual gap, which showed a marginal improvement, but noted that there remained a disproportionate number of men in the most senior management roles. Progress in 2021/2022 included introducing coaching support for senior female medical staff and a task and finish group for flexible working. Actions were clearly defined, aligned with the EDI strategy and People plan.

Governance

Leaders operated largely effective governance processes, throughout the trust and with partner organisations, although there was more to do to strengthen this. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the services.

At our last inspection we noted that incident reporting was not consistent and there was limited thematic learning from incidents. There was a lack of capacity for clinical governance, leadership and management.

During this inspection, we found that incident reporting and learning from incidents was much improved, with incidents being more frequently reported and investigated in a timely way and oversight of incidents was more comprehensive. Governance systems were in place and generally working well, although some collaboratives were further developed than others, there was further work to do on the risk register to make this fully effective, and an external governance review was overdue.

The trust had entirely revised its reporting and accountability structures since our last visit. A total of 10 self-selected clinical collaboratives now reported to a clinical policy group, made up of clinical directors, representatives from the BMA and staffside, medical, nursing and allied health professional leaders. The chairs of the clinical collaboratives formed part of the senior leadership team alongside directors.

Our findings

Alongside this route, the board had a total of seven subcommittees; remuneration, audit and risk, quality assurance, resources, people, charitable funds and a joint partnership board.

Board papers were comprehensive, and although the board did not receive full reports from subcommittees, updates by note or exception were clear. All papers presented to board and subcommittees required the author to state the level of assurance the information provided, and we saw evidence from subcommittees where this was challenged appropriately when the committee had a different view.

Chairs of board subcommittees were clear about the role of their committee, the part it played in the trust's improvement journey, and how they shared risks and matters for escalation. We saw examples of issues identified at collaborative level that were escalated through the governance system all the way to quality assurance committee and board as needed, and how the learning from these was also shared at this level and below. Non-executive directors were clear about how they received assurance through the subcommittees, and the ways in which external accreditation and internal audit contributed to this.

Each committee had a standard agenda including minutes and action logs, an annual workplan and annual effectiveness review including a review of its terms of reference.

The quality assurance committee received a monthly quality and performance report, reviewed the board assurance framework and any emerging risks, and urgent escalations such as new never events. This work was planned throughout the year and was described by those attending as manageable. Each quality assurance committee meeting also received chair's logs from the supporting connecting groups which included an overview of topics discussed, actions with responsibilities and timescales, and risks for escalation.

The trust board assurance framework was reviewed monthly at the quality assurance committee and assurance ratings amended as necessary.

The trust's senior leadership team also met fortnightly and had oversight of all patient safety incidents, duty of candour, legal claims, inquests, patient moves, infection control outbreaks, complaints and concerns.

The trust governance systems ensured visibility of medicines at all levels. Clear terms of references were in place to ensure that medicines governance groups were multidisciplinary. There were clear workplans for both internal pharmacy services but also trust wide initiatives and to ensure medicines concerns and good practice could be learnt from. The trust worked with other organisations in the local healthcare economy to improve medicines outcomes for patients and there was a clear strategy for how this could be further developed.

Serious Incident Review Process

The trust's serious incident and never event reporting policy, a sub-policy of the incident reporting and investigation policy, was in line with national guidance and also directed the reporter to consider Duty of Candour, signposting to the correct policy. All Serious Incidents (SI) were included in a patient safety incident monthly update report, which went to the quality assurance committee and the board monthly. This monitored overall levels of incidents, how many were graded as a serious incident, how quickly initial reports were completed, and timescales for completion of final reports.

We reviewed eight incident files and found that these were generally well completed. All of the files showed evidence that patients and their families had been consulted and feedback sought around the incident investigation process, with the majority of families allocated a named family liaison officer. All files showed evidence that Duty of Candour (a legal

requirement for trusts to say sorry when things have gone wrong) had been discussed with the patient or their family, and seven of the eight files we reviewed contained a copy of the letter sent to the family. Duty of candour compliance was monitored at the patient safety steering group, and we saw that reports showed good oversight of the verbal communication of duty of candour (100% complete in November 2022) and written follow up (86%).

Learning from incidents had been identified in all of the eight files we requested, and we could see that this learning had been fed back to families, who received a covering letter describing this learning, and a full copy of the incident report.

Complaints

We reviewed six complaints files supplied by the trust. The files contained evidence that complaints had been assessed to consider any ongoing clinical risk. Complaints meetings were regularly offered and frequently accepted. We saw that where these took place, agendas were appropriate, and complainants received a copy of the audio recording of the meeting promptly. It was clear from complaints files what learning, and improvement had been made. Two complaints responses also contained action plans, where it had been identified where things could have been better. These actions were concise, each had an allocated member of staff and a timescale for completion. However, it was not clear from the information provided if or when these were followed up. Patient experience was monitored monthly at the patient experience steering group, which reported to the quality assurance committee.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified risks had actions taken to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At our last inspection in 2019, we found that the organisation did not have good oversight of all risks, and we wrote to the trust requesting further assurance around key patient safety risks and how these were managed and mitigated.

At this inspection, we saw that the trust had overhauled its reporting structures and practices, and had an improved grasp of risk, issues, and performance. At core service level, we found staff knew how to report risks, and were largely consistent about the top risks to their service, however the trust needs to ensure it maintains its focus and pace of delivery to improve patient safety issues in medical services.

The trust had a clear process for identifying risk and escalation. This was outlined in the risk management policy, which was in date and ratified in 2022. This included a risk escalation structure, showing a ‘ward to board’ thread of how a risk could be escalated, if appropriate, all the way to board, but also clearly outlining all the steps that were in place to determine the correct place for this to be managed. Risks could be managed at ward, directorate, collaborative, subcommittee or board level.

A corporate risk review group reviewed all risks initially scoring 15 and above and ensured that they had been correctly categorised and appropriate mitigation taken. The clinical policy group also received all risks scored 15 and above which had been through the corporate risk review group, and also checked the collaborative risk registers monthly. Both groups checked progress on actions to mitigate or reduce risks and fed back to collaboratives and directorates.

Our findings

The corporate risk register had been the subject of focussed work to try and reduce the number of risks. However, there were still so many high risks rated above 15, that a summary document, combining numbers of risks into general themed risks, was presented to board rather than the full register. We heard from staff that the aspiration was to reduce this further, to the point where a full register was presented instead.

In order to strengthen the trust's corporate risk management, a dedicated clinical risk manager was starting in post imminently. Additionally, collaboratives were engaging in training to refine their knowledge of risk mitigation and risk appetite which had the potential to further reduce escalated risk by better recognition of appropriate mitigation. There were regular audits of incident grading, including low risk and no harm incidents.

The trust had conducted a thematic review of its never events, with a key finding being to widen learning from incidents, and in response to a request from junior doctors, a searchable repository of previous serious incidents including learning from these was available for staff to consult.

The chair of the risk and audit committee was clear about the financial challenges for the trust and how this related to safe care. They had plans to improve accountability for actioning external audit recommendations, and regularly reviewed the BAF, corporate risk register, and internal and external audit reports.

Patient safety alerts were discussed and disseminated through the patient safety steering group which received a quarterly report, detailing how these were disseminated and what action had been taken.

Fire risk assessments were regularly undertaken, and we found these were thorough and action plans with timescales were in place.

The trust had embedded just culture and restorative practice into the patient safety strategy and just culture workstreams were supported by a programme board. It was early days and there was more to do to embed this fully into all documentation.

The trusts medicines safety officer was embedded in the trust governance processes. There was a structured review of medicines incidents and clear demonstration of how learning from medicines incidents was shared throughout the trust. This included learning events, medicines alerts, ward medicines safety boards and a dedicated medicines safety week. As the trust embedded technology systems, the review and oversight of prescribing and administration of medicines would be improved further.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, and had begun to use this to make decisions and improvements, although there was more work to do. The information systems were becoming more integrated and were secure. Data or notifications were consistently submitted to external organisations as required.

At our last trust wide inspection, we found the trust's digital status was relatively poor, and there were several legacy systems and aging hardware making transformation a challenge. This time, we found the organisation remained digitally challenged, and somewhat behind the curve when compared to others in the ICB, however many of the practical obstacles preventing widespread change at pace had begun to be removed.

Our findings

Since our last trust wide inspection, the trust had appointed a digital director, who was experienced in the widespread digital transformation the trust was looking to achieve. Their team recognised that digitally, the organisation was coming from a low starting point and remained digitally immature, being currently at level 3, but aiming to meet the NHSE digital foundations investment agreement level 6 by 2025.

The trust had significantly invested in replacing over 8,000 pieces of ageing hardware and was part way through a digital roadmap to move to paper free records. This tied into the Digital Plan, which had an executive lead for each part and was monitored through digital strategy group.

However, there was more to do to fully use business intelligence to improve clinical services. Some examples were given by the trust of how technology was being used to improve productivity and patient safety, such as a drop of a third in in-hospital cardiac arrests when patient observations were moved online, and the use of electronic solutions to free up admin staff, but it was acknowledged the organisation could still make further improvements in areas such as digitally enabled wards.

The trust's information governance policy was in date and was monitored by the information governance steering group. The trust had not met the standards for information governance requirements set out in the NHS information governance toolkit, was classed as approaching standards, but had an action plan in place for those elements where it was not yet compliant. Mandatory training targets for information governance had not been reached (90% against a target of 95%) and yearly 'pen' tests, crucial to testing network security, had not been as regular as planned.

Progress had also been made in coding which had led to the trust's reporting of death data falling more closely in line with expected levels.

The board hosted a digital session at a recent away day to outline the new digital aims and strategy, and digital is now a standing agenda item at the clinical policy group.

Trust systems enabled staff to capture patient specific information in line with the accessible information standard, and infographics were available to staff to tell them what they needed to capture, how to do this, and why it was important. An accessible information standards group, a subset of the patient experience steering group, monitored progress against the six standards.

The trust had begun its implementation of the Electronic Prescribing and Medicines Administration (EPMA) system. The pharmacy team had supported and trained staff in the use of the system and this continued to be rolled out across the trust. Dashboards were being developed to enable a detailed oversight of patients' needs so that work could be focussed and streamlined. The trust had also invested in automated medicines cabinets which had helped to reduce omitted doses, picking errors and made savings on nursing time.

Engagement

Leaders and staff actively and openly engaged with patients and those closest to them, staff and the public to plan and manage services. They acknowledged that wider engagement with equality groups, the public and local organisations was needed. They collaborated with partner organisations to help improve services for patients.

Our findings

At our previous inspection of the well-led domain at the trust, we saw that there was a deterioration in staff engagement, no staff networks, and no engagement strategy in place. During this inspection, we saw that while staff reported a vastly improved culture, and staff networks were now in place, there was no staff specific engagement plan, and engagement with patients and wider stakeholders was a developing area.

During the COVID-19 pandemic, it had been challenging for the trust to maintain all its usual engagement avenues, such as inviting local Healthwatch to conduct enter and view visits, but there were plans in place to pick these up again as soon as possible.

The trust did not have a current staff engagement strategy. There was a communication and engagement strategy, however this was very much externally focussed and described communication, branding and stakeholder engagement, but did mention development of staff social media content and staff surveys.

There was no current patient experience and involvement strategy, however we were told that this was a work in progress, and we saw from minutes of the quality assurance committee that this was being co-produced with local Healthwatch to involve patients, carers and their families. Ensuring effective ways of receiving feedback from patients, relatives and carers was a quality priority for 2022/2023.

The trust did have a staff engagement working group, which involved colleagues from network groups and those with an interest in staff engagement. Examples of recent engagement and recognition work included the South Tees Appreciation Reports (STAR), a system for sharing positive appreciation from colleague to colleague. The trust had also implemented an onboarding questionnaire to learn from staff who had recently joined the organisation on their recruitment experience.

Since our previous inspection, the trust had introduced family liaison officers to support serious incident investigations, patient and staff stories were presented at board meetings and a maternity voices partnership group met monthly, with an ethnic minority subgroup which was conducting some focussed work on the experiences of people from ethnic minority groups.

The trust's patient experience steering group was chaired by the deputy director of quality and had been established since our last well led inspection. It met monthly and fed directly into the trust quality assurance committee. A quarterly report included an analysis of patient feedback from complaints, concerns, compliments and friends and family test data. The trust benchmarked its complaints against others in the area and was not an outlier.

The trust pharmacy team proactively engaged with patients in cardiology to not only improve patient experience of pharmacy service but also patients' outcomes from use of medicines.

Learning, continuous improvement and innovation

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

At the time of our last well led inspection of the trust, there were limited systems and staff in place to support improvement or innovation, and no methodology or structured improvement work. During this inspection, we saw that learning and continuous improvement was high on the trust's agenda, was prioritised, and that there were several structured programmes in place to support this.

Our findings

The trust had an active STRIVE (South Tees Research Innovation and Education) unit, providing a range of courses, one-off sessions, mentoring and apprenticeships covering leadership, patient safety, clinical skills, administration skills, wellbeing, and human factors.

To nurture a culture of compassionate leadership, the trust had developed a leadership, improvement and safety academy (LISA). This included human factors and civility training and education, leadership development with additional specific support as needed, and one to one externally mentored coaching support. There was a strategic plan in place for LISA and we saw that progress, including numbers of learners by clinical collaborative was monitored through the people committee.

The trust had devised a South Tees Accreditation for Quality of Care (STAQC) scheme for wards and departments. STAQC assessment is against a set of standards with areas for improvement identified and areas of excellence celebrated with silver awards, and gold and diamond accreditation. This involved a thorough review of their data, including clinical safety markers such as falls and medication incidents, and staffing. An action plan was then developed by the ward with support by the accreditation team, who also observed practice and the working environment. The ward then worked to put assurances in place against the action plan and received accreditation when the desired change had been achieved.

The trust has partnered with the newly created the South Tees Academic Centre for Surgery (ACeS), a collaboration with trusts in Hull and York, and the Royal College of Surgeons to create a centre for collaborative surgical research. The trust has founded the South Tees Academic Cardiovascular Unit (ACU) in conjunction with Newcastle University Medical School.

The trust has implemented training to support and further develop medicines education and knowledge, there was a comprehensive training package for the EPMA roll out as well as monthly topic-based learning which was recorded and uploaded onto the intranet to allow all staff access to ongoing medicines-based learning.

Learning from Deaths

Since 2017 there has been a requirement for trusts to publish via their quarterly board papers, information relating to the deaths of patients. The trust was fulfilling this duty. The trust's responding to deaths policy was in date and available on the public facing website for all to access.

We met with the medical director, deputy director for clinical effectiveness and lead medical examiner to discuss the trust's processes around learning from deaths. We also reviewed five files to check investigations were thorough, and judgement reviews were used to improve care. A total of 97% of all deaths in hospital were reviewed by the medical examiners, and we saw evidence that reviews were carried out in discussion with patients' families. The trust used a bespoke method to examine all deaths and could articulate clearly why this worked for them, being based on their early adopter work. Learning from deaths was discussed at the quality assurance committee, and board, shared with teams via a twice monthly newsletter and patient safety briefings, and was a standing item on the clinical policy group agenda. We saw evidence from mortality and morbidity group meetings that policies and practice were changed in response to learning from deaths.

Mortality

There are two main measures used nationally; the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI). The HSMR is worked out according to observed deaths divided by expected deaths, multiplied by 100. A score of 100 means that the number of deaths is what would be expected. A higher score

means more deaths; a lower score, means fewer. Mortality data at the trust between April 2021 and March 2022 showed the HSMR was 104.1 which was within expected limits. Weekend rates of death were also within the expected range. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. Between April 2021 and March 2022, the SHMI rate was 1.08, which was within expected limits. Mortality data was discussed at a mortality surveillance group, reporting through to an additional three groups and subcommittees and SHMI data went to board monthly.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ May 2023	Good ↑ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ↑ May 2023	Good ↑ May 2023

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Good	Good	Good	Good	Good	Good
Community	Good	Good	Good	Good	Good	Good
Overall trust	Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Redcar Primary Care Hospital	Not rated	Good Oct 2016	Not rated	Not rated	Good Oct 2016	Good Oct 2016
Friarage Hospital	Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023
The James Cook University Hospital	Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023
Overall trust	Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023

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

Rating for Redcar Primary Care Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Not rated	Good Oct 2016	Not rated	Not rated	Good Oct 2016	Good Oct 2016

Rating for Friarage Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ May 2023	Requires Improvement ➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Requires Improvement ➔ May 2023
Services for children & young people	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
End of life care	Good Oct 2016	Good Oct 2016	Good Jun 2015	Good Jun 2015	Good Oct 2016	Good Oct 2016
Maternity and gynaecology	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015
Outpatients and diagnostic imaging	Good Oct 2016	Not rated	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Oct 2016
Surgery	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ➔ May 2023	Good ➔➔ May 2023
Diagnostic imaging	Requires improvement Jul 2019	Not rated	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Overall	Good ➔ May 2023	Good ➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ➔ May 2023	Good ➔ May 2023

Rating for The James Cook University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← May 2023	Requires Improvement →← May 2023	Good →← May 2023	Good →← May 2023	Good →← May 2023	Requires Improvement →← May 2023
Services for children & young people	Good Oct 2016	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Oct 2016
Critical care	Good ↑↑ May 2023	Good ↑ May 2023	Good →← May 2023	Good ↑ May 2023	Good ↑ May 2023	Good ↑ May 2023
End of life care	Good Oct 2016	Good Oct 2016	Good Jun 2015	Good Jun 2015	Good Oct 2016	Good Oct 2016
Maternity and gynaecology	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015
Outpatients and diagnostic imaging	Good Oct 2016	Not rated	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Oct 2016
Surgery	Good ↑ May 2023	Good ↑ May 2023	Good →← May 2023	Good →← May 2023	Good ↑ May 2023	Good ↑ May 2023
Urgent and emergency services	Good ↑ May 2023	Good →← May 2023	Good →← May 2023	Requires Improvement ↓ May 2023	Good →← May 2023	Good →← May 2023
Diagnostic imaging	Requires improvement Jul 2019	Not rated	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Overall	Good ↑ May 2023	Good ↑ May 2023	Good →← May 2023	Good →← May 2023	Good ↑ May 2023	Good ↑ May 2023

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Community urgent care service	Good Jun 2015	Requires improvement Jun 2015	Good Jun 2015	Good Jun 2015	Requires improvement Jun 2015	Requires improvement Jun 2015
Community health inpatient services	Good Oct 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Oct 2016
Overall	Good	Good	Good	Good	Good	Good

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

Friarage Hospital

Bullamoor Road
Northallerton
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www.southtees.nhs.uk

Description of this hospital

The Friarage Hospital in Northallerton, North Yorkshire is one of two acute hospitals forming South Tees Hospitals NHS Foundation Trust. It serves a rural population of around 122,000 people and serves an area of 1,000 square miles extending from the North Yorkshire moors to the central Pennines, the borders of York district in the south and the borders of Darlington in the north. The Friarage Hospital has 170 beds and at the time of the inspection provided medical, surgical and end of life care for people across the Hambleton and Richmondshire area. The hospital also provided outpatient and diagnostic services. There is a surgical day unit, and a Midwifery Led Unit, a Short Stay Paediatric Assessment Unit and a diagnostic imaging department. The Sir Robert Ogden Macmillan Cancer Centre opened in December 2018 and is located on the Friarage Hospital site. The centre was jointly funded by Sir Robert Ogden and Macmillan Cancer Relief to provide cancer care, treatment and counselling under one roof.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

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

Mandatory Training

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

Training compliance trust wide for medicine was 92.94% for nursing staff, which exceeded the trust target of 90%. However, medical staff compliance was below trust target at 69.24%. This meant the trust was not assured all medical staff received mandatory training.

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

Managers monitored mandatory training on the electronic staff record system and prompted staff when they needed to update their training. This was confirmed by staff we spoke with and we saw red/amber/green (RAG) rated training compliance sheets displayed in staff areas as a visual prompt for nursing staff.

There was a clinical educator who delivered face to face practical training. For example, staff we spoke with described simulation training designed to develop skills in management of deteriorating patients.

Staff were supported to complete extended role training. For example, some healthcare assistants we spoke with completed training in cannulation and venepuncture, to collect blood samples.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the trust did not ensure everyone completed it.

Nursing staff accessed safeguarding adults and children and PREVENT policies on the intranet. PREVENT aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

All nursing staff we spoke with told us they received adults and children safeguarding training online. In addition, they described periodic scenario training and supervision delivered by the trust safeguarding team. Data provided by the trust showed training compliance by nursing staff was 89.86%, which almost met the trust target of 90%.

Data provided by the trust indicated the levels of safeguarding training nursing and medical staff received. However, overall compliance with up to date safeguarding training by medical staff was below the trust target, at 68.82%.

Medical care (including older people's care)

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, they identified patients at risk via referral documentation completed by general practitioners (GPs) and paramedics and via shared local authority information. We saw patients at risk identified in clinical records and on electronic white boards, with an alert icon.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. For example, the trust named safeguarding lead and local authority safeguarding teams. Out of hours, staff escalated safeguarding concerns to the duty matron and patient-flow coordinator. Staff gave specific examples of safeguarding concerns they had raised. The trust kept a log of all safeguarding concerns raised and recorded learning outcomes.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, they kept the premises visibly clean.

Wards benefited from dedicated housekeepers and a central trust domestic team to support staff in maintaining levels of infection control. Environmental cleaning schedules for domestic staff to follow, were displayed at entrances to wards we visited.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. All wards we visited displayed posters indicating high compliance with environmental cleanliness.

Clinical equipment was cleaned by clinical staff. Most cleaned equipment we saw such as stored commodes and toileting aids were labelled with the date when cleaned.

Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

We observed staff adhered to ‘bare below the elbow’ guidance. However, we saw inconsistent use of personal protective equipment (PPE) in clinical areas. For example, we observed staff did not always change their PPE between patient contacts.

When we asked staff to clarify trust policy on wearing of face coverings, they explained wearing a face covering in clinical areas was a personal choice. However, after our inspection, the trust provided their policy, which reflected national guidance and gave specific examples of when face coverings must be worn. This policy was accessible to all staff on the trust intranet.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities were available and antibacterial gel dispensers were situated at the entrance of the wards and on corridors. We saw 5-moments of hand hygiene posters displayed.

Patients we spoke with confirmed staff washed their hands before and after treating them. We observed hand hygiene practice. On the wards we saw that staff either washed their hands before and after each patient contact or used hand gel, as recommended in trust and national policy. Staff we spoke with described how they worked with the trust’s infection prevention control team on a programme of quality improvement at ward level.

The wards had link nurses for infection control, and they conducted annual handwashing competency checks for all staff.

As of June 2022, the trust was in the bottom 25% per 100,000 bed days (latest 12 months & 3 months), for rates of E. coli, Klebsiella and C.difficile healthcare acquired infections and in the top 25% for MRSA rate per 100,000 bed days (latest 12 months & 3 months).

Environment and equipment

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

Access to all wards was via secure buzzer and camera entry system.

All corridors and fire exits were free of obstructions. Fire appliances were signposted and tested. The fire alarm was tested weekly.

Patients could reach call bells and staff mostly responded quickly when called. However, we did observe instances of call bells persistently buzzing for prolonged periods of time on one ward. We brought this to the attention of staff who then responded immediately.

Equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that portable electrical equipment was maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Most equipment we looked at had been serviced in accordance with trust policy. The exception was a hoist subject to annual service under lifting operations and lifting equipment regulations 1998 (LOLER), which was last serviced in May 2019. We also found a portable observations monitor was overdue service in June 2022. We brought this to the attention of the nurse in charge who told us they would report it as a matter of priority.

Staff carried out daily safety checks of specialist equipment. For example, records we reviewed for checks of the emergency resuscitation trolleys had no gaps.

The trust had formally assessed the risk that emergency resuscitation trolleys may be vulnerable to tampering and recorded controls to mitigate risk.

However, on one ward, the tamper-evident seal sticker on the anaphylaxis medicines box, stored within the emergency resuscitation equipment trolley, was not intact. This meant the contents may have been incomplete. We brought this to the attention of staff at the time and they said it would be replaced.

The service had suitable facilities to meet the needs of patients' families. For example, patients in the same day emergency care unit (SDEC), were accommodated according to need and were allocated a chair, trolley or a bed.

The service had enough suitable equipment to help them to safely care for patients. For example, staff we spoke with reported they had enough equipment to provide safe care to patients including moving and handling equipment and equipment for bariatric patients.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to Health (COSHH) Regulations (2002). For example, on one ward, in the dirty utility room, we saw a chlorine spray solution bottle on the countertop and chlorine tablets and acetone stored in an unlocked cupboard. This meant there was a risk vulnerable people could access potentially hazardous substances. We made staff aware at the time and were told there was a lockable domestic storeroom off the ward but no lockable COSHH cupboard on the ward.

However, on a second ward, dirty utility room cupboards containing substances hazardous to health were locked.

The endoscopy unit had Joint Advisory Group (JAG) accreditation (certificate JAGWEB/0137). The new endoscopy and urology diagnostic hub opened in September 2022. A 6-month action plan for both James Cook University Hospital and Friarage Hospital was in place and the trust had completed 12 of 17 actions identified on the plan.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff accessed the recognition and management of the acutely ill and deteriorating patient policy via the intranet.

The hospital had a same day emergency care ward (SDEC). The aim of this was to improve patient flow by diverting patients away from urgent care. Referrals were received from the urgent treatment centre, GPs and paramedics. Admissions were risk assessed by the on-call consultant for the unit to ensure they were clinically appropriate. An escalation policy was in place for management of deteriorating patients. Staff from SDEC also attended a safety huddle on the Clinical Decisions Unit.

Staff used a nationally recognised NEWS2 tool to identify deteriorating patients. Trust wide, nurse and medical staff NEWS2 training compliance was 100%.

NEWS2 completion and escalation compliance audits were completed monthly across all wards. Data we reviewed from January 2022 to the date of our inspection showed compliance ranged from 85.7% to 100%. The trust's recording of physiological observations audit (taken from electronic patient records), for the current inpatients, up to 14 November 2022, showed 100% observations were complete in the expected time period.

However, we observed NEWS2 scores were not always recorded consistently well and escalated appropriately. For example, we reviewed 20 NEWS2 charts. 15 out of 20 had not been recorded on the electronic system. This meant there was a risk staff did not always have up to date records to monitor patients. We brought this to the attention of managers and following the inspection, the trust organised a review of all patients on the ward to ensure patient safety.

Staff we spoke with told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

Unannounced resuscitation scenarios were conducted periodically to ensure staff practiced emergency responses to deteriorating patients.

Clinical risk assessments were held as paper documents and in electronic formats. Staff did not always complete and update paper risk assessments for each patient. For example, we saw a patient had an initial venous thromboembolism (VTE) risk assessment completed on 25 October (chart 1) but VTE risk was not reassessed when the chart was re-written on chart 2. However, VTE risk was reassessed when re-written again (chart 3) on 06 November. Another patient had a VTE assessment completed but not signed, although prophylaxis was prescribed.

We brought this to the attention of medical staff at the time and they told us this was a persistent issue.

In addition, visual infusion phlebitis (VIP) risk assessments we reviewed were incomplete. The VIP scale provides a score from 0 to 5, in ascending order of severity of inflammation. For example, one patient had the same cannula in place for 6 days, with no rationale recorded for this.

However, we also saw examples of how staff dealt with specific risk issues such as patients at risk of falls. There was a falls co-ordinator who monitored all inpatient falls. We saw patient falls risk assessments were completed on admission and falls risk was managed by cohorting patients, with a staff member allocated as a falls watch person. In addition, patients were provided with non-slip socks and a therapeutic care team staff identified by yellow tops, were utilised to sit with patients most at risk.

Managers explained the trust had purchased falls sensors which were placed under mattresses and seating to alert staff when vulnerable patients attempted to mobilise unaided.

Trust data for the period November 2021 to October 2022 showed there were only 2 falls that resulted in harm across the 2 medical wards and CDU at Friarage hospital.

The trust recognition and management of the acutely ill and deteriorating patient policy provided best practice guidance to all staff involved in the care of patients presenting with sepsis. The trust provided annual sepsis updates for staff and compliance was 83%. All staff we spoke with described what they would do to treat and escalate sepsis. All patients with an elevated NEWS2 score were considered for screening and escalation to senior medical staff. The trust used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis screening tools in the records we reviewed. The wards had sepsis boxes. Further management, such as the use of the sepsis care bundle and antibiotics were implemented.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. For example, on the wards, handover from night to day nursing staff was at 7am. Staff received a printed handover sheet which included any specific patient risks, for example, falls risk, resuscitation status and identified patients that required assistance with diet and fluids.

Staff attended multidisciplinary safety huddles at the start of each shift. These were attended by, for example, physiotherapists, speech and language therapists, occupational therapists, medical social workers, discharge coordinator and dietitians in addition to medical and nursing staff.

Board rounds on the CDU occurred 3 times a day. Doctors handed over to the night shift at 9pm.

Medical care (including older people's care)

The trust clarified that due to COVID-19 pandemic, acute illness management (AIMs) training was suspended. However, this training recommenced in June 2022 and monthly courses were scheduled up until August 2023. In addition, there was educational outreach to wards and departments to deliver training in recognition and response to the deteriorating patient. Compliance by nursing staff was 90%.

The trust acutely ill patient group met twice monthly to discuss for example, audit themes and trends, sepsis data and critical incidents.

Nurse staffing

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

The medicine collaborative nurse staffing plan was reviewed annually with establishments amended to be in line with provision of safe standards of care. The most recent review went to trust board in November 2022.

On the wards, staffing requirements were calculated by ward managers using a recognised safer care process. However, the service did not always have enough nursing and support staff to keep patients safe. For example, on the wards we visited we saw that planned and actual staffing displayed did not always match. On one ward, staffing including the ward sister, was planned as 4 registered nurses and 3 healthcare assistants (HCAs) for early and late shifts and 2 registered nurses and 2 HCAs at night. However, actual staffing was 2 registered nurses and 4 HCAs on the early and late shifts. Night actual staffing on this ward exceeded planned numbers, with an additional HCA. Similarly, on a second ward, there was a shortfall of 1 registered nurse on early, late and night shifts and 1 HCA short on the late shift. Staff we spoke with told us this was a regular occurrence.

There was a staffing escalation process in place. Staff we spoke with explained, when staffing was suboptimal, they reported to the matron and Safe care team. The matron redeployed staff from other wards, requested bank staff via the NHSP system and unfilled shifts were offered to staff via a closed social media group. Agency staff were used and allocated where needed on arrival.

Staff we spoke with told us they had sufficient rest and meal breaks and usually left duty on time. This was an improvement on our previous inspection, where staff did not always have time to take breaks or provide person centred care that met individual patient needs.

Trust wide, the medicine service had a vacancy rate of 4.5%. The trust employed additional healthcare assistants, above the budgeted establishment, to help support the shortfall in registered nurses.

Trust wide, the medicine service had a turnover rate of 9.01%.

Trust wide, the medicine service had a sickness rate of 6.59%.

Managers we spoke with explained the trust was actively recruiting registered nurses.

Medical staffing

Medical care (including older people's care)

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

The service had enough medical staff to keep patients safe. In January 2022, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same as the England average.

At Friarage Hospital, in CDU for example there were 4 junior doctors on every day shift and 2 on the late, supported by a specialist registrar. Most doctors we spoke with told us they felt very well supported by senior medical staff and had protected teaching time. However, some expressed concerns that the induction they received was not sufficient.

The medical staff matched the planned number.

Trust wide, the medicine service had a vacancy rate of 5.1% consultants and recruited above establishment for other medical staff.

Trust wide, the medicine service had a turnover rate of 27.41% for all permanent medical staff employed by the trust including those on fixed term contracts.

Trust wide, the sickness rate for medical staff within the medicine collaborative was low at 0.67%

Managers could access locums when they needed additional medical staff. Rotas we reviewed had no gaps in medical cover.

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

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were mostly stored securely.

Records were held in paper and electronic formats. However, they were not always comprehensive and contemporaneous. The trust was aware of poor compliance with record keeping and promoted improvement via 'documenting for great care' posters.

For example, we looked at 20 full sets of patient records and saw gaps, including skin and wound management, height and weight, malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts and best interest decision making.

It was not always clear whether all patients were reviewed by a consultant within 14 hours of admission.

Not all nursing and medical records indicated the time of completion.

The trust had implemented a weekly MUST audit following our inspection in February 2022 and had moved MUST scores on to an electronic system which automatically prompted completion when required. Information provided to CQC for August 2022 showed that the trust was meeting its 90% target of completion of MUST assessment within 24 hours of admission, with 95% of scores completed on time and 100% of appropriate actions implemented as a result of these assessments.

Electronic white boards were used on all wards we visited and these recorded key information about patient risks and treatment, including alert icons for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Records were mostly stored securely. The exception was one ward where notes were being stored temporarily in a cupboard while under-counter cupboard locks were fitted.

Medicines

The service did not always use systems and processes to safely prescribe, administer and record medicines.

Patients had wrist bands in place, and we observed medication rounds in which staff checked patients name and date of birth.

We observed the electronic prescribing system (EPMA) had been recently introduced on some wards at the trust, which prompted staff when medicines were due to be administered and this was now used to monitor compliance with administration of time-critical medicines. On wards where EPMA was not yet in use, pharmacists reconciled (checked) medicine prescriptions and now highlighted time critical medicines.

Records we looked at assured us most medicines were being given as prescribed and where medicines were omitted, we saw evidence of reasoning why.

However, we saw, weight and height were not consistently recorded in the care pathways and medicine prescription charts. Oxygen prescribing was not always completed consistently well. This concurred with trust audit data, which concluded oxygen prescribing continued to be poorly undertaken. We observed two patients receiving oxygen, which was not prescribed.

We discussed oxygen prescribing with managers and were told compliance by prescribers was variable. However, they anticipated the new EPMA system would help to make the prescribing and administration fields mandatory, to improve compliance.

We saw evidence of prompt action by the medical team where changes were made to medicines via specialist teams.

Medicine reconciliation was carried out by the pharmacy team based on the ward. The trust target for reconciliation within 24 hours was 80%, however, medicines reconciliation on admission had not improved since our last inspection. For example, trust data for the period January to October 2022 showed the trust target was met only once, in January 2022. The trust was aware of the issue with medicine reconciliations and pharmacy staff we spoke with told us there was work ongoing to help the trust meet this target. In the charts we looked at, medicines reconciliation was completed within 48 hours of admission.

Patient own controlled drugs were recorded in a separate register. Most were returned upon discharge. However, we found 3 instances on one ward where patient's own medicines were not returned on discharge and still stored on the ward.

Pharmacists audited staff compliance against medicines policy monthly and sent results to ward managers. For example, antibacterial agent documentation audit data for November 2022 showed compliance ranged between 45.24% to 100% in the metrics audited and the trust had an action plan in place to address non-compliance.

Medicines required to take home out of hours was dispensed in over labelled packaging from the wards. There was a robust checking system in place.

A total of seventeen wards across the trust were using an automated medication dispensing system in use, which staff accessed via biometric thumb print verification. This system reduced the risk of mis-doses and improved record keeping. The trust had plans to roll this system out across both sites over the next three years to cover all wards.

Staff stored medicines and prescribing documents safely. For example, FP10 prescription pads were locked away and there was a register in place to record prescription issue.

Ward staff were supported by pharmacists Monday to Friday. Out of hours, pharmacists were contactable via an on-call system

Incidents

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

Staff accessed the incident reporting and investigation policy on the intranet. All staff we spoke with knew what incidents to report and how to report them. All managers we spoke with knew their ward's most recurring top three incidents and gave examples of how these were being addressed and monitored.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff we spoke with were familiar with the electronic incident reporting system and provided clear examples of incidents and near miss incidents they had reported recently.

Managers shared learning about never events with their staff and across the trust. From 9 September 2021 to 3 October 2022 two never events were reported. Staff we spoke with were aware of trust never events and serious incidents reported within the collaborative and described the actions the trust had taken as a result of learning. For example, changes to policy and learning incorporated into junior doctor's induction programmes. They explained learning from incidents was shared in safety bulletins on the intranet and during safety huddles at shift changes.

All staff we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Medical care (including older people's care)

We saw recent patient safety alerts displayed and managers we spoke with explained how these were implemented and monitored. The alerts were also shared via an established monthly electronic quality and safety briefing. This signposted staff to further information and covered key topics each month, such as learning from falls, prevention of pressure ulcers and incident reporting.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff we spoke with explained how they accessed the most current best practice guidance online and trust intranet, for example NICE guidance and up to date COVID-19 guidance.

Compliance against policy was monitored throughout the year using an annual trust audit schedule.

Nutrition and hydration

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

Staff now made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was a significant improvement since our last inspection.

Where modified diets were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station.

All wards had a trained nutritional link nurse to support them with meeting patients' needs.

Protected mealtimes were promoted via intranet banners and the quality and safety briefing, which was sent to all staff electronically. Clinical assurance rounds were in place to observe protected mealtimes and feedback was provided to staff if improvement was needed.

We observed mealtimes on various wards and noted that all staff were involved in serving meals to patients, including senior staff. Patients that needed support with eating their meals were given it. We observed additional comfort rounds taking place with options for biscuits, juice, tea and coffee.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Staff used a red/ amber/ green lid system on water jugs to help monitor patients' fluid intake throughout the day. However, fluid balance charts in the records we reviewed did not always accurately capture fluid input and output where this was required.

On Romanby ward we saw posters that promoted a takeaway meal service. There was a wide choice of options which included frozen meals together with high and calorie dense and altered texture meals. Patients could request brochures from the nursing and housekeeping staff.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was recorded routinely as part of electronic physiological observation recording. The system ensured completion of the assessment was mandatory. This was an improvement since our last visit, when we found pain assessment charts were not consistently completed.

The trust audited pain scores following analgesia to monitor effectiveness.

Patients we spoke with told us they received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

The service participated in relevant national clinical audits, for example, the national lung cancer audit, national heart failure audit, national diabetes audit, national audit of inpatient falls, national audit of dementia and chronic obstructive pulmonary disease audits.

Due to the pandemic there were delays to the publication of some audits. For the audits listed above, some of the data in the latest publications was at least two years old or data was not available at trust level, therefore results have not been included here.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local scheduled audits (QIC audits) of 15 different sets of notes on each ward each month, were recorded on an electronic system, via a handheld device. These included medical records audits, hand hygiene observation, donning and doffing PPE, sepsis 6 documentation, falls, pressure ulcers and venous thromboembolism (VTE) risk assessments.

The trust developed action plans to improve outcomes. For example, the falls action plan we saw was developed in response to the findings from the national audit of inpatient falls results from 2020/21, in addition to the themes emerging from the structured reviews, incident reports, patient feedback and complaints.

We saw audit quality metrics displayed on wards, indicated high compliance. For example, 1 question asked whether the VTE risk assessment was recorded on the medication chart. Results from this audit were 98% in August, 98% in September and 100% in October. However, the audit results did not concur with our observations of records and clinical staff involved in audit activities confirmed to us that completion of VTE assessments on paper was often poor. They anticipated implementation of electronic prescribing with mandatory fields would improve compliance and the trust had an action plan in place.

The trust held mortality and morbidity meetings to discuss learning from deaths.

The service was accredited by Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in 2018. The trust updated the action plan in November 2022.

Competent staff

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

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, on one ward there was a patient with a bowel management system in place. There was inconsistent evidence about the additional care required to manage this device. Staff we spoke with told us they had received no additional training and were not aware of some aspects of safe management. We escalated this to the trust at the time. The trust conducted an immediate review and organised clinical educators to visit the ward and staff to support additional training.After our inspection the trust provided an action plan to address staff training needs. This applied to all registered nurses and included cascade of a presentation and flagging of patients that used this device so that ad- hoc training could be provided when needed.

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

Staff we spoke with told us they had the opportunity to discuss training needs with their line manager and felt they would be supported to develop their skills and knowledge. However, when asked about clinical supervision, staff we spoke to told us they did not receive any.

Staff had 1 to 1 meetings with their managers. Managers we spoke with told us they were on trajectory to meet trust targets for completion of staff performance appraisals and this was confirmed on spreadsheets we saw displayed in staff areas. Managers identified poor staff performance promptly and supported staff to improve.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. For example, doctors we spoke with told us they participated in a grand round twice a week, led by care of the elderly consultants and teaching time was protected.

The clinical educators supported the learning and development needs of staff.

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

Managers we spoke with told us that they could identify any training needs their staff had. However, they shared concerns that giving them the time and opportunity to develop skills and knowledge was not always possible due to staffing constraints.

Managers made sure staff received any specialist training for their role. For example, 41% of ward staff completed non-invasive ventilation (NIV) training and competency training compliance for care of NIV patients. Although the compliance appeared low, the trust explained patients that required NIV were transferred to James Cook University Hospital, so there was no requirement to train all staff in NIV. However, there were sufficient numbers of staff trained to ensure the rosters supported the safe care of patients prior to transfer.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. For example, we observed MDT board rounds which included consultants, junior doctors, physiotherapists and nurses.

Patients had their care pathway reviewed by relevant consultants. For example, patients accommodated on non-medical wards due to medical bed shortages, were reviewed by the appropriate consultant for their care needs.

Nursing and medical staff we spoke with told us there was good teamwork across all disciplines and managers were approachable. Staff said they felt empowered to challenge colleagues' practice if they were concerned.

Staff liaised with the multidisciplinary team directly. For example, they referred to diabetes specialist nurses, dietitians, learning disability staff, elderly care psychiatric team and therapies colleagues.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Managers we spoke with told us they received support from clinical in-reach services, for example, respiratory, palliative care, cardiology, pain team, speech and language therapy and stroke. However, this was not available 7 days a week.

There was daily physiotherapy support from 8am to 8pm.

SDEC operated Monday to Sunday 8am to 8pm, with the last admission accepted at 6.30pm. This was staffed by 2 band 7 practitioners during weekdays and by 1 band 7 practitioner and an HCA at the weekend. There was a doctor in the department at all times when operational and a coordinator.

Health promotion

Medical care (including older people's care)

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

The service had relevant information promoting healthy lifestyles and support on wards.

The trust website patient and visitors section had links to health promotion information, including leaflets in easy-read format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always use measures that limit patients' liberty appropriately.

Staff we spoke with told us they received training in the MCA and DoLS incorporated within mandatory adults safeguarding training. There was a policy for enhanced observation of patients.

Staff we spoke with described a multidisciplinary team approach to making best interests decisions. For example, they involved clinicians, safeguarding team, patients and their family/carers. Medical and nursing staff received training to complete mental capacity assessments.

We reviewed 5 records of patients subject to deprivation of liberty safeguards (DoLs). Four records showed staff had completed assessments and recorded best interest decisions, however they were not in line with the requirements of the legislation or trust policy. For example, they were not explicit enough and we saw two examples of expired DoLs. Staff used the electronic incident reporting system to record when patients were subject to a DoLs order, however, we did not always see evidence that this was an effective way to maintain oversight.

Four records we reviewed showed that decisions around DNACPR (Do Not attempt cardiopulmonary resuscitation) were not always fully informed, or discussion recorded.

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

However, staff we spoke to knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The trust had recently appointed a lead practitioner for MCA and DOLS. While this was a positive step, and numbers of referrals for DoLS were increasing, potentially indicating greater awareness, there was further work to do to embed this learning and adhere consistently to legal requirements. After our inspection, the trust provided an action plan to address this.

Is the service caring?

Good 

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

Medical care (including older people's care)

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. This was an improvement on our last inspection, when we found staff were not always discreet and responsive.

Patients we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

At the time of our last visit, patients were not regularly dressed and out of bed, wearing either their own clothes or nightwear. At this visit, we observed patients sitting out of bed and wearing their own clothes.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

At the time of our last inspection, visiting had been suspended due to the COVID-19 pandemic. It was recognised by the trust that this had had an impact on the emotional support patients received, when isolated from their families. Following our inspection, the trust immediately, following appropriate assessment of risk, reinstated visiting. Patients and staff told us this had been a huge boost to morale, and staff explained that this had also improved patients eating and drinking, as friends and families are encouraged by staff to support those close to them with their meals at lunchtime and tea time, and to bring in favourite foods and drinks if they wished to do so.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand.

Medical care (including older people's care)

Patients and their families gave positive feedback on the service and their treatment. Staff we spoke with told us they received positive feedback from patients and their carers. Since our last inspection, staff were now allocated to remind patients to complete satisfaction surveys and share their views on the care and treatment they received. This improved the numbers of returns. The most recent friends and family feedback and satisfaction scores for August to October 2022 were 100%.

The trust scored above the national average in several areas of the 2021 Cancer Patient Experience Survey 2021, with 91% of patients stating they found it very or quite easy to contact their main contact person, against a national average of 85%, and 84% of patients (national average 78%) felt that the right amount of information and support was offered to the patient between final treatment and follow up appointment.

Staff we spoke with described how families and carers were encouraged to participate in care if they and the patient wished to. Staff now utilised therapeutic care staff to sit and ensure patients nearing end of life were not left alone if their carers were away.

Is the service responsive?

Good

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

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

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

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day. For example, SDEC which provided a same day service to patients.

Meeting people's individual needs

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

Wards aimed to meet the needs of patients living with dementia. For example, on one ward we saw a dementia and learning disabilities resource trolley containing leaflets, communication aids, forget-me-not hospital passports, activities and nutrition aids.

Staff accessed advice from a learning disabilities nurse specialist when required. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients were identified on the electronic white board with a nationally recognised forget-me-not icon. Patients identified as requiring 1 to 1 supervision were allocated a therapeutic carer, identifiable by their yellow top.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff accessed interpreters when required online or via telephone. They also utilised staff who spoke languages other than English, where appropriate. Staff had access to information leaflets available in languages spoken by the patients and local community.

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

Pastoral care was available as required from a multi-faith chaplaincy service. There was a multi-faith chapel on site.

Access and flow

Most people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in mostly line with national standards.

The hospital had a same day emergency care ward (SDEC). The aim of this was to improve patient flow by diverting patients away from the urgent care centre.

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. For example, the percentage of patients treated within 18 weeks slowly declined from 85% in March 2021 to 78% in August 2022. However, referral to treatment on completed admitted pathways in 'Medicine', within 18 weeks for August 2022 was 94.4% which is higher than the 90.5% reported in August 2021 and better than the national average of 78.4%.

In August 2022, 333 patients had been waiting 52 weeks or more for treatment compared to 445 in June 2021. This was a decrease of 25%. For the region, there was a 6.3% increase in the number of patients waiting 52 weeks or more.

Managers and staff started planning each patient's discharge as early as possible. From February 2021 to January 2022 the average length of stay for medical elective patients at Friarage Hospital was 4.7 days, which is lower than England average of 6.4 days. For medical non-elective patients, the average length of stay was 3.7 days, which is lower than England average of 6.0 days.

The average length of stay for elective patient in gastroenterology and general medicine is lower than the England average. However, for elective patients in general medicine it is higher. The average length of stay for elective patients in general medicine, infectious diseases and respiratory medicine is lower than the England average.

Medical care (including older people's care)

There was a discharge facilitator in post since January 2022. However, the role was still under development. They covered discharges for the whole hospital and attended daily meetings, with medical social worker and reablement team colleagues, to facilitate discharges jointly.

The team also liaised with adult social care colleagues. Staff we spoke with shared concerns that delayed discharged were a persistent issue and causes for delay were not always possible for the trust to resolve. For example, there were delays in allocating medical social workers, which could take 8-10 days and this impacted on provision of care packages in the community.

Patient discharge planning commenced on admission and staff recorded this on a discharge check list in the patient record. Discharge letters were generated electronically and sent to referrers and copied to the patient. Timely discharge was promoted via digital posters, which prompted staff to be proactive in ensuring patients were discharged safely before midday, where possible.

Managers monitored patient moves between wards. Staff we spoke with explained they tried to provide as much advance notice to patients as possible. The average number of bed moves per day for medical wards at Friarage hospital in last 6 months was 0.8 bed moves, of which 0.1 was out of hours. Days with high numbers of bed moves largely reflected ward moves such as decant for deep cleans, where all patients residing on a ward were moved. Other key reasons for moves were infection prevention control (isolation, cohorting), moving patients to a side room for privacy and dignity (including care of the dying patients), and patients moved to James Cook University Hospital from to Friarage Hospital according to required level of care.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Length of stay was shown on electronic white boards on the ward. Some lengths of stay were excessive, particularly on one ward where several patients stays were in excess of 40 days and one was 126 days. Staff we spoke with told us they escalated their concerns to managers.

As of September 2022, 70% of patients were delayed at discharge. This was the fourth highest in the North East and Yorkshire, Cumbria and North East ICS and 6% under the regional average (76%).

For 45% of the adult care setting, the main reasons for delayed discharge were due to awaiting availability of resource for assessment and start of care at home (39.8%), and awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement (15.7%). Second highest (38%) was for the community setting. The main reason for delayed discharge was awaiting availability of a rehabilitation bed in a community hospital or other bedded setting. This was similar to the regional and national picture.

Since our last inspection, the trust had improved its discharge processes by rolling out a centralised discharge process through a new transfer of care hub. Dedicated discharge staffing had doubled, and the team worked 7 days a week. Every discharge was now followed up with a welfare call to the patient or their carers.

There had been a 50% reduction in safeguarding concerns related to discharge in the first quarter of 2022/2023 when compared to the same quarter in the previous year. There had equally been a 50% reduction in complaints and concerns raised relating to these discharges over the same period. A total of 84% of patients contacted post-discharge had no issues or concerns with their discharge.

Medical care (including older people's care)

Managers worked to minimise the number of medical patients on non-medical wards. There was now a formal procedure in place for management of patients outside of their base speciality location (medical patients accommodated on non-medical wards). These patients were always reviewed by their specialist medical teams. The site sister and flow coordinator were aware of the locations of all patients in real time, via the electronic white board system, which was updated regularly on each ward.

There was a fast track system in place to facilitate prompt discharge for patients at end of life who expressed a wish to die at home. However, staff we spoke with shared concerns that some patients at end of life who required fast track discharges had to wait 4 to 6 weeks. This meant that some patients were not discharged to their preferred place of death in time.

Staff aimed to facilitate discharges prior to 10am and following risk assessment, patients awaiting transport waited in a discharge lounge. Where possible, medicines to take home were prescribed and dispensed the day prior to discharge.

From January 2021 to December 2021, patients at Friarage Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Patients in medical oncology, clinical oncology had a higher than expected risk of readmissions. However, Gastroenterology had a lower than expected risk of readmissions for elective admissions.

Patients in general medicine and respiratory medicine had a lower than expected risk of readmissions. However, Infectious diseases had a higher than expected risk of readmissions for non-elective admissions.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. For example, they discussed with staff directly, contacted the trust patient advices and liaison service (PALs) and submitted feedback on the NHS choices website.

The service clearly displayed information about how to raise a concern in patient areas. For example, the trust used an electronic platform to receive feedback on Friends and Family Test (FFT) and in real time, using electronic tablet devices in all inpatient's areas.

Staff we spoke with understood the policy on patient and carer experience (complaints) and knew how to handle them. Staff we spoke with said most complaints were about poor communication between staff and family members and carers. This concurred with trust board papers we reviewed. Trust wide, medicine and emergency care services received the highest number of complaints. Most were acknowledged within 3 working days. However, data for the period July 2021 to June 2022, showed medicine and emergency care services consistently did not meet trust closure timeframes.

Managers investigated complaints and identified themes.

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

Medical care (including older people's care)

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Is the service well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Managers had the right skills and abilities to run the service. However, they did not always manage the priorities and issues the service faced. For example, we had concerns regarding the management and processes which underpinned the delivery of safe and effective care and treatment.

Staff spoke positively about their leaders and felt respected. Staff we spoke with told us the chief nurse, deputy chief nurse, head of nursing and matrons were accessible and visible.

Staff we spoke with told us how management had supported them to take on more senior roles and succession planning.

Vision and Strategy

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

Staff we spoke with were unable to describe the overarching vision and strategy for the trust. However, we observed the trust's quality priorities 2022-2023 displayed on posters in all areas we visited. Wards also displayed their own vision for the service.

All staff we spoke with told us they felt there had been ''significant improvements'' since our last inspection.

Culture

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

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff completed mandatory equality and diversity training.

Medical care (including older people's care)

Staff at all levels were actively encouraged to speak up and raise concerns. Staff we spoke with described an 'open' culture. For example, there was a freedom to speak up policy to enable staff to speak up if they had concerns about colleagues' professional behaviours. All staff we spoke with were aware of this, had received training and told us they felt empowered to challenge behaviours.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

Governance

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

Core services were arranged within clinical collaborative groups. The governance structure was clear, and the local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports, to maintain quality.

Managers attended bimonthly Clinical Collaborative Board Meetings with ED teams. The agenda included for example, discussions about key safety messages from serious incidents, finance, IPC updates and human resources business.

Frequency of staff meetings on wards was variable and some staff we spoke with could not recall when they last attended a meeting. However, staff we spoke with told us minutes of meetings were emailed to them by the ward manager, when they were unable to attend in person.

Staff we spoke with were aware that senior management colleagues, for example managers, matrons and clinical leads, attended monthly clinical governance meetings and discussed incidents and learning from them. Staff we spoke with told us these were held virtually and were recorded.

Following our last inspection, the trust had identified that there had been an issue with the uploading of historical data to external reporting systems. Since then, the trust has revised the process for incident management and review.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. For example, we observed wards had computers labelled for use as ''business continuity only''. These functioned as a backup system to enable staff access to patient records in the event the main IT system failed.

The trust had a winter plan in place to manage anticipated surges in demand and associated staffing needs.

Information Management

Medical care (including older people's care)

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, information systems were not all integrated. Data or notifications were consistently submitted to external organisations as required.

Staff we spoke with shared concerns that current electronic records systems were not integrated. For example, the system used in urgent care was not compatible with ward systems and staff could not access electronic records held externally by GPs. Staff we spoke with explained they would be trialling the implementation of a single on- line patient record, which would integrate with other electronic systems, such as GP records. However, they were unclear when this would commence.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The Trust participated in annual national patient experience surveys, including those living with dementia. The trust had developed a dementia strategy.

We reviewed the latest trust wide staff survey results for 2021. This indicated average satisfaction scores when compared with the national benchmark. Medicine collaborative staff satisfaction scores were similar to results trust wide.

The trust also completed periodic staff health needs assessment surveys. These looked at indicators such as anxiety, depression, post-traumatic symptoms and sleep disturbance, by staff groups and ward / team areas. As a result of the survey, the staff psychology service was set up. The service provided on site psychological support to frontline staff in relation to difficulties arising through the course of their clinical duties.

Learning, continuous improvement and innovation

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

Staff we spoke with told us how managers had supported them to develop their career. For example, they attended courses to extend clinical skills such as non-medical prescribing. Staff that were non-medical prescribers received appropriate supervision.

The hospital supported student nurses from a local university though structured placements.

In addition, the trust piloted a 12-week programme of clinical simulation training. This used state-of-the-art immersive simulation suites and virtual reality headsets for students to gain virtual practical working experience in real life hospital ward environments and scenarios.

Staff received recognition for achievements. For example, the trust held ‘star of the month’ awards whereby staff could nominate each other. Public could also nominate staff at the annual ‘Nightingale awards’.

Two cancer teams had been shortlisted for a nursing times award in the last 12 months, and one shortlisted for nurse of the year.

Medical care (including older people's care)

The trust had implemented an innovative system tied to the move to electronic assessment and recording of patients' nutrition and hydration. This meant that on a daily basis, at a glance, it was possible to see how many patients in the hospital required additional support to meet their nutrition and hydration needs. When a ward tipped over a predetermined point on the system, for example, when multiple patients required additional support, the system triggered allocation of an additional support worker to the ward to assist with eating and drinking

Surgery

Good

Is the service safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Although medical staff were lower than the Trust target in their completion of mandatory training.

Nursing staff received and kept up-to-date with their mandatory training. The nursing staff achieved an overall completion rate of 92.04% against the Trust target of 90% compliance.

Medical staff received and kept up-to-date with their mandatory training. The medical staff compliance rate was 84.21% which is below the Trust target of 90%.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although compliance rates for training in medical staff were below the Trust target.

Nursing staff received training specific for their role on how to recognise and report abuse. The compliance figures for nursing staff were at 90.75% overall for Safeguarding Level 2 training for both adults and children, this was slightly above the trust target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse. The compliance rates for medical staff were at 84.68% overall for Safeguarding Levels 2 and 3 for both adults and children, and this was below the Trust target of 90% completion.

Surgery

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were for support. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (February 2022), version controlled and had a review date of January 2025.

Staff told us matrons produced safeguarding reports where any learning for staff was included.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient.

The service generally performed well for cleanliness. Cleanliness audits scored between 90% and 95% in the previous 6 months before inspection. Cleaning records were not all up-to-date and we saw gaps on the week of our inspection on records we were shown on site. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE.

Staff worked effectively to prevent, identify and treat surgical site infections.

Not all Control of Substances Hazardous to Health (COSHH) cleaning products were safely stored away in cleaning cupboards as per process and we found one unlocked cupboard when on site during our inspection. Staff were made aware and rectified this immediately.

Environment and equipment

Surgery

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

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys on Gara ward, in POSDU and in the theatre suite. Daily checks were completed correctly on all wards.

The service had suitable facilities to meet the needs of patients' families.

Fire extinguishers were present on all inspected services and in date. We also saw that fire exits were checked and clear and the fire safety logbook and reference manual clearly stated who the fire safety advisor was. The fire safety policy was available to all staff and staff were aware of hospital fire procedures.

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

Staff disposed of clinical waste safely. The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records showed that staff had used the early warning scoring system that the trust used to correctly record, calculate and review patients for signs of deterioration as required. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust's early warning and sepsis scoring protocols.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at sets of records across six wards and theatres which were a combination of paper and digital records on the trust's EPR system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

We observed the World Health Organisation checklist for safe surgery (WHO checklist) being used and noted good practice in that patients were checked in by both the surgeon and anaesthetist. We looked at five records for patients in theatre during our inspection and the WHO checklist was correctly followed and recorded in all cases. The service carried out regular audits of the use of the checklist and for the last three months compliance with the use of the checklist was at 100%.

Surgery

Staff knew about and dealt with any specific risk issues. A bank nurse was able to tell us about the sepsis protocols and shared with us the training she had received. Where an indicator of sepsis was identified, the trust followed the Sepsis Six model to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

Early warning scores were used to monitor patients and detect deteriorating patients, or patients who required escalation or additional care or treatment. The trust had a dedicated critical care outreach team, staff knew the process with regard escalating concerns for deteriorating patients with the team and could give examples of when this had happened. We saw in patient records that the team attended promptly.

There was a recognition and management of the deteriorating patient policy, which included sepsis. Staff we spoke with were clear about signs and symptoms of deteriorating patients and gave examples of when and how they would escalate a concern.

The service had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

Staff shared key information to keep patients safe when handing over their care to others. The wards had daily safety briefings which highlighted potential risks to patients. The agenda included points such as 'patient specific risks', capacity in the ward, staffing levels and a review of patients coming to the unit.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers were supported using briefing documents to ensure consistent messages across shifts. We observed hand over sheets on all wards we inspected. The nursing handover document included key information regarding individual patients which included a plan of care, key risks, and discharge plans.

Nurse staffing

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

The service did have enough nursing and support staff to keep patients safe. Staffing has continued to be a challenge across the Trust with short notice unavailability associated with Covid isolation, Covid related absence and non-covid sickness and vacancies. Stretch staffing ratios in line with national guidance have been implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care meetings.

Nursing Turnover for October 2022 had decreased to 8.60% which was one of the lowest rates in the country.

The percentage of shifts filled against the planned nurse staffing across the Trust was 95.9% for October 2022. Overnight average fill rates for staffing were at least 100% for the three months before inspection.

Surgery

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients.

The service had reducing turnover rates. In October 2022, nursing turnover had decreased from 9.25% to 8.60%.

The service had reducing sickness rates.

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

On inspection we observed staff working hard to complete tasks for patients; however, we were not assured that staff had the time to always provide person centred care that met individual patient needs.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

Medical staffing

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

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rota's we reviewed for the three months prior to inspection.

The medical staff matched the planned number.

The service had reducing vacancy rates for medical staff.

The service had low turnover rates for medical staff.

Sickness rates for medical staff were low at 0.38% for medical staff in October 2022. The Trust sickness target was 3.90%.

Managers could access locums when they needed additional medical staff.

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw enough numbers of medical staff on the wards we visited to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Records

Surgery

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

Patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We reviewed five sets of patient records across the ward and theatres which were a combination of paper and digital records on the trust's Electronic Patient Record (EPR) system. We noted that they were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Food and fluid balance charts and MUST charts were completed in line with guidance; weight was recorded on admission and then weekly thereafter, we saw recording of patient weights in line with this.

We observed robust medical admission and daily review information recorded by the ortho geriatrician and medical team consistently across the records that we reviewed.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Records assured us patients were receiving their medicines as prescribed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

We saw evidence of pharmacist clinical checks to review patients' medicines regularly whilst they were an inpatient and saw that actions raised by pharmacists were actioned by the medical team in a timely manner.

Staff completed medicines records accurately and kept them up-to-date. Staff followed national practice to check patients had the correct medicines when they were admitted. Medicines recorded on both paper and digital systems for the five sets of records we looked at were fully completed, accurate and up-to-date.

Staff usually stored and managed all medicines and prescribing documents safely. In theatres, Controlled Drugs (CD) were kept securely and staff checked them twice a day. Similarly, drugs that needed to be kept cool were kept in a locked fridge and were found to be in date. Fridge temperatures were recorded daily, and no concerns were noted by the inspection team. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

Staff stored and managed all medicines and prescribing documents safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date.

Surgery

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

The pharmacy team provided a weekday medicines reconciliation service and in all but one of the records we looked at had received a medicines reconciliation. Data provided us to after the inspection however demonstrated that the trust were not hitting their target of 80% completed medicines reconciliation in 24 hours on all surgical wards.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

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

Staff knew what incidents to report and how to report them. Staff we spoke with were able to clearly share how to report incidents and shared examples of this with us. Staff were able to articulate doing this in line with Trust policy.

Incident learning was shared with staff and we saw the 'Patient Safety Newsletter' which is issued regularly to all staff. This included information on learning from incidents and improvements across the Trust.

The service had no never events on any wards.

Managers for the service had sight of all incidents and all incident rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Staff met to discuss the feedback and look at improvements to patient care

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care

Staff reported serious incidents clearly and in line with trust policy.

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

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

Managers debriefed and supported staff after any serious incident. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email.

Surgery

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. During inspection we saw staff on all wards having designated staff to serve patient food and separate staff able to help assist patients with positioning or feeding as required. We saw that patients were encouraged to sit at chairs at mealtimes.

Kitchen staff were clear on patients' dietary requirements and needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw that this was accurately completed on the patients we looked at during our inspection.

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

The trust had nutrition specialist nurses to support patients including those receiving artificial nutrition support, for example percutaneous endoscopic gastrostomy (PEG); A PEG feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed the Trusts standard operating procedure (SOP) for surgical patients who were nil by mouth. The SOP was in date and due for review in February 2024. The policy had information to support staff with a protocol for intravenous fluids and information for pre fasting guidance for patients before surgery.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The trust used differing methods to assess patient pain levels which included FLACC assessment, Burford thermometer and VAS score.

FLACC is a behavioural pain assessment scale used for nonverbal or preverbal patients who are unable to self-report their level of pain. Pain is assessed through observation of 5 categories including face, legs, activity, cry, and consolability. The Burford thermometer assesses pain by asking patients to indicate the intensity or severity of their pain on a diagram of a thermometer. It is a version of a verbal descriptor scale that visually represents increasing degrees of pain along the thermometer. Visual analogue scales (VAS's) are used for subjective ratings of emotion or other sensations such as pain.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. We saw staff completing and updating the patient records.

All staff we asked knew about the trust's specialist pain management team (SPT). They knew how to contact them either by bleep, formal referrals via the ICE system or just ringing them for advice.

The latest pain relief audit results received from the Trust showed that they were at an overall average of 87% for September 2022 in pain score being evaluated following analgesia in patients.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. All staff working at the hospital had an induction programme relevant to their role and the department they worked in. New staff were required to complete e-learning and face-to-face training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Line and ward managers completed annual appraisals including any learning and development opportunities with their staff and we saw these scheduled-on noticeboards on individual wards.

The clinical educators supported the learning and development needs of staff.

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

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported by their managers to improve their practice where indicated.

We reviewed the general security policy which had an issue date of January 2022 and a review date of December 2024.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

When we visited the wards and observed a handover, we saw a variety of staff working together, such as nurses and support workers, to benefit patients. Nursing staff said they had good communication between theatre and ward staff. They felt the trust had an informal culture of cross-service collaboration, for example by borrowing equipment and asking advice.

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

There was a dedicated discharge team and they had been in place since January 2022. They had links with local services, local authorities and care providers.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff of all grades and all disciplines worked together as a team to benefit patients. Doctors, nurses, healthcare professionals and administration staff supported each other to provide excellent care.

There were many examples of multidisciplinary working including the daily safety briefing, ward rounds which included input from a consultant, doctors, pharmacist, physiotherapist and as well as nursing staff.

Surgery

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

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight. There was no dedicated occupational therapist but referrals could be made.

Speech and language therapy were offered Monday to Friday. There were a low number of speech and language therapists available within the trust which reflects a nationwide shortage of this staff group.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

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

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw displays on wards we visited through our inspection on healthy lifestyles and health promotion. There were leaflets available for patients to take on a variety of topics including diabetes, weight loss, stop smoking and stress.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

There were guidelines in place to support patients withdrawing from drugs or alcohol. Staff told us the pharmacy department and consultants would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed additional sections of service user records relating to Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications. We saw capacity assessments, best interest decisions and consent to care and treatment were in line with legislation and guidelines and staff did recognise and respond to concerns in relation to mental capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

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

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with had attended mandatory training surrounding mental capacity act and deprivation of liberty safeguards training and understood capacity was decision and time specific.

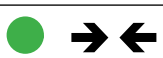
Staff liaised with the psychiatric liaison team (PLT) for all mental health patients and PLT would make decisions about required mental health treatment in conjunction with trust staff. PLT staff undertook mental health assessments to identify if a Mental Health Act Assessment was required.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good 

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

Compassionate care

Surgery

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We reviewed the friends and family data results for surgical wards for the three months prior to our inspection visit, and the average result for these was 95.4%. This was higher than the Trust target of 90%.

We also reviewed patient satisfaction surveys for surgical wards for the three months prior to our inspection visit. These scored an average of 96.6%.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with compassion and saw staff provided care in a respectful manner that maintained patient dignity. For example, staff drew bay curtains to have private conversations or examine the patient.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

Surgery

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

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

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

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

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

Initiatives to enhance the care of those with a learning disability were in place. Hospital passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individuals during difficult periods.

Surgery

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and what expectations to have of the services being provided.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

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

Access and flow

People could access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The overall waiting list for surgery has increased over the 12 months prior to inspection, but the longer waiting times had decreased due to the management of the lists. At the time of inspection, there were no 104 week waits for patients.

The trust performed well in comparison to other providers and the national average for 52 and 78 week waits, which were at 97% and 99.8% respectively. For combined surgical specialties, the 18 week performance was 67% which was better than the 61% national average in October 2022. Since May 2022, 18 week waits had improved by 11%. Some specialties were performing better than others. Endocrinology was top (93%) and urology was bottom (58%) however urology waits had reduced by 62% for 52 week waiters in March 2023.

The trust was on par with or better than other providers and the national average for cancer waiting times. The 14 day cancer referral rate was 73%, slightly below the national average of 80%. However, the 14 day breast cancer referral rate was 100% and much better than the national average of 72%. The rates for 31 and 62 days were 94% and 56%, just above and slightly below the national averages of 93% and 62% respectively. The trust had prioritised the 62 week wait which had shown improvement towards its end of year plan and had met its target. Since our inspection, the Trust have achieved their cancer diagnosis level in March 2023 for 62 day waits for cancer treatment.

In response to a request from NHS England, the trust provided mutual aid to other NHS trusts in the region for spinal surgery and cardiothoracic surgery. Although this meant the trust's referral to treatment times were impacted, the trust had contributed to the reduction of the longest waits across the region.

The Trust met NHS targets set overall for 104, 78 and 52 week waits for surgery.

Surgery

The Trust was in Tier three for elective recovery (including cancer) in November 2022 due to the reduction in patients waiting to be seen. This meant the Trust did not need regional oversight and had moved into an improved tier because of this.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Gara ward is a dedicated orthopaedic elective ward and therefore would not have any medical outliers.

As part of last year's winter plan there was an agreed pathway to use part of POSDU (12 beds) for medical patients, with a set criteria and this was only used during the winter.

Managers monitored that patient moves between wards were kept to a minimum. The average bed move per day in the 12 months prior to inspection was 0.2. There were no patients moved out of hours.

Managers and staff started planning each patient's discharge as early as possible. The average length of stay for surgical specialities was 2.1 days for patients at the time of our inspection.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of patients whose discharge was delayed. In the 12 months prior to inspection, there was an average of 0.5 patients per day on surgical wards that had delayed discharge.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

In September 2022, the diagnostic hub opened at Friarage Hospital and because of this, 40% more patients have been treated since then in endoscopy and urology.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with had said they felt able to raise concerns and could see that the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There were 16 complaints in progress at the time of inspection and these were all being handled as per the Trust process. The average length of time to respond to a formal complaint was 56 days.

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

Surgery

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgery had managers with the right skills and abilities to ensure the service was providing high quality care. Leaders were inspiring a shared purpose and were focussed on delivering and motivating staff to succeed. Managers were keen to retain staff and invested in education for staff to progress.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care.

The clinical leadership team were visible and approachable. From speaking with staff, it was clear that staff had confidence in working together and in leaders understanding issues and working better to improve them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders want to achieve in surgery and this is in line with the Trust vision. The service promoted training, and staff were aware of the vision for surgery and were able to share this with us during inspection.

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

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

Culture

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

Surgery

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

The care and service delivered showed a strong team approach to work. Staff from all disciplines told us they felt valued in their roles and were very much part of the team. Staff we spoke with expressed pride and commitment in their work.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

Governance

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

Staff at all levels of the organisation understood what to escalate to a more senior person, and this happened for reporting low staffing levels Ward managers told us that they have the option to report red flags due to low staffing levels. The number of red flags were reported monthly to the board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks, and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

There was a robust governance process related to risk with monthly risk meetings. The risks were escalated via the collaborative governance meetings and the directorate meetings. The collaborative board and the corporate risk review group oversaw the reported risks.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

Information Management

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

Staff had access to the IT equipment and systems needed to do their work and the trust's IT systems had received international recognition for how they helped improve the quality of care.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams. The trust had automated data collection systems which ensured monitoring performance was not over burdensome for front line staff.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the Trust had asked additional questions regarding the awareness of Trust values.

There was a flexible working group which has a focus on providing more varied options of working to deliver care that will help to help retain staff and improve retention. There was an individual toolkit and a line manager toolkit developed within this to support requests for flexible working and encourage a flexible workplace.

There was a clear focus on engagement activities to develop a culture of inclusion. The Trust delivers quarterly 'Reciprocal Mentoring' group events and these have led to the launch of Discovery Events for staff from ethnic minority groups.

Learning, continuous improvement and innovation

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

The Trust has a Trust Talent Management Strategy which has three levels drawing together core talent management interventions. Since 2018, the Trust have had 51 members of staff who have undertaken Level 7 Leadership Courses, of which 29 have obtained promotion since completing the course and only 2 have left the organisation.

The James Cook University Hospital

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Description of this hospital

James Cook University hospital in Middlesbrough provides a wide range of district general hospital services and specialist services such as neurosciences, renal medicine, spinal injuries, major trauma, cardiothoracic, vascular surgery and cancer services. It has 1,024 beds, a 24-hour acute admissions unit and an emergency department which houses the major trauma centre for Durham, East Cleveland, Tees Valley and North Yorkshire and has its own helipad. The hospital has a central operating suite containing 20 theatres, with two recovery areas, which is next to an adult surgical day unit (containing a further three theatres) and the paediatric day unit. Two additional theatres for gynaecology and obstetrics are in the central delivery suite and there are two more in the ophthalmology (eye) day unit. Maternity services deliver more than 4,400 babies a year in purpose-built delivery and low dependency suites. The hospital has a regional tertiary neonatal intensive care unit and support a neonatal transport service. James Cook University hospital has a 21-room imaging department and a purpose built six-bed radiology day unit. A medical physics department is also on this site together with isotope imaging. There is a central clinical laboratory which provides pathology services to wards and departments and the wider Tees Valley in partnership with North Tees and Hartlepool NHS Foundation Trust."

Urgent and emergency services

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

Although the service provided mandatory training in key skills to all staff, training compliance rates for medical staff still did not meet the trust target.

Managers monitored mandatory training and could alert staff when they needed to update their training. Since the last inspection there had been high levels of input from clinical educators who had played a key role in improving overall compliance rates and supporting staff to develop their clinical knowledge and standards within the department.

Content of training and information posters on display in the staffing areas were comprehensive and promoted the needs of patients.

Staff could gain quick access to training modules via the use of QR codes displayed within staff only areas.

Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Nursing staff received and kept up to date with their mandatory training, exceeding the trust target of 90%.

However, not all medical staff received and kept up to date with their mandatory training, with an overall compliance rate of 77% which was below the trust target.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff training compliance remained below the trust target.

Nursing staff received training specific for their role on how to recognise and report abuse. At the time of the inspection nursing staff exceeded the trust target of 90% for safeguarding training.

Although medical staff received training specific for their role on how to recognise and report abuse, the overall compliance rate for safeguarding training was 72%.

The trust's safeguarding adults and safeguarding children's policies were in date and version controlled. The policies stated that safeguarding training is mandatory for all staff and the level of training required is based upon their role.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding was a standard agenda item across the department and during the inspection we observed safeguarding issues being discussed within handover meetings and safety huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and we saw examples of staff contacting the relevant authorities to ensure safety concerns were appropriately flagged.

Relevant processes were in place for medical staff to conduct child protection medical examinations and staff were able to explain how they would escalate their concerns regarding a child's safety.

Staff followed safe procedures for children visiting the ward. Access to the children and young people's emergency department (CYPED) could only be obtained via the use of a swipe card.

Within the department there were various information posters promoting the safety and wellbeing of individuals, such as support for victims of domestic violence and keeping children safe from harm. The department also had support from a designated safeguarding link nurse to provide additional support and advice around safeguarding concerns.

Cleanliness, infection control and hygiene

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

All areas appeared visibly clean and had suitable furnishings which were clean and well-maintained. We saw regular continuous cleaning across the department with domestic staff accessing the department 24 hours a day.

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

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

We inspected seven treatment bays, all were visibly clean. Disposable labelled curtains were used and all mattresses were clean and free from breaks.

We saw that staff regularly cleaned equipment after patient contact.

All sharps bins were dated, signed and less than three quarters full.

The IPC environmental audit tool completed in September 2022 for the paediatric department scored 93%.

During the inspection the department had put in place a no mask policy. However, when a patient displayed potential signs of COVID-19, we saw staff following infection control principles including the use of appropriate personal protective equipment (PPE) and were bare below the elbow.

There were sinks available in the department with hand gel and handwashing instructions on posters displayed near the sinks. Staff were observed washing their hands before and after patient contact.

However, the most recent infection prevention and control (IPC) environmental audit tool completed in September 2022 for the adult emergency department scored only 79%.

Environment and equipment

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

Access to the department was clearly signposted, along with trust guidance on the criteria for attending in order to promote appropriate use of the service by the public. Face coverings and hand sanitising stations were available for those attending the department, although, at the time of the inspection, mask wearing was not mandatory.

The design of the environment now followed national guidance. There was now a separate CYPED for children up to the age of 18 years, which could be accessed 24 hours a day.

Both the adult department and CYPED waiting areas had adequate seating available for those attending. Overall, staff based in reception had good oversight of the waiting areas. However, on the first day of the inspection during a particularly busy period, visibility of the adult waiting area was limited by people standing directly in front of the check-in area. There was also a blind-spot in the corridor area leading up to the triage area which presented further visibility issues for reception staff. However, the trust told us they had buildings works planned to address this.

Vending machines had been scheduled for installation in the adult department waiting area. However, this had been delayed due to ongoing building work. Following the inspection, the trust provided evidence that vending machines had been successfully installed within the department.

At the time of the inspection, there was access to a tap for fresh water and we also saw staff members providing patients, particularly those experiencing long waits, with refreshments when possible.

Patients were able to safely share personal information with reception staff in both the adult and paediatric departments who sat behind protective screens away from the main waiting area. The reception desk was at a height enabling patients in wheelchairs to speak to staff members and there was also a hearing loop system in place.

For patients arriving by ambulance, a new ‘impact nurse’ post had recently been introduced to liaise with ambulance crews and prioritise patients in need of more urgent treatment. At the time of the inspection patients arriving by ambulance were allocated a position in a corridor adjacent to the department. Ambulance crews described experiencing extended handover times due to the level of activity within the department. However, we saw instances where the impact nurse used their professional judgement to prioritise cases on a risk basis.

Within the majors and minors areas of the adult department, not all patients could easily reach call bells. However, we saw multiple examples of staff responding proactively when called upon and patient feedback was positive about the efforts of staff to ensure they were supported to be as comfortable as possible.

There were dedicated relatives’ rooms located within quiet areas of both the adults and paediatric emergency departments.

The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment such as hoists and oxygen cylinders which were appropriately stored within the department.

Clinical waste was managed in a way that kept people safe. Arrangements were in place for the segregation, storage and disposal of waste.

There was evidence of back-up generators receiving regular essential service and testing and the department fire risk assessment was in place**.**

Security support was available to the emergency department 24 hours a day and reception staff had easy access to a panic alarm to request urgent help if needed.

Within the adults department, there was now a dedicated ligature-free room in accordance with the Psychiatric Liaison Accreditation Network (PLAN) standards which could be allocated to patients deemed to be at potential risk of harm as a result of mental health crisis. The room was minimally furnished and near the nurses' station for monitoring purposes.

However, within the CYPED mental health room, ligature points were identified on door hinge covers. This was flagged with the trust during the inspection and relevant adjustments were made to immediately resolve the issue.

Although most resuscitation trolleys were appropriately stored within the department and included all relevant equipment and had a designated safety checklist in place, we found an unlocked trolley stored in one of the link corridors between the CYPED and paediatric same day emergency care unit (SDEC). This was immediately addressed by the senior nurses in charge.

On inspection we found multiple consumable items from storage areas within the CYPED which were missing an expiry date or were out of date. These included face masks and nebulisers. This was immediately escalated to staff and the items restocked. There were no issues with the stock checked in the adults department.

Unlike the adult emergency department, the CYPED had three separate resuscitation rooms, both of which were spacious and enabled staff quick and easy access to the patient.

Assessing and responding to patient risk

Staff completed risk assessments for each patient's physical health and quickly acted upon patients at risk of deterioration. However, the systems in place to monitor risks associated with patients experiencing mental health crisis were not always clearly visible.

Upon arriving in the department, patients were triaged using a nationally recognised clinical risk management tool used to safely manage patient flow and help identify deteriorating patients.

We also saw some evidence of subsequent checks of patient physical observations being completed within the waiting area. The most recent records audit completed within the department for October 2022 highlighted that 88% of the 56-person sample had their observations repeated whilst waiting to access the department. The same audit for September 2022 highlighted 92% compliance from a sample of 81 patient records and 100% compliance from 21 records checked in August 2022.

Staff knew about and dealt with any specific risk issues. The trust provided us with a range of audit information and there was also information on display in staffing areas highlighting both audit outcomes and learning from incidents to aid staff awareness and development to deliver safe care and treatment.

There were relevant guidance and policies for managing falls and evidence in patient records that falls assessments had been appropriately completed for patients considered to be at risk of falling. Information on display for staff highlighted that since July 2022 there had been one fall within the wider trust which had been declared as a serious incident due to the patient suffering a fractured neck of femur. Learning points from this incident were clearly highlighted to promote departmental learning and to mitigate the risk of a potential similar incident occurring within the emergency department.

Audit data obtained from the trust highlighted that staff now consistently checked patients' skin integrity and ensured that the Braden Score, a universally recognised tool for identifying patients at risk of developing pressure ulcers, was logged in patient records.

The most recent audit data obtained for National Early Warning Score (NEWS) compliance highlighted that all the 158 patient records checked between August 2022 and October 2022 had observations clearly documented. The audit results also highlighted that staff had consistently repeated physical observation in August 2022 and September 2022. However, only 88% of patient records audited in October 2022 had repeated physical observations documented.

The most recent audit for Paediatric Early Warning Score (PEWS) compliance completed in October 2022 highlighted that staff had taken all appropriate actions when needed to ensure the safety of the 15 paediatric patients taken as part of the audit sample.

The department also now had a dedicated sepsis link worker providing additional support and advice to staff.

Department board rounds now took place at regular intervals throughout the day in order to monitor patient risk and access and flow within the department. Shift changes and handovers also included all necessary key information to keep patients safe.

The service had 24-hour access to mental health liaison, mental health crisis teams and specialist mental health support from an NHS psychiatric hospital located within a short distance to James Cook University Hospital.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide and there were examples of risk assessments which had been compiled with the support of psychiatric services.

However, the completed mental health risk assessments were not always clearly visible on the electronic system and not all staff we spoke with were able to locate the risk assessment when requested by the attending inspectors.

Although there was a basic alert system in place to highlight risks associated with individuals, such as risk of absconding from the department, there was no clear system to categorise and flag actual level of risk to both self and others for patients experiencing mental health. We found examples where this lack of clarity presented some challenges delivering additional support to mental health patients accessing the department.

Nurse staffing

Urgent and emergency services

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

The number of nurses and healthcare assistants matched the planned numbers and the service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could adjust staffing levels daily according to the needs of patients.

Information provided by the trust post-inspection highlighted the service had a vacancy rate of 11.9% for nursing staff and 10.3% for unqualified nursing staff. However, we were told by the department manager that there had been a recent recruitment drive and that the department was no longer experiencing a shortage of staff.

The service had a turnover rate of 7.6% for nursing staff.

The service had a sickness rate of 8.7% for nursing staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers also made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

The service had enough medical staff to keep patients safe and the medical staff matched the planned numbers on the day. Overall, the service had a good skill mix of medical staff on each shift and this was reviewed on a regular basis.

There was 24 hour Consultant cover available across the emergency department for both adults and paediatric patients, which exceeded the recommended 16 hours of cover recommended by the Royal College of Emergency Medicine.

During the inspection the medical staffing matched the planned number.

The service was over established by 7% for consultants and 8.2% for other medical staff.

The service had a turnover rate of 19.9% for all permanent medical staff employed by the trust, including those on fixed-term contracts.

At the time of the inspection there were no medical staff off sick.

Managers could access locums when they needed additional medical staff and ensured that a full induction to the service was provided before they started work.

Staffing rotas provided by the trust highlighted that the department had a good skill mix of medical staff on each and there was always a consultant available during evenings and weekends.

Records

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

Patient notes were comprehensive and all staff could access them easily. Records were stored securely using an electronic system which could only be accessed with an individual staff login.

When patients transferred to a new department or team, there were no delays in staff accessing their records.

Patient records audits provided by the trust for the period August 2022 until October 2022 highlighted that staff had consistently ensured accurate and contemporaneous records were kept for patients attending the emergency department. However, there were shortfalls with staff ensuring that patient property had been accurately documented during this period with only 76%, 80% and 79% compliance across the three months.

Medicines

The service had systems and processes in place to safely prescribe, administer, record and store medicines. However, some medicines were out of date and we identified a potential security issue regarding the secure storage of medicines which the trust took proactive steps to immediately resolve.

Staff completed medicines records accurately and kept them up-to-date. Staff also followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice and we saw examples on display within the department to promote learning and development.

Systems and processes were in place for staff to prescribe and administer medicines safely. However, there were some issues with the oversight of medication expiry dates. During the inspection of the CYPED we found one bag of dextrose saline intravenous infusion and one unopened tray containing nine bottles of chlorhexidine that were out of date. These were immediately removed and the remaining stock checked by staff.

Medicines were stored and dispensed using an automated dispensing cabinet where users had fingerprint logins for security. However, this took over one minute to log out of the system leaving the system and medicines accessible. This was immediately highlighted with the department sister and the time-out session reduced.

Department managers were aware of some issues with staff training when the automated dispensing cabinet was initially introduced. This had been logged on the department risk register in 2020 and subsequently removed in 2021 following the successful re-training of staff. We found that any concerns regarding the automated dispensing cabinet were proactively flagged with the pharmacy team for action to be taken. However, at the time of the inspection there was no dedicated pharmacy worker in place for the emergency department.

Urgent and emergency services

The trust provided us with additional evidence that demonstrated regular electronic stock checks were completed using the dispensing cabinet database to ensure storage and prescribing was done so in-line with national guidance.

The amount of controlled drug wasted at each medicine administration was recorded on the automated dispensing cabinets within CYPED and the adult department.

Incidents

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

Staff we spoke with could describe how to raise concerns and knew how to report incidents and near misses in line with trust policy.

There were examples on display where a range of staff shared learning about serious incidents. Staff now received feedback from investigation of incidents and had the opportunity to discuss the feedback and look at improvements to patient care.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed an incident where a staff member had taken the opportunity to produce a video for the department in which they openly reflected upon their own personal learning from a safety incident which had been flagged by the trust.

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

Managers debriefed and supported staff after any serious incident and shared learning with their staff about incidents and never events that happened elsewhere.

Is the service effective?

Good ➔➔

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff had access to a wide range of policies and treatment guidelines which were stored electronically. Policies and procedures were based on best practice from NICE and the Royal College of Emergency Medicine guidelines (RCEM). A lead consultant had the responsibility of assessing the guidance and updating when necessary.

The department maintained strong links with the neighbouring psychiatric hospital which enabled staff to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice.

During handover meetings and in patient records, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Every patient attending the department had their mental health needs taken into consideration throughout the triage process with a risk assessment being completed if any signs of mental health crisis were identified.

Nutrition and hydration

Staff ensured that patients had enough food and drink to meet their needs and improve their health.

The trust told us food and drinks had not been routinely provided to patients within the adult and paediatric departments, other than by exception. However, in response to patient feedback and recognition that patients were now staying longer in the department, the trust introduced notices in the waiting rooms advising patients to inform staff if they were hungry or thirsty. The department had also introduced hydration stations and a hot drinks machine.

During the inspection we also saw patients experiencing prolonged waits being provided with food from the main patient kitchen, which could be selected from a set menu.

The emergency department intentional rounding audits for September 2022, October 2022 and November 2022 highlighted that 95%, 86% and 92% of the patients included in the audit sample had been offered food and fluids.

Staff had completed patients' fluid and nutrition charts where needed and used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain management audit results from April 2022 up until October 2022 highlighted that staff consistently completed an initial pain score and re-evaluation of pain in patient records, with overall compliance between 97% and 100% for the seven-month period.

Staff prescribed, administered and recorded pain relief accurately.

Information and guidance clearly displayed within the staffing areas promoted staff awareness of ensuring a consistent and safe approach to pain management within the department.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and worked hard to achieve the best possible outcomes for patients.

Urgent and emergency services

For acute trusts, NHS England's operational pressures escalation levels (OPEL) had been nationally defined as being levels one to four, with four being the highest level of operational pressure. At the time of the inspection the hospital was running at full capacity, causing delays in patient transfers and discharge. Despite the challenges, staff worked hard to achieve positive outcomes for patients.

The department took part in Royal College of Emergency Medicine (RCEM) audits and benchmarked its performance against best practice and other emergency departments.

We found evidence that managers and staff carried out a programme of repeated audits to check improvement over time. Regular support was provided to the department by the clinical educators and the information gathered from audits was shared with staff and used to improve care and treatment.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Between November 2021 and October 2022, the emergency department had a total of 118,742 attendances, with an unplanned re-attendance rate within seven days of 2.19%, which was less than the national average of 5.2% logged in September 2022 by RCEM.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of both adults and children attending the department.

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

Managers supported staff to develop through yearly, constructive appraisals of their work.

The department had practice education and development displays in the staffing areas focussing on the basic nursing care needs as well as more specialised areas of learning unique to the local population. Staff told us they had the opportunity to discuss training needs with their line manager and the recent input from the clinical educators had played a key role in supporting to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to full notes, which were displayed within staffing areas, when they could not attend.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. During the inspection, we saw examples of multi-disciplinary working with occupational therapy to support patient discharge, as well as input from diagnostic services to help inform the most appropriate treatment pathway for patients.

Urgent and emergency services

A new frailty team had been set up in January 2022 on a trial basis until March 2023 to support patients over the age of 70 years with a frailty score and NEWS score of five and under. The team comprised of nurses, occupational therapists and physiotherapists. They identified patients with a frailty flag on the electronic system and aimed to assess the patient within two hours with a view to facilitating transfer or discharge from the department. Feedback obtained from emergency department staff regarding the frailty team was incredibly positive, with hopes that the service could be extended beyond March 2023.

Staff worked effectively across health care disciplines and with other agencies such as adult and children's social care, addictions services and mental health services when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The department could refer patients to psychiatric liaison services 24 hours a day and also had access to an assessment suite based at the neighbouring psychiatric hospital for patients deemed to be at a heightened risk of harm to themselves or others.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. However, patients could experience delays accessing support due to the overwhelming demand being placed upon the hospital and wider integrated care system.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support. There were a selection of QR codes on display within the waiting area which patients could access. Within the department additional information on health conditions prevalent in the local community were also on display.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, not all medical staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, only 72% of medical staff had completed relevant training.

However, staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Urgent and emergency services

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. We found some examples within patient records where staff had assessed and documented patients' capacity prior to commencing treatment in their best interests.

Staff gained consent from patients for their care and treatment during triage in line with legislation and guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw examples where staff had completed relevant MCA documentation and followed appropriate guidance. Information documented was accurate and legible.

Is the service caring?

Good 

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

Compassionate care

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

In the department staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introduce themselves and explain who they were and their role. They spoke quietly to patients to try and ensure they maintained a level of patient confidentiality.

Patients told us staff treated them well and with kindness and that they were happy with the care and support provided despite their frustrations with the long waits to receive it.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients' needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed multiple positive interactions wherein staff were ensuring the emotional wellbeing of both patients and their relatives/ carers

Urgent and emergency services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and undertook training on breaking bad news. Provisions had also been made to support staff with their emotional wellbeing, with a dedicated paediatric bereavement co-ordinator in-post to support both parents and staff after the loss of a child accessing the service.

Understanding and involvement of patients and those close to them

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the department patient feedback and the actions taken by the trust to act upon concerns were clearly on display. Within the staff room we also saw examples of positive patient experiences and highlighted good areas of practice.

The feedback from the Emergency department survey test was generally positive. From August 2022 up until October 2022 a total of 1328 patient surveys had been completed, with 75.3% rating their experience as either very good or good.

Is the service responsive?

Requires Improvement ↓

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

Service delivery to meet the needs of local people

Due to the hospital running at full capacity and a lack of community-based resources there were delays in treatment and discharge from the service. However, the service worked with others in the wider system and local organisations to plan care.

The current pressures in the wider Integrated Care System continued to place pressure on the department in terms of access and flow, resulting in long waits for patients and extended stays in the department. However, staff worked hard to keep patients safe, regardless of their presentation.

Due to the increasing numbers attending the department, patients could experience long stays and delays in treatment. Patients we spoke with told us they had attended hospital as they could not get an appointment with their GP surgery and despite the long wait, knew they would be seen in the emergency department.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke positively about the support of psychiatric liaison. However, the trust highlighted that there was a lack of suitable resources available within the community for patients experiencing mental health difficulties. We were told that patients experiencing mental health crisis would present to the department to seek support and often there would be delays discharging patients due to difficulty accessing appropriate community-based services.

Meeting people's individual needs

Urgent and emergency services

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw positive interactions between staff and patients with complex needs to ensure they remained settled on the department. There were also link workers available to provide additional support and advice to staff for supporting patients with dementia and mental health difficulties. However, at the time of the inspection there was not a dedicated learning disabilities link worker for the department.

In recognition of the diverse local demographic, there was welcome information on display in multiple languages within the CYPED.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Two members of staff were British Sign Language trained and the department had access to the Big Word service to support patients, loved ones and carers with face-to-face interpreting and translation.

Access and flow

The trust faced ongoing challenges with access and flow which meant that they could not ensure people were able to access the department and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in-line with national standards. Despite these pressures, staff worked hard to keep patients safe.

Patients could not access the department in a timely way and the trust faced known challenges with access and flow. Managers and staff worked to make sure patients did not stay longer than they needed to. However, this was not always possible due to increasing numbers of patients attending the department, lack of available beds within the wider hospital and wider pressures within the integrated care system.

A total of 8,932 patients attended the department in January 2022 and 8,592 in February 2022. Data provided by the trust highlighted that attendance rates had steadily increased over the duration of 2022 with 9,680 attendances recorded for September 2022 and 10,435 for October 2022.

Staff told us that they felt there were often difficulties activating the full capacity protocol for the emergency department due to senior trust leaders' views of access and flow challenges differing from their own. Department staff also highlighted that there could be logistical challenges accessing relevant strategic managers to activate the protocol.

On day one of the inspection we were told by reception staff that initial triage within the adults department was taking up to 50 minutes to be completed. We were also told that it was possible to escalate concerns regarding patients deemed to be at risk of deterioration directly to the triage nurse to try and expediate admission to the department. Healthcare assistants also supported with regular observations for patients in the waiting area and were able to escalate concerns if necessary.

The department had been proactive in trying to address the extended waiting times for patients and had introduced various new roles to try and optimise access and flow.

Urgent and emergency services

Within the adults department a navigation nurse was now in place to support with streaming patients to the appropriate care pathway, along with a consultant based in ambulatory care from 9am until 11pm to further support access and flow.

The department had also introduced a 'Ready to Proceed' area consisting of four beds which could be allocated to patients with either a 'decision to admit' or 'awaiting transport home' status. We reviewed the standard operating procedure (SOP) which highlighted clear criteria for patients accessing these beds.

Patients with minor injuries and illness could also be streamed to the same day emergency care (SDEC) unit which operated 24 hours a day.

The introduction of the frailty team had also helped to optimise access and flow within the adults department. Since January 2022, 54% of patients seen by the team had avoided admission, with 40% of the patients seen requiring admission due to medical reasons. The remaining 6% had remained in hospital overnight due to a specialist therapy assessment being required prior to discharge.

Due to sustained pressure placed upon the department, data provided by the trust highlighted that the average time to treatment for both adults and children for October 2022 was approximately one hour 40 minutes against the national target of one hour. Data for the period 16 October 2022 up until day one of the inspection on 08 November 2022 highlighted that between 39.1% and 46% of patients attending the department were treated within 60 minutes of arrival. Overall, within this timeframe, the department performed better than the regional average of 30% of patients being treated within 60 minutes.

For the period May 2022 until October 2022, 61,678 patients attended both the adult and CYPED, with 26.9% of those patients remaining in the department for over 6 hours.

Of the 10,839 admitted patients within the six-month time period, only 16.1% achieved the national standard four hour wait. Of admitted patients, 64.9% waited between four hours and 12 hours from decision to admit to admission.

Within the same six-month period, 2842 of 42,605 total arrivals within the adults department left before being seen. The adult and CYPED both had Left Without Being Seen (LWOBS) guidelines. If a patient had left the department prior to being seen, the emergency physician in charge (EPIC) or emergency nurse in charge (ENIC) would be notified. If the patient had been deemed to have capacity and there were no identified risks or concerns, the patient notes would be updated to reflect any actions taken by staff. If there were any concerns around patients' risk to self or others, the department would take appropriate actions and escalate appropriately as per the policy, depending upon the identified risks. Each day as part of the consultant ward round the consultant would review all patients who had left the department the previous day and would take appropriate actions if there were still any ongoing concerns which had not been actioned.

Data provided by the trust showed that CYPED attendances had been approximately 2000 for January 2022, with a steady rise up to 2,690 for October 2022.The average time to treatment for October 2022 was recorded as one hour 50 minutes. Of the 2,690 attendees, 73% met the four-hour national waiting time target.

Due to the ongoing challenges faced with ambulance handovers, processes had been put in place to mitigate potential risks to patients waiting extended periods of time to be transferred into the department. On the first day of inspection we saw ambulances waiting up to two hours 30 minutes with patients on stretchers, with some paramedics describing up to seven hour waits during some shifts.

There was now a corridor allocated to patients arriving by ambulance. Although this did not resolve the long waiting times, ambulance crews described feeling safer waiting in the corridor rather than in the back of the vehicle. The introduction of the new impact nurse role also enabled ambulance crews to escalate any concerns to a designated member of staff within the department in the event of patient deterioration.

The trust had worked collaboratively with the local NHS ambulance service trusts to improve ambulance handover times. The department now had 24 hour access to a hospital ambulance liaison officer (HALO) and impact nurse as part of the work to optimise flow. For the period August 2022 until October 2022 a total of 6,644 ambulances had arrived at James Cook University Hospital. The emergency department achieved 51% of ambulance handovers being completed within 15 minutes against the trust target of 65%.Managers and staff started planning each patient's discharge as early as possible. However, due to a lack of community-based resources or limited bed availability, it was not always possible to discharge or transfer patients in a timely manner, particularly for those with complex mental health and social care needs. However, staff took all possible measures to ensure patients remained safe when accessing the department.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in all patient areas. Staff understood the policy on complaints and knew the process on how to handle them.

Data provided by the trust showed a total of 87 complaints were received for the collaborative area of medicines and emergency care services over the previous 12 months. Further data showed that the trust consistently acknowledged complaints within the three-day time period set by the trust.

Managers investigated complaints, identified themes and shared feedback with staff and learning was used to improve the service. Staff we spoke with could give examples of how they used patient feedback to improve daily practice and we saw examples clearly displayed in the staff room for ease of access.

Staff knew how to acknowledge complaints and we saw examples where patients had received feedback after the investigation into their complaint.

Is the service well-led?

Good 

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

Leadership

Urgent and emergency services

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced related to pressures from within the hospital and wider integrated care system. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The department leaders had the relevant skills, knowledge, experience and integrity to run the service.

Local leaders understood the challenges to quality and sustainability related to internal and external system pressures. We saw multiple examples of departmental initiatives which had been put in place to optimise access and flow challenges and to maintain patient safety.

There were regular departmental audits and action plans with evidence of progress against most of the actions. Senior managers were aware of any shortfalls in audit results and there was evidence of accountability for this.

Trust-wide results from the most recent staff survey showed that 68.4% of staff either agreed or strongly agreed that their immediate manager cared about their concerns which was just above the national average of 66.9%.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision in place which was on display within the department, with the provision of safe patient-centred care was at the core.

The vision and strategy also placed emphasis on promoting a positive working environment for all staff members, conducive to the delivery of safe care and treatment.

Culture

Staff within the emergency department felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff continued to display resilience as a result of the COVID-19 pandemic. However, staff had found their situation challenging at times and described being tired. There was a recognition that the wellbeing and morale of staff was impacted over the past year. Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining the urgent and emergency care system despite the tremendous pressure it was under.

Despite the challenging circumstances, staff were positive about working within the service and praised the teamwork and educational ethos. Staff felt there was good support from senior members of staff.

Promoting staff wellbeing was high on the departmental managers agenda and there was information on display within staffing areas to encourage awareness of mental health and emotional wellbeing.

Managers had arranged an away day as a team building exercise and had also put in place two regular slots on a weekly basis to focus upon staff wellbeing and mindfulness.

Nursing and medical staff described a positive working relationship with each other.

Results from the most recent staff survey showed improvements in staff feedback regarding the working culture of the trust, with 76% of trust-wide staff responses either agreeing or strongly agreeing that care of patients is the trust's top priority and 70.7% feeling valued by their team.

Governance

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

Staff we spoke with clearly understood their role within the wider team and took responsibility for their actions.

Information boards within staffing areas highlighting specific learning and development requirements contained easy access to relevant trust policies.

Governance processes were used to monitor standards of performance at both departmental level and trust-wide. However, improvements were required to ensure risks associated with mental health patients attending the department were clearly logged on electronic records. There were ongoing challenges with the oversight of controlled drugs stocks and medical staff training compliance rates which remained below the trust target.

Management of risk, issues and performance

All regulatory breaches identified at previous CQC inspection of the service had been addressed by the trust. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Managers understood the risks faced by the department and were proactive in taking steps to mitigate the potential impact upon patients. At the time of the inspection the biggest risk faced by the department was access and flow as a result of the wider hospital running at full capacity.

Although all of the must do actions had been addressed from the last inspection, we still found that not all patients had access to call bells which the last inspection in 2019 highlighted as a should do action for the trust to address.

Information Management

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

Effective data management processes were used both during the inspection and when receiving additional data from the trust post-inspection.

Information was stored securely at department-level and could only be accessed by staff using a unique log-in.

The department had a clear contingency plan available to it in the event of the electronic system experiencing interference.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Regular meetings were held at trust-level with other external organisations such as the neighbouring local authorities and other third parties such as domestic violence and addictions services to help improve patient experience.

The trust continued to work hard to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback in order to align service delivery with the needs of the local population and to ensure the highest possible standards of care are being delivered.

Staff were invited to engage with the trust-wide staff survey which had an overall trust-wide response rate of 31% in 2021, a slight improvement on 28% achieved the previous year.

Learning, continuous improvement and innovation

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

Although medical mandatory training compliance rates were not in-line with the trust target, we found nurse managers, along with the clinical educators and matron, had taken steps to promote a learning culture which adhered to both RCEM and NICE guidelines.

The introduction of the QR code system for accessing training courses had received positive feedback from staff members, enabling easy access to a range of basic training modules.

We found information and guidance on display in the staffing areas of the department to promote awareness of issues such as sepsis, safe prescribing of medication, domestic violence and safeguarding guidelines.

The department had access to link workers for specialist input with a range of areas such as infection prevention and control, sepsis, dementia awareness, safeguarding children and adults, domestic violence, wound care, diabetes management and palliative care.

The introduction of the new frailty team pilot in January 2022 had played a positive role in optimising access and flow within the department, with multiple staff members highlighting the positive work undertaken by the team.

Urgent and emergency services

The department played a key role in supporting student nurses completing University placements and provided longstanding members of staff with the opportunity to access secondment posts with the prospect of career progression within the wider trust.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory Training

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

Training compliance trustwide for medicine was 92.94% for nursing staff, which exceeded the trust target of 90%. However, medical staff compliance was below trust target at 69.24%. This meant the trust was not assured all medical staff received mandatory training.

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

Managers monitored mandatory training on the electronic staff record system and prompted staff when they needed to update their training. This was confirmed by staff we spoke with and we saw red/amber/green (RAG) rated training compliance sheets displayed in staff areas as a visual prompt for nursing staff.

There was a clinical educator who delivered face to face practical training. For example, staff we spoke with described simulation training designed to develop skills in caring for patients who were confused.

Staff were supported to complete extended role training. For example, some healthcare assistants we spoke with completed training in cannulation and venepuncture, to collect blood samples.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the trust did not ensure everyone completed it.

Nursing staff accessed safeguarding adults and children and PREVENT policies on the intranet. PREVENT aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

All nursing staff we spoke with told us they received adults and children safeguarding training online. In addition, they described periodic scenario training and supervision delivered by the trust safeguarding team. Data provided by the trust showed training compliance by nursing staff was 89.86%, which almost met the trust target of 90%.

Data provided by the trust indicated the levels of safeguarding training nursing and medical staff received. However, overall compliance with up to date safeguarding training by medical staff was below the trust target, at 68.82%.

Medical care (including older people's care)

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, they identified patients at risk via referral documentation completed by general practitioners (GPs) and paramedics and via shared local authority information. We saw patients at risk identified in clinical records and on electronic white boards, with an alert icon.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. For example, the trust named safeguarding lead and local authority safeguarding teams. Out of hours, staff escalated safeguarding concerns to the duty matron and patient-flow coordinator. Staff gave specific examples of safeguarding concerns they had raised. The trust kept a log of all safeguarding concerns raised and recorded learning outcomes.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, they kept the premises visibly clean.

Wards benefited from dedicated housekeepers and a central trust domestic team to support staff in maintaining levels of infection control. Environmental cleaning schedules for domestic staff to follow, were displayed at entrances to wards we visited.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. All wards we visited displayed posters indicating high compliance with environmental cleanliness.

We saw fabric privacy curtains on the wards. They were visibly clean and were scheduled to be laundered every 3 months and in between times, during terminal cleaning. The records were held by the housekeeping staff.

Clinical equipment was cleaned by clinical staff and 2 wards we visited had a dedicated equipment support worker, who checked and cleaned clinical equipment. However, there was inconsistent use of 'I am clean' labels on cleaned equipment. For example, we saw a mobile observations monitor in use on ward 1 with a sticker dated 02/09/2022 and stored equipment we saw was not labelled at all. This meant we were unclear how the trust was assured all equipment was clean and fit for use for patients.

The resuscitation trolley top on one ward was dirty although records documented it was cleaned daily. We brought this to the attention of the ward manager who told us they would ensure this was cleaned.

Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

We observed staff adhered to 'bare below the elbow' guidance. However, we saw inconsistent use of personal protective equipment (PPE) in clinical areas. For example, on one ward, we saw a surgical team enter a room where universal precautions were to be observed. We observed one doctor wore an apron and gloves and the others did not wear any PPE. In addition, we observed nursing staff who provided direct care to different patients used hand gel but had not changed their PPE between contacts. We brought this to the attention of senior nursing staff at the time and observed they spoke with staff about our concerns.

When we asked staff to clarify trust policy on wearing of face coverings, they explained wearing a face covering in clinical areas was a personal choice. However, on ward 4, wearing of a face covering was stated as mandatory on a poster at the ward entrance and we saw staff were compliant. After our inspection, the trust provided their policy, which reflected national guidance and gave specific examples of when face coverings must be worn. This policy was accessible to all staff on the trust intranet.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities were available and antibacterial gel dispensers were situated at the entrance of the wards and on corridors. We saw 5-moments of hand hygiene posters displayed.

Patients we spoke with confirmed staff washed their hands before and after treating them and we observed a consultant washed their hands after examining a patient. The service has had high levels of Clostridium difficile (C. difficile) infections, and at the time of inspection was undergoing a schedule of deep cleaning on the wards. Staff we spoke with described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level.

The wards had link nurses for infection control, and they conducted annual handwashing competency checks for all staff.

As of June 2022, the trust was in the bottom 25% per 100,000 bed days (latest 12 months & 3 months), for rates of E. coli, Klebsiella and C.difficile healthcare acquired infections and in the top 25% for MRSA rate per 100,000 bed days (latest 12 months & 3 months).

Environment and equipment

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

Access to all wards was via secure buzzer and camera entry system.

All corridors and fire exits were free of obstructions. Fire appliances were signposted and tested. The fire alarm was tested weekly.

Patients could reach call bells and staff responded quickly when called.

Equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that portable electrical equipment was maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers.

Staff carried out daily safety checks of most specialist equipment. The exception was on ward 1 where we saw records for checks of the emergency resuscitation trolley had apparent gaps. For example, 29th and 30th September and 1st, 2nd, 3rd and 10th October. The record did not state the reason for the apparent gaps. However, after our inspection, the trust clarified these apparent gaps may have coincided with ward moves.

The trust had formally assessed the risk that emergency resuscitation trolleys may be vulnerable to tampering and recorded controls to mitigate risk.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. For example, staff we spoke with reported they had enough equipment to provide safe care to patients moving and handling equipment and equipment for bariatric patients.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to Health (COSHH) Regulations (2002). For example, on one ward, in the dirty utility room, we saw chemical cleaning spray on the countertop and chlorine tablets stored in a cabinet without a lock. This meant there was a risk vulnerable people could access potentially hazardous substances. We made staff aware at the time and were told a new cabinet was on order.

However, ona second ward, dirty utility room cupboards containing substances hazardous to health were locked.

The endoscopy unit had Joint Advisory Group (JAG) accreditation (certificate JAGWEB/0137) and the last accreditation review (December 2018) highlighted non-compliance with regard mixed sex patient flow. A 6-month action plan was in place to address this issue and updated November 2022. The trust had completed 12 of 17 actions identified on the plan and self-assessed as on target to complete capital works to improve the environment.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff accessed the recognition and management of the acutely ill and deteriorating patient policy via the intranet.

Staff used a nationally recognised NEWS2 tool to identify deteriorating patients. Trustwide, nurse and medical staff NEWS2 training compliance was 100%.

NEWS2 completion and escalation compliance audits were completed monthly across all wards. Data we reviewed from January 2022 to the date of our inspection showed compliance ranged from 85% to 100%. The trust's recording of physiological observations audit (taken from electronic patient records), for the period 08 to 10 November 2022, showed 66.8% observations were completed in the expected time period and 94.6% were completed prior to the next set of observations being required.

However, we observed NEWS2 scores were not always recorded consistently well and escalated appropriately. For example, we reviewed 10 NEWS2 charts and 5 had observations over-due by 2 hours. One patient had a NEWS2 score of 7, and observations were not repeated in accordance with the NEWS2 protocol.

This meant there was a risk staff did not always have up to date records to monitor patients.

Staff we spoke with told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team. Unannounced resuscitation scenarios were conducted periodically to ensure staff practiced emergency responses to deteriorating patients.

Clinical risk assessments were held as paper documents and in electronic formats. Staff did not always complete and update paper risk assessments for each patient. For example, we saw venous thromboembolism (VTE) risk assessments on paper documents signed as complete but the process boxes demonstrating how clinical decisions were made were incomplete. We brought this to the attention of medical staff at the time and they told us this was a persistent issue.

In addition, 8 out of the 10 visual infusion phlebitis (VIP) risk assessments we reviewed were incomplete. The VIP scale provides a score from 0 to 5, in ascending order of severity of inflammation. There were 2 examples of patients having a phlebitis score of 1 and the cannula remaining in place for over 5 days with no rationale recorded. Risk assessments for the use of bed rails were also inconsistent. Two out of the 5 assessments we reviewed did not correlate to observed practice.

However, we also saw examples of how staff dealt with specific risk issues such as patients at risk of falls. There was a falls co-ordinator who monitored all inpatient falls. We saw patient falls risk assessments were completed on admission and falls risk was managed by cohorting patients, with a staff member allocated as a falls watch person. They wore a visible armband to ensure they were not called away or disturbed and the armband was passed to another staff member when they required meal break cover. In addition, patients were provided with non-slip yellow socks and coloured blankets to make them more visible to staff as at risk. Managers explained the trust had purchased falls sensors which were placed under mattresses and seating to alert staff when vulnerable patients attempted to mobilise unaided.

Trust data for the period November 2021 to October 2022 showed there were 27 falls that resulted in harm across the medicine collaborative at James Cook University Hospital.

The trust recognition and management of the acutely ill and deteriorating patient policy provided best practice guidance to all staff involved in the care of patients presenting with sepsis. The trust provided annual sepsis updates for staff and compliance was 91%. All staff we spoke with described what they would do to treat and escalate sepsis. All patients with an elevated NEWS2 score were considered for screening and escalation to senior medical staff. The trust used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis screening tools in the records we reviewed. The wards had sepsis boxes. Further management, such as the use of the sepsis care bundle and antibiotics were implemented.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. For example, on the wards, handover from night to day nursing staff was at 7am. Staff received a printed handover sheet which included any specific patient risks, for example, falls risk, resuscitation status and identified patients that required assistance with diet and fluids.

Staff attended multidisciplinary safety huddles at the start of each shift. These were attended by, for example, physiotherapists, speech and language therapists, occupational therapists, medical social workers, discharge coordinator and dietitians in addition to medical and nursing staff.

Board rounds on the acute admissions unit occurred 3 times a day. Doctors handed over to the night shift at 9pm.

The trust clarified that due to COVID-19 pandemic, acute illness management (AIMs) training was suspended. However, this training recommenced in June 2022 and monthly courses were scheduled up until August 2023. In addition, there was educational outreach to wards and departments to deliver training in recognition and response to the deteriorating patient. Compliance by nursing staff was 93%.

Medical care (including older people's care)

The trust acutely ill patient group met twice monthly to discuss for example, audit themes and trends, sepsis data and critical incidents.

Nurse staffing

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

The medicine collaborative nurse staffing plan was reviewed annually with establishments amended to be in line with provision of safe standards of care. The most recent review went to trust board in November 2022.

On the wards, staffing requirements were calculated by ward managers using a recognised safer care process. However, the service did not always have enough nursing and support staff to keep patients safe. For example, on the wards we visited we saw that planned and actual staffing displayed did not always match. On one ward, staffing including the ward sister, was planned as 5 registered nurses and 5 healthcare assistants (HCAs) for early and late shifts and 3 registered nurses and 4 HCAs at night. However, actual staffing was 4 registered nurses on the early and late shifts and there was a shortfall of 1 HCA on the late shift. Night actual staffing on this ward met planned numbers. Similarly, on a second ward, there was a shortfall of 1 registered nurse and 1 HCA on each of the early, late and night shifts. A third ward had a shortfall of 1 registered nurse for early and late shifts and 1 HCA at night.

Staff we spoke with told us this was a regular occurrence and shared concerns that short staffing correlated with increased numbers of patient falls.

There was a staffing escalation process in place. Staff we spoke with explained, when staffing was suboptimal, they reported to the matron and Safe care team. The matron redeployed staff from other wards, requested bank staff via the NHSP system and unfilled shifts were offered to staff via a closed social media group. Agency staff were used and allocated where needed on arrival.

Staff we spoke with told us they had sufficient rest and meal breaks and usually left duty on time. This was an improvement on our previous inspection, where staff did not always have time to take breaks or provide person centred care that met individual patient needs.

Trust wide, the medicine service had a vacancy rate of 4.5%. The trust employed additional healthcare assistants, above the budgeted establishment, to help support the shortfall in registered nurses.

Trust wide, the medicine service had a turnover rate of 9.01%.

Trust wide, the medicine service had a sickness rate of 6.59%.

Managers we spoke with explained the trust was actively recruiting registered nurses.

Medical staffing

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

Medical care (including older people's care)

The service had enough medical staff to keep patients safe. In January 2022, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same as the England average. At James Cook University Hospital, there were 11 whole time equivalent consultants responsible for the acute medicine wards and same day emergency care (SDEC) unit. They were supported by registrars and junior doctors.

The medical staff matched the planned number.

Trust wide, the medicine service had a vacancy rate of 5.1% consultants and recruited above establishment for other medical staff.

Trust wide, the medicine service had a turnover rate of 27.41% for all permanent medical staff employed by the trust including those on fixed term contracts.

Trust wide, the sickness rate for medical staff within the medicine directorate was low at 0.67%

Managers could access locums when they needed additional medical staff. Rotas we reviewed had no gaps in medical cover.

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

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

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were mostly stored securely.

Records were held in paper and electronic formats. However, they were not always comprehensive, contemporaneous and legible. The trust was aware of poor compliance with record keeping and promoted improvement via 'documenting for great care' posters.

For example, we looked at 13 full sets of patient records and saw gaps, including skin and wound management, height and weight, malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts and best interest decision making. In addition, a consultant brought to the attention of nursing staff that several patient's stool charts were not completed. When we discussed this with senior staff, they identified colleagues who did not know how to complete the charts on the electronic records system. They rectified this immediately by showing them how to complete electronic charts.

Written evaluations made by consultants in 3 records we reviewed were illegible and it was not always clear whether all patients were reviewed by a consultant within 14 hours of admission.

Not all nursing and medical records indicated the time of completion.

In 3 sets of paper records, we saw there were 2 different versions of the adult nursing care pathway in use. For example, one version contained a completed MUST assessment template and the other did not. When we asked staff about this, they explained the MUST assessment for this patient record was held in electronic rather than paper format.

The trust had implemented a weekly MUST audit following our inspection in February 2022 and had moved MUST scores on to an electronic system which automatically prompted completion when required. Information provided to CQC for August 2022 showed that the trust was meeting its 90% target of completion of MUST assessment within 24 hours of admission, with 95% of scores completed on time and 100% of appropriate actions implemented as a result of these assessments.

Electronic white boards were used on all wards we visited and these recorded key information about patient risks and treatment, including alert icons for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Records were mostly stored securely on all wards we visited except for one, where we observed records stored in unlocked trolleys and records left unattended on a computer trolley.

Medicines

The service did not always use systems and processes to safely prescribe, administer and record medicines.

Most patients had wrist bands in place, and we observed medication rounds in which staff checked patients name and date of birth. There was one exception where we saw an elderly confused patient without a wristband. We brought this to the attention of staff at the time and a band was applied and the patient assisted back to their bed space.

We observed the electronic prescribing system (EPMA) had been recently introduced on some wards, for example, ward 11, which prompted staff when medicines were due to be administered and this was now used to monitor compliance with administration of time-critical medicines. On wards where EPMA was not yet in use, pharmacists reconciled (checked) medicine prescriptions and now highlighted time critical medicines.

Records we looked at assured us most medicines were being given as prescribed and where medicines were omitted, we saw evidence of reasoning why.

However, we saw, weight and height were not consistently recorded in the care pathways and medicine prescription charts. Oxygen prescribing was not always completed consistently well. This concurred with trust audit data, which concluded oxygen prescribing continued to be poorly undertaken. We observed two patients receiving oxygen, which was not prescribed.

We discussed oxygen prescribing with managers and were told they anticipated the new EPMA system would help to make the prescribing and administration fields mandatory, to improve compliance.

We saw evidence of prompt action by the medical team where changes were made to medicines via specialist teams.

Medicine reconciliation was carried out by the pharmacy team based on the ward. The trust target for reconciliation within 24 hours was 80%, however, medicines reconciliation on admission had not improved since our last inspection.

For example, trust data for the period January to October 2022 showed the trust target was met only once, in January 2022. The trust was aware of the issue with medicine reconciliations and pharmacy staff we spoke with told us there was work ongoing to help the trust meet this target. In the charts we looked at, medicines reconciliation was completed within 48 hours of admission.

Pharmacists audited staff compliance against medicines policy monthly and sent results to ward managers. For example, antibacterial agent documentation audit data for November 2022 showed compliance ranged between 45.24% to 100% in the metrics audited and the trust had an action plan in place to address non-compliance.

Medicines required to take home out of hours was dispensed in over labelled packaging from the wards. There was a robust checking system in place.

A total of seventeen wards across the trust were using an automated medication dispensing system in use, which staff accessed via biometric thumb print verification. This system reduced the risk of mis-doses and improved record keeping. We saw this on one of the wards we visited. The trust had plans to roll this system out across both sites over the next three years to cover all wards.

Staff stored medicines and most prescribing documents safely. There was one exception where we observed a pad of outpatient prescriptions left on the counter in the clean utility room. We brought this to the attention of a pharmacist and the prescriptions were removed and secured.

Ward staff were supported by pharmacists Monday to Friday. Out of hours, pharmacists were contactable via an on-call system.

Incidents

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

Staff accessed the incident reporting and investigation policy on the intranet. All staff we spoke with knew what incidents to report and how to report them. All managers we spoke with knew their ward's most recurring top three incidents and gave examples of how these were being addressed and monitored.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff we spoke with were familiar with the electronic incident reporting system and provided clear examples of incidents and near miss incidents they had reported recently.

Managers shared learning about never events with their staff and across the trust. From 9 September 2021 to 3 October 2022 two never events were reported. Staff we spoke with were aware of trust never events and serious incidents reported within the directorate and described the actions the trust had taken as a result of learning. For example, changes to policy and learning incorporated into junior doctor's induction programmes. They explained learning from incidents was shared in safety bulletins on the intranet and during safety huddles at shift changes. On ward 1 we saw a poster presentation about learning from incidents.

Medical care (including older people's care)

All staff we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

We saw recent patient safety alerts displayed and managers we spoke with explained how these were implemented and monitored. The alerts were also shared via an established monthly electronic quality and safety briefing. This signposted staff to further information and covered key topics each month, such as learning from falls, prevention of pressure ulcers and incident reporting.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff we spoke with explained how they accessed the most current best practice guidance online and trust intranet, for example NICE guidance and up to date COVID-19 guidance.

Compliance against policy was monitored throughout the year using an annual trust audit schedule.

Nutrition and hydration

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

Staff now made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. For example, staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was a significant improvement since our last inspection.

Where modified diets were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station.

Ward 11 had initiated a 'let's do lunch' initiative in response to feedback from carers, who wanted to be involved in helping their relative at mealtimes. The ward had also recently appointed a nutritional assistant, to help with feeding patients. All wards had a trained nutritional link nurse to support them with meeting patients' needs.

On the wards we observed a bell system to inform patients and staff that meals were due. This meant staff could ensure patients were comfortable and ready to have their meals at a protected time. Protected mealtimes were also promoted via intranet banners and the quality and safety briefing, which was sent to all staff electronically. Clinical assurance rounds were in place to observe protected mealtimes and feedback was provided to staff if improvement was needed.

We observed mealtimes on various wards and noted that all staff were involved in serving meals to patients, including senior staff. Patients that needed support with eating their meals were given it. We observed additional comfort rounds taking place with options for biscuits, juice, tea and coffee.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Staff used a red/ amber/ green lid system on water jugs to help monitor patients' fluid intake throughout the day. However, fluid balance charts in the records we reviewed did not always accurately capture fluid input and output where this was required.

On ward 11 we saw 'feeding families' food boxes, which were provided by a charitable organisation and free for patients going home. This ensured they did not have to worry about buying food in advance of their discharge.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessment was recorded routinely as part of electronic physiological observation recording. The system ensured completion of the assessment was mandatory. This was an improvement since our last visit, when we found pain assessment charts were not consistently completed.

The trust audited pain scores following analgesia to monitor effectiveness.

Patients we spoke with told us they received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

The service participated in relevant national clinical audits, for example, the sentinel stroke national audit programme (SSNAP).

The trust scored a SSNAP level of B for April to June 2022, which was an improvement on the last two periods where they scored level C. Performance in a few indicators saw an improvement and a decline in others.

The trust also participated in, for example, the national lung cancer audit, national heart failure audit, national diabetes audit, national audit of inpatient falls, national audit of dementia and chronic obstructive pulmonary disease audits.

Due to the pandemic there were delays to the publication of some audits. For the audits listed above, data in the latest publications was at least two years old or data was not available at trust level, therefore results have not been included here.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local scheduled audits (QIC audits) of 15 different sets of notes on each ward each month, were recorded on an electronic system, via a handheld device. These included medical records audits, hand hygiene observation, donning and doffing PPE, sepsis 6 documentation, falls, pressure ulcers (grade 3 and above) and venous thromboembolism (VTE) risk assessments.

The trust developed action plans to improve outcomes. For example, the falls action plan we saw was developed in response to the findings from the national audit of inpatient falls results from 2020/21, in addition to the themes emerging from the structured reviews, incident reports, patient feedback and complaints.

We saw audit quality metrics displayed on wards indicated high compliance. For example, 1 question asked whether the VTE risk assessment was recorded on the medication chart. Results from this audit were 98% in August, 97% in September and 98% in October. However, the audit results did not concur with our observations of records and clinical staff involved in audit activities confirmed to us that completion of VTE assessments on paper was often poor. They anticipated implementation of electronic prescribing with mandatory fields would improve compliance and the trust had an action plan in place.

The trust held mortality and morbidity meetings to discuss learning from deaths.

The service was accredited by Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in 2018. The trust updated the action plan in November 2022.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with who were new to post, told us they felt well supported by their managers and peers. For example, they were allocated a 'buddy' and shadowed colleagues on supernumerary shifts. They attended 1 to 1 meetings throughout their probationary period.

Staff we spoke with told us managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Staff had 1 to 1 meetings with their managers. Managers we spoke with told us they were on trajectory to meet trust targets for completion of staff performance appraisals and this was confirmed on spreadsheets we saw displayed in staff areas. Managers identified poor staff performance promptly and supported staff to improve.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. For example, doctors we spoke with told us they participated in a grand round twice a week, led by care of the elderly consultants and teaching time was protected.

The clinical educators supported the learning and development needs of staff.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. For example, non-invasive ventilation (NIV) training and competency training compliance for care of NIV patients was 97% and 100% respectively.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. For example, we observed MDT board rounds which included consultants, junior doctors, physiotherapists and nurses.

Patients had their care pathway reviewed by relevant consultants. For example, patients accommodated on non-medical wards due to medical bed shortages, were reviewed by the appropriate consultant for their care needs.

Nursing and medical staff we spoke with told us there was good teamwork across all disciplines and managers were approachable. Staff said they felt empowered to challenge colleagues' practice if they were concerned.

Staff liaised with the multidisciplinary team directly. For example, they referred to diabetes specialist nurses, dietitians, learning disability staff, elderly care psychiatric team and therapies colleagues.

Seven-day services

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

Consultants led twice weekly ward rounds on all wards. However, there was consultant presence every day, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Managers we spoke with told us they received support from clinical in-reach services, for example, respiratory, palliative care, cardiology, pain team, speech and language therapy and stroke. However, this was not available 7 days a week.

There was daily physiotherapy support from 8am to 8pm.

SDEC was operational 24 hours a day from October to March and from 7am to 10pm April to September.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. For example, on ward 11 we saw a 'carers together' board aimed at raising awareness and signposting families and carers to sources of practical help, such as the nationally recognised 'carer's passport' scheme.

The trust website patient and visitors section had links to health promotion information, including leaflets in easy-read format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always use measures that limit patients' liberty appropriately.

Staff we spoke with told us they received training in the MCA and DoLS incorporated within mandatory adults safeguarding training. There was a policy for enhanced observation of patients.

Staff we spoke with described a multidisciplinary team approach to making best interests decisions. For example, they involved clinicians, safeguarding team, patients and their family/carers. Medical and nursing staff received training to complete mental capacity assessments.

We reviewed 8 records of patients subject to deprivation of liberty safeguards (DoLs). Four records showed staff had completed assessments and recorded best interest decisions, however they were not in line with the requirements of the legislation or trust policy. For example, they were not explicit enough or they were out of date. On one ward,we found one DoLs application was made the day before completion of a mental capacity assessment.

However, staff we spoke to knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The trust had recently appointed a lead practitioner for MCA and DoLS. While this was a positive step, and numbers of referrals for DoLS were increasing, potentially indicating greater awareness, there was further work to do to embed this learning and adhere consistently to legal requirements.

Is the service caring?

Good 

Medical care (including older people's care)

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. This was an improvement on our last inspection, when we found staff were not always discreet and responsive.

Patients we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

At the time of our last visit, patients were not regularly dressed and out of bed, wearing either their own clothes or nightwear. At this visit, patients were encouraged to dress and spend time out of bed where appropriate, to encourage patients to move around and eat at a table.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

At the time of our last inspection, visiting had been suspended due to the COVID-19 pandemic. It was recognised by the trust that this had had an impact on the emotional support patients received, when isolated from their families. Following our inspection, the trust immediately, following appropriate assessment of risk, reinstated visiting. Patients and staff told us this had been a huge boost to morale, and staff explained that this had also improved patients eating and drinking, as friends and families are encouraged by staff to support those close to them with their meals at lunchtime and tea time, and to bring in favourite foods and drinks if they wished to do so.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand.

Medical care (including older people's care)

Patients and their families gave positive feedback on the service and their treatment. Staff we spoke with told us they received positive feedback from patients and their carers. Since our last inspection, staff were now allocated to remind patients to complete satisfaction surveys and share their views on the care and treatment they received. This improved the numbers of returns. The most recent friends and family feedback and satisfaction scores ranged between 90.2% to 100%.

The trust scored above the national average in several areas of the 2021 Cancer Patient Experience Survey 2021, with 91% of patients stating they found it very or quite easy to contact their main contact person, against a national average of 85%, and 84% of patients (national average 78%) felt that the right amount of information and support was offered to the patient between final treatment and follow up appointment.

Staff we spoke with described how families and carers were encouraged to participate in care if they and the patient wished to. Staff now utilised therapeutic care staff to sit and ensure patients nearing end of life were not left alone if their carers were away.

Is the service responsive?

Good

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

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

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

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust reported 2 incidences for the period May to October 2022, where the trust was unable to provide single sex accommodation. Both breaches occurred on the respiratory ward (Ward 9) in the Respiratory Surveillance Unit (RSU) for patients requiring enhanced respiratory care.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day. For example, SDEC which provided a same day service to patients, improved patient experience and reduced hospital admissions.

Meeting people's individual needs

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

Medical care (including older people's care)

Some wards were designed to meet the needs of patients living with dementia. For example, on ward 11 we saw low light levels, lowered ceilings, dementia friendly cutlery and crockery and adapted diets, to enable patients to eat with fingers if they chose to. Toilet facilities were labelled with pictures for easy identification.

Staff accessed advice from a learning disabilities nurse specialist when required. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients were identified on the electronic white board with a nationally recognised forget-me-not icon. Patients identified as requiring 1 to 1 supervision were allocated a therapeutic carer, identifiable by their yellow top.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff accessed interpreters when required online or via telephone. They also utilised staff who spoke languages other than English, where appropriate. Staff had access to information leaflets available in languages spoken by the patients and local community.

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

Pastoral care was available as required from a multi-faith chaplaincy service. There was a multi-faith chapel on site.

Access and flow

Most people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in mostly line with national standards.

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. For example, the percentage of patients treated within 18 weeks slowly declined from 85% in March 2021 to 78% in August 2022. However, referral to treatment on completed admitted pathways in 'Medicine', within 18 weeks for August 2022 was 94.4% which is higher than the 90.5% reported in August 2021 and better than the national average of 78.4%.

In August 2022, 333 patients had been waiting 52 weeks or more for treatment compared to 445 in June 2021. This was a decrease of 25%. For the region, there was a 6.3% increase in the number of patients waiting 52 weeks or more.

Managers and staff started planning each patient's discharge as early as possible. From February 2021 to January 2022 the average length of stay for medical elective patients at The James Cook University Hospital was 7.1 days, which was higher than England average of 6.4 days. For medical non-elective patients, the average length of stay was 5.3 days, which is lower than England average of 6.0 days.

The average length of stay for elective patients in general medicine and cardiology was lower than the England average. However, for patients in stroke medicine it was higher.

Patient discharge planning commenced on admission and staff recorded this on a discharge check list in the patient record. Discharge letters were generated electronically and sent to referrers and copied to the patient. Timely discharge was promoted via digital posters, which prompted staff to be proactive in ensuring patients were discharged safely before midday, where possible.

Managers monitored patient moves between wards. Staff we spoke with explained they tried to provide as much advance notice to patients as possible. The average number of bed moves per day for medical wards at James Cook University hospital in last 6 months was 7.1 bed moves, of which 1.9 was out of hours. Days with high numbers of bed moves largely reflected ward moves such as decant for deep cleans, where all patients residing on a ward were moved. Other key reasons for moves were infection prevention control (isolation, cohorting), moving patients to a side room for privacy and dignity (including care of the dying patients), moves between general and specialist medical wards (stroke, neurology, for example) and patients moved from James Cook University Hospital to Friarage Hospital according to required level of care.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Patients awaiting discharge were identified on the electronic white board, which also recorded their length of stay.

Although the discharge process had improved since our last inspection, staff we spoke with shared concerns that delayed discharges remained a persistent problem and understood this was due to lack of capacity to provide care packages and accommodation in the community.

As of September 2022, 70% of patients were delayed at discharge. This was the fourth highest in the North East and Yorkshire, Cumbria and North East ICS and 6% under the regional average (76%).

For 45% of the adult care setting, the main reasons for delayed discharge were due to awaiting availability of resource for assessment and start of care at home (39.8%), and awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement (15.7%). Second highest (38%) was for the community setting. The main reason for delayed discharge was awaiting availability of a rehabilitation bed in a community hospital or other bedded setting. This was similar to the regional and national picture.

Since our last inspection, the trust had improved its discharge processes by rolling out a centralised discharge process through a new transfer of care hub. Dedicated discharge staffing had doubled, and the team worked 7 days a week. Every discharge was now followed up with a welfare call to the patient or their carers.

There had been a 50% reduction in safeguarding concerns related to discharge in the first quarter of 2022/2023 when compared to the same quarter in the previous year. There had equally been a 50% reduction in complaints and concerns raised relating to these discharges over the same period. A total of 84% of patients contacted post-discharge had no issues or concerns with their discharge.

Managers worked to minimise the number of medical patients on non-medical wards. There was now a formal procedure in place for management of patients outside of their base speciality location (medical patients accommodated on non-medical wards). These patients were always reviewed by their specialist medical teams. The site sister and flow coordinator were aware of the locations of all patients in real time, via the electronic white board system, which was updated regularly on each ward.

Medical care (including older people's care)

There was a fast track system in place to facilitate prompt discharge for patients at end of life who expressed a wish to die at home. Staff aimed to facilitate discharges prior to 10am and following risk assessment, patients awaiting transport waited in a discharge lounge. Where possible, medicines to take home were prescribed and dispensed the day prior to discharge.

From January 2021 to December 2021, patients at The James Cook University hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Patients in general medicine had a lower than expected risk of readmissions. However, patients in cardiology and gastroenterology had a higher risk than expected of readmissions for non-elective admissions.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. For example, they discussed with staff directly, contacted the trust patient advices and liaison service (PALs) and submitted feedback on the NHS choices website.

The service clearly displayed information about how to raise a concern in patient areas. For example, the trust used an electronic platform to receive feedback on Friends and Family Test (FFT) and in real time, using electronic tablet devices in all inpatient's areas.

Staff we spoke with understood the policy on patient and carer experience (complaints) and knew how to handle them. Staff we spoke with said most complaints were about poor communication between staff and family members and carers. This concurred with trust board papers we reviewed. Trust wide, medicine and emergency care services was the largest clinical collaborative and received the highest number of complaints. Most were acknowledged within 3 working days. However, data for the period July 2021 to June 2022, showed medicine and emergency care services consistently did not meet trust closure timeframes.

Managers investigated complaints and identified themes.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, we saw a file in the staff area on one ward containing details of complaints and compliments.

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

Is the service well-led?

Good 

Medical care (including older people's care)

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

Leadership

Leaders had the skills and abilities to run the service. They managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Managers had the right skills and abilities to run the service.

Staff spoke positively about their leaders and felt respected. Staff we spoke with told us the chief nurse, deputy chief nurse, associate chief nurse and matrons were accessible and visible.

Staff we spoke with told us how management had supported them to take on more senior roles and succession planning.

Vision and Strategy

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

Staff we spoke with were unable to describe the overarching vision and strategy for the trust. However, we observed the trust's quality priorities 2022-2023 displayed on posters in all areas we visited. Wards also displayed their own vision for the service.

All staff we spoke with told us they felt there had been ''significant improvements'' since our last inspection. For example, we spoke with a member of staff we had visited at our previous inspection who at that time, had been very concerned that the area they worked in could not provide safe care. They explained that while things were not perfect, the pace of change in response to our concerns had been swift, and they had felt well supported to make the required changes. They now felt the care provided was safe, and that patients had a better experience while staying in hospital.

Culture

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

All staff we spoke with were proud of the organisation as a place to work and spoke highly of the culture. Staff completed mandatory equality and diversity training.

Staff at all levels were actively encouraged to speak up and raise concerns. Staff we spoke with described an 'open' culture. For example, there was a freedom to speak up policy to enable staff to speak up if they had concerns about colleagues' professional behaviours. All staff we spoke with were aware of this, had received training and told us they felt empowered to challenge behaviours.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

Medical care (including older people's care)

Governance

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

Core services were arranged within clinical collaborative groups. The governance structure was clear, and the local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports, to maintain quality.

Managers attended bimonthly Clinical Collaborative Board Meetings with ED teams. The agenda included for example, discussions about key safety messages from serious incidents, finance, IPC updates and human resources business.

Frequency of staff meetings on wards was variable, however, staff we spoke with told us minutes of meetings were emailed to them by the ward manager, when they were unable to attend in person.

Staff we spoke with were aware that senior management colleagues, for example managers and matrons, attended monthly safety and quality meetings. Minutes we reviewed evidenced and discussed incidents and learning from them. However, staff we spoke with below matron level told us they did not routinely receive copies of the minutes and did not know how to access them.

Following our last inspection, the trust had identified that there had been an issue with the uploading of historical data to external reporting systems. Since then, the trust has revised the process for incident management and review.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. For example, we observed wards had computers labelled for use as ‘’business continuity only’’. These functioned as a backup system to enable staff access to patient records in the event the main IT system failed.

The trust had a winter plan in place to manage anticipated surges in demand and associated staffing needs.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, information systems were not all integrated. Data or notifications were consistently submitted to external organisations as required.

Staff we spoke with shared concerns that current electronic records systems were not integrated. For example, the system used in ED was not compatible with ward systems and staff could not access electronic records held externally by GP’s. Staff we spoke with explained they would be trialling the implementation of a single on- line patient record, which would integrate with other electronic systems, such as GP records. However, they were unclear when this would commence.

On ward 11, staff we spoke with told us they were to begin a pilot of electronic prescribing, which would allow risk assessments such as VTE assessments, to auto-populate the electronic white board system.

Although most data was stored securely, staff we spoke with explained patients on ward 1 were often moved during the night. Their name, location and next of kin details were recorded in a book held at reception. Staff told us this was as a backup in the event the IT system failed and for easy reference, as not all staff could use the electronic system. This meant there was a risk sensitive data was not always stored securely. We brought this to the attention of staff at the time and they said the book would be locked away when not in use.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The Trust participated in annual national patient experience surveys, including those living with dementia. The trust had developed a dementia strategy.

We reviewed the latest trust wide staff survey results for 2021. This indicated average satisfaction scores when compared with the national benchmark. Medicine directorate staff satisfaction scores were similar to results trust wide.

The trust also completed periodic staff health needs assessment surveys. These looked at indicators such as anxiety, depression, post-traumatic symptoms and sleep disturbance, by staff groups and ward / team areas. As a result of the survey, the staff psychology service was set up. The service provided on site psychological support to frontline staff in relation to difficulties arising through the course of their clinical duties.

Learning, continuous improvement and innovation

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

Staff we spoke with told us how managers had supported them to develop their career. For example, they attended courses to extend skills such as phlebotomy (taking blood) and cannulation. Healthcare assistants told us they were supported to commence nursing associate, apprenticeships and registered nurse training.

The hospital supported student nurses from a local university though structured placements.

In addition, the trust piloted a 12 week programme of clinical simulation training. This used state-of-the-art immersive simulation suites and virtual reality headsets for students to gain virtual practical working experience in real life hospital ward environments and scenarios.

Staff received recognition for achievements. For example, ward 11 staff were awarded ‘Diamond Accreditation’ in the South Tees Accreditation for Quality of Care programme in September 2021, in recognition of adherence to cleanliness standards, staff interactions with patients and audit compliance. Medical wards also developed their own recognition awards and congratulated staff on trust social media.

The trust also held ‘star of the month’ awards whereby staff could nominate each other. Public could also nominate staff at the annual ‘Nightingale awards’.

Medical care (including older people's care)

Staff on ward 11 told us there were plans to build a kitchenette area to enable occupational therapy assessments of how patients might manage when discharged home and identify any specific needs and adaptations required.

Two cancer teams had been shortlisted for a nursing times award in the last 12 months, and one shortlisted for nurse of the year.

The trust had implemented an innovative system tied to the move to electronic assessment and recording of patients' nutrition and hydration. This meant that on a daily basis, at a glance, it was possible to see how many patients in the hospital required additional support to meet their nutrition and hydration needs. When a ward tipped over a predetermined point on the system, for example, when multiple patients required additional support, the system triggered allocation of an additional support worker to the ward to assist with eating and drinking.

Surgery

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Although medical staff were lower than the Trust target in their completion of mandatory training.

Nursing staff received and kept up-to-date with their mandatory training. The nursing staff achieved an overall completion rate of 92.04% against the Trust target of 90% compliance.

Medical staff received and kept up-to-date with their mandatory training. The medical staff compliance rate was 84.21% which is below the Trust target of 90%.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although compliance rates for training in medical staff were below the Trust target.

Nursing staff received training specific for their role on how to recognise and report abuse. The compliance figures for nursing staff were at 90.75% overall for Safeguarding Level 2 training for both adults and children, this was slightly above the trust target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse. The compliance rates for medical staff were at 84.68% overall for Safeguarding Levels 2 and 3 for both adults and children, and this was below the Trust target of 90% completion.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were for support. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern.

We reviewed the trust's safeguarding adults at risk of abuse and neglect policy which was in date (February 2022), version controlled and had a review date of January 2025.

Staff told us matrons produced safeguarding reports where any learning for staff was included.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient.

The service generally performed well for cleanliness. Cleanliness audits scored between 90% and 95% in the previous 6 months before inspection. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE.

Staff worked effectively to prevent, identify and treat surgical site infections.

Data on infection rates was also collected monthly for each ward as part of the directorates summary documents and displayed in the areas we visited. This included information on MRSA, clostridium difficile, pseudomonas, E.coli and methicillin-susceptible Staphylococcus aureus (MSSA). In the period April 2022 to October 2022, data showed that the infection rates for surgical wards were low.

Environment and equipment

Surgery

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

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys on wards 5, 7, 10, 25, 35, 36 and in the theatre suite. Daily checks were completed correctly on all wards.

Patients could reach call bells and staff responded quickly most of the time when called.

The service had suitable facilities to meet the needs of patients' families.

Fire extinguishers were present on all inspected services and in date. We also saw that fire exits were checked and clear and the fire safety logbook and reference manual clearly stated who the fire safety advisor was. The fire safety policy was available to all staff and staff were aware of hospital fire procedures.

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

Staff disposed of clinical waste safely. The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records showed that staff had used the early warning scoring system that the trust used to correctly record, calculate and review patients for signs of deterioration as required. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust's early warning and sepsis scoring protocols.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked at sets of records across six wards and theatres which were a combination of paper and digital records on the trust's EPR system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

We observed the World Health Organisation checklist for safe surgery (WHO checklist) being used and noted good practice in that patients were checked in by both the surgeon and anaesthetist. We looked at five records for patients in theatre during our inspection and the WHO checklist was correctly followed and recorded in all cases. The service carried out regular audits of the use of the checklist and for the last three months compliance with the use of the checklist was at 100%.

Staff knew about and dealt with any specific risk issues. A bank nurse was able to tell us about the sepsis protocols and shared with us the training she had received. Where an indicator of sepsis was identified, the trust followed the Sepsis Six model to provide testing and treatment to patients within one hour. We reviewed the trust sepsis assessment form and noted that the trust used an SBAR approach (situation, background, assessment, and situation) to review patients following an acute episode of deterioration.

Early warning scores were used to monitor patients and detect deteriorating patients, or patients who required escalation or additional care or treatment. The trust had a dedicated critical care outreach team, staff knew the process with regard escalating concerns for deteriorating patients with the team and could give examples of when this had happened. We saw in patient records that the team attended promptly.

There was a recognition and management of the deteriorating patient policy, which included sepsis. Staff we spoke with were clear about signs and symptoms of deteriorating patients and gave examples of when and how they would escalate a concern.

The service had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

The service did have a specific process for medical patients who were being cared for on surgical wards (outlying patients). The trust had agreed principles for caring for these patients and could identify them as part of their winter pressures position; this information included that there was appropriate medical consultant oversight from a medical speciality.

Staff shared key information to keep patients safe when handing over their care to others. The wards had daily safety briefings which highlighted potential risks to patients. The agenda included points such as 'patient specific risks', capacity in the ward, staffing levels and a review of patients coming to the unit.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers were supported using briefing documents to ensure consistent messages across shifts. We observed hand over sheets on all wards we inspected. The nursing handover document included key information regarding individual patients which included a plan of care, key risks, and discharge plans.

Nurse staffing

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

The service did not always have enough nursing and support staff to keep patients safe. Staffing has continued to be a challenge across the Trust with short notice unavailability associated with Covid isolation, Covid related absence and non-covid sickness and vacancies. Stretch staffing ratios in line with national guidance have been implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care meetings.

Surgery

Nursing Turnover for October 2022 had decreased to 8.60% which was one of the lowest rates in the country.

The percentage of shifts filled against the planned nurse staffing across the Trust was 95.9% for October 2022. Overnight average fill rates for staffing were at least 100% for the three months before inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients.

The service had reducing turnover rates. In October 2022, nursing turnover had decreased from 9.25% to 8.60%.

The service had reducing sickness rates.

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

On inspection we observed staff working hard to complete tasks for patients; however, we were not assured that staff had the time to always provide person centred care that met individual patient needs.

We witnessed some delays to call bell responses due to staff being busy with other patient needs during our inspection on 2 occasions. Patients also told us about delays to responses particularly at night-time, due to staff already working with other patients. However, on other occasions call bells were answered quickly and patients told us they were always responded to quickly in their experience.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

Medical staffing

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

The service had enough medical staff to keep patients safe. Medical staff matched the planned numbers on rotas we reviewed for the three months prior to inspection.

The medical staff matched the planned number.

The service had reducing vacancy rates for medical staff.

The service had low turnover rates for medical staff.

Sickness rates for medical staff were low at 0.38% for medical staff in October 2022. The Trust sickness target was 3.90%.

Managers could access locums when they needed additional medical staff.

Surgery

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards. We saw enough numbers of medical staff on the wards we visited to meet the needs of patients.

The service always had a consultant on call during evenings and weekends.

Records

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

Patient notes were comprehensive and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. We reviewed 16 sets of patient records across four wards and theatres which were a combination of paper and digital records on the trust's Electronic Patient Record (EPR) system. We noted that they were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Food and fluid balance charts and MUST charts were completed in line with guidance; weight was recorded on admission and then weekly thereafter, we saw recording of patient weights in line with this.

We observed robust medical admission and daily review information recorded by the ortho-geriatrician and medical team consistently across the records that we reviewed.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Records assured us patients were receiving their medicines as prescribed. On one ward however we found prescribing was not always in line with policy, for example we found medicine charts with antibiotics prescribed with no indication and the route of administration not prescribed. We raised these issues with the ward sister who confirmed electronic prescribing was being implemented that day which would resolve these issues. The Trust have confirmed that since inspection, electronic prescribing has been implemented. This has resulted in mandatory fields and prompts for clinical indicators and route of administration is documented.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

We saw evidence of pharmacist clinical checks to review patients' medicines regularly whilst they were an inpatient and saw that actions raised by pharmacists were actioned by the medical team in a timely manner.

Surgery

Staff completed medicines records accurately and kept them up-to-date. Staff followed national practice to check patients had the correct medicines when they were admitted. Medicines recorded on both paper and digital systems for the 12 sets of records we looked at were fully completed, accurate and up-to-date.

Staff usually stored and managed all medicines and prescribing documents safely. In theatres, Controlled Drugs (CD) were kept securely and staff checked them twice a day. Similarly, drugs that needed to be kept cool were kept in a locked fridge and were found to be in date. Fridge temperatures were recorded daily, and no concerns were noted by the inspection team. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

Staff stored and managed all medicines and prescribing documents safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date.

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

The pharmacy team provided a weekday medicines reconciliation service and in all but one of the records we looked at had received a medicines reconciliation. Data provided us to after the inspection however demonstrated that the trust were not hitting their target of 80% completed medicines reconciliation in 24 hours on all surgical wards. For example, on Ward 5 from May 2022 – October 2022 the trust did not hit their medicines reconciliation target, with the figure falling to 20% in August 2022. The pharmacy department however had identified actions to improve these figures in their Medicines reconciliation audit such as a seven-day working service. This improvement plan was ongoing.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

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

Staff knew what incidents to report and how to report them. Staff we spoke with were able to clearly share how to report incidents and shared examples of this with us. Staff were able to articulate doing this in line with Trust policy.

Incident learning was shared with staff and we saw the 'Patient Safety Newsletter' which is issued regularly to all staff. This included information on learning from incidents and improvements across the Trust.

The service had no never events on any wards.

Managers for the service had sight of all incidents and all incidents rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Staff met to discuss the feedback and look at improvements to patient care.

Surgery

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Staff reported serious incidents clearly and in line with trust policy.

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

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

Managers debriefed and supported staff after any serious incident. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. During inspection we saw staff on all wards having designated staff to serve patient food and separate staff able to help assist patients with positioning or feeding as required. We saw that patients were encouraged to sit at chairs at mealtimes.

Kitchen staff were clear on patients' dietary requirements and needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw that this was accurately completed on the patients we looked at during our inspection.

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

The trust had nutrition specialist nurses to support patients including those receiving artificial nutrition support, for example percutaneous endoscopic gastrostomy (PEG); A PEG feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed the Trusts standard operating procedure (SOP) for surgical patients who were nil by mouth. The SOP was in date and due for review in February 2024. The policy had information to support staff with a protocol for intravenous fluids and information for pre fasting guidance for patients before surgery.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The trust used differing methods to assess patient pain levels which included FLACC assessment, Burford thermometer and VAS score.

FLACC is a behavioural pain assessment scale used for nonverbal or preverbal patients who are unable to self-report their level of pain. Pain is assessed through observation of 5 categories including face, legs, activity, cry, and consolability. The Burford thermometer assesses pain by asking patients to indicate the intensity or severity of their pain on a diagram of a thermometer. It is a version of a verbal descriptor scale that visually represents increasing degrees of pain along the thermometer. Visual analogue scales (VAS's) are used for subjective ratings of emotion or other sensations such as pain.

Patients usually received pain relief soon after requesting it. We spoke to patients who had received pain relief on time and when requested. Although we did see 1 occasion when we witnessed a patient who became so distressed due to the delay to their pain relief that they left the ward to discharge themselves and staff were able to talk them into returning back to the ward and then they had their pain relief given. We reviewed the patient records and saw they had waited five hours since they had been able to have the pain relief to when it was administered to them.

Staff prescribed, administered and recorded pain relief accurately. We saw staff completing and updating the patient records.

All staff we asked knew about the trust's specialist pain management team (SPT). They knew how to contact them either by bleep, formal referrals via the ICE system or just ringing them for advice.

The latest pain relief audit results received from the Trust showed that they were at an overall average of 86.3% for September 2022 in pain score being evaluated following analgesia in patients.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. All staff working at the hospital had an induction programme relevant to their role and the department they worked in. New staff were required to complete e-learning and face-to-face training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Line and ward managers completed annual appraisals including any learning and development opportunities with their staff and we saw these scheduled-on noticeboards on individual wards.

The clinical educators supported the learning and development needs of staff.

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

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported by their managers to improve their practice where indicated.

We observed security staff within the hospital during inspection. The trust told us the role of the security staff included, regular welfare checks, rapid response to security requests, supporting enhanced observations on the advice of clinical teams and staff escorts.

The security service was outsourced to an external company contracted to provide the security staff at James Cook University Hospital, and deliver the training, except for safeguarding level 2 which was done in house. Each training module had a refresher requirement. Training was undertaken once security staff commenced their role; however, they would not be allocated a task until they had completed role specific task training. The training compliance for security staff evidenced 100% compliance.

We reviewed the general security policy which had an issue date of January 2022 and a review date of December 2024.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service as a multidisciplinary team (MDT).

When we visited the wards and observed a handover, we saw a variety of staff working together, such as nurses and support workers, to benefit patients. Nursing staff said they had good communication between theatre and ward staff. They felt the trust had an informal culture of cross-service collaboration, for example by borrowing equipment and asking advice.

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

There was a dedicated discharge team and they had been in place since January 2022. They had links with local services, local authorities and care providers.

We saw therapist input and contributions to patients' discharge. For example, we saw the occupational therapy team visit a patient on ward during our inspection. The patient input into care was included throughout and involvement of family member as the patients next of kin was also present.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff of all grades and all disciplines worked together as a team to benefit patients. Doctors, nurses, healthcare professionals and administration staff supported each other to provide excellent care.

There were many examples of multidisciplinary working including the daily safety briefing, ward rounds which included input from a consultant, doctors, pharmacist, physiotherapist and as well as nursing staff.

There was a dedicated physiotherapist team who worked collaboratively with the nursing and medical staff to ensure that patients received the support they required. The physiotherapy team worked seven days per week.

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

Seven-day services

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

Surgery

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight. There was no dedicated occupational therapist but referrals could be made.

Speech and language therapy were offered Monday to Friday. There were a low number of speech and language therapists available within the trust which reflects a nationwide shortage of this staff group.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

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

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw displays on wards we visited through our inspection on healthy lifestyles and health promotion. There were leaflets available for patients to take on a variety of topics including diabetes, weight loss, stop smoking and stress.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

There were guidelines in place to support patients withdrawing from drugs or alcohol. Staff told us the pharmacy department and consultants would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. Although decision making was not always recorded correctly on documentation we reviewed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed additional sections of service user records relating to Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications. We saw capacity assessments, best interest decisions and consent to care and treatment was not always in line with legislation and guidelines and staff did not consistently recognise and respond to concerns in relation to mental capacity. Staff did not always consistently assess capacity in a way that was decision-

specific and time-specific. We found examples in service user records where staff had recorded that service users had 'no capacity'. Staff did not record the decision prompting the consideration of the service user's capacity or record the mental capacity assessment and decision made in the service user's best interest. However, the Trust has been completing significant work across the area, and we have seen clear improvement in audits for record keeping since inspection. The Trust had appointed a Mental Capacity Act and DoLS/ LPS Lead Practitioner in post and work has been carried out overall in the Trust because of this appointment. We have seen improvements in DoLS audits on wards to show consistent improvement from October 2022 – March 2023. This has included decision specific capacity assessment form/ detailed in records audit compliance rise from 54& to 96%.

The Trust held MCA steering group meetings every 12 weeks and we have seen the minutes of the meetings held.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

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

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with had attended mandatory training surrounding mental capacity act and deprivation of liberty safeguards training and understood capacity was decision and time specific. Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. The mental capacity assessment form contained a stage two assessment and a determination of best interests. It identified if an independent mental capacity advocate was required. Mental Capacity assessment forms were not always fully completed in all the records reviewed. The forms did not always clearly summarise the reasoning behind the best interest decision or identify the names of other people that had been consulted in the making of that decision. However, since inspection we have seen significant improvements in this area through Trust audits carried out. The Trust also had a clear action plan in place for better practice and this has progressed well since inspection.

Staff liaised with the psychiatric liaison team (PLT) for all mental health patients and PLT would make decisions about required mental health treatment in conjunction with trust staff. PLT staff undertook mental health assessments to identify if a Mental Health Act Assessment was required.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Surgery

Is the service caring?

Good ➔➔

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We reviewed the friends and family data results for surgical wards for the three months prior to our inspection visit, and the average result for these was 95.01%. The is higher than the Trust target of 90% and higher than our previous inspection in May 2022, where it was 90.03%.

We also reviewed patient satisfaction surveys for surgical wards for the three months prior to our inspection visit. These scored an average of 88.46%.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with compassion, and we saw staff provided care in a respectful manner that maintained patient dignity. For example, staff drew bay curtains to have private conversations or examine the patient.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

Surgery

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

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

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

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

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

Surgery

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

Initiatives to enhance the care of those with a learning disability were in place. Hospital passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individuals during difficult periods.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and what expectations to have of the services being provided.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

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

Access and flow

People could access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The overall waiting list for surgery has increased over the 12 months prior to inspection, but the longer waiting times had decreased due to the management of the lists. At the time of inspection, there were no 104 week waits for patients and 52 week waits had significantly decreased over the previous year.

The trust performed well in comparison to other providers and the national average for 52 and 78 week waits, which were at 97% and 99.8% respectively. For combined surgical specialties, the 18 week performance was 67% which was better than the 61% national average in October 2022. Since May 2022, 18 week waits had improved by 11%. Some specialties were performing better than others. Endocrinology was top (93%) and urology was bottom (58%) however urology waits had reduced by 62% for 52 week waiters in March 2023.

The trust was on par with or better than other providers and the national average for cancer waiting times. The 14 day cancer referral rate was 73%, slightly below the national average of 80%. However, the 14 day breast cancer referral rate

was 100% and much better than the national average of 72%. The rates for 31 and 62 days were 94% and 56%, just above and slightly below the national averages of 93% and 62% respectively. The trust had prioritised the 62 day wait which had shown improvement towards its end of year plan and had met its target. Since our inspection, the Trust have achieved their cancer diagnosis level in March 2023 for 62 day waits for cancer treatment.

In response to a request from NHS England, the trust provided mutual aid to other NHS trusts in the region for spinal surgery and cardiothoracic surgery. Although this meant the trust's referral to treatment times were impacted, the trust had contributed to the reduction of the longest waits across the region.

The Trust met NHS targets set overall for 104, 78 and 52 week waits for surgery.

The Trust was in Tier three for elective recovery (including cancer) in November 2022 due to the reduction in patients waiting to be seen. This meant the Trust did not need regional oversight and had moved into an improved tier because of this.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. In the 12 months prior to inspection, there was an average of 29 medical outlier patients being cared for on designated surgical wards. We have reviewed the standard operating procedure for management of patients outside their base speciality location (outliers) which was published in September 2022, and due for review in December 2024. The scope is to ensure patient safety and care is maintained to the highest standard despite where a patient is 'located' on site.

Managers worked to minimise the number of surgical patients on non-surgical wards. Bed occupancy levels in the 12 months prior to inspection was at 90.01% on average.

Managers monitored that patient moves between wards were kept to a minimum. The average bed move per day in the 12 months prior to inspection was 2.8. Reasons for increased bed moves included decant of wards for deep cleaning, ongoing infection prevention control, moving a patient to a side room for privacy and dignity, patients moved from Friarage Hospital in anticipation of enhanced level of care needed and reconfiguration of ward footprint which took place in July 2022.

Managers and staff started planning each patient's discharge as early as possible. The average length of stay for surgical specialities was 2.1 days for patients at the time of our inspection.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. In the 12 months prior to inspection, there was an average of 17 patients per day on surgical wards that had delayed discharge.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

In September 2022, the diagnostic hub opened at Friarage Hospital and because of this, 40% more patients have been treated since then in endoscopy and urology.

Learning from complaints and concerns

Surgery

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with had said they felt able to raise concerns and could see that the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There were 16 complaints in progress at the time of inspection and these were all being handled as per the Trust process. The average length of time to respond to a formal complaint was 56 days.

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

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgery had managers with the right skills and abilities to ensure the service was providing high quality care. Leaders were inspiring a shared purpose and were focussed on delivering and motivating staff to succeed. Managers were keen to retain staff and invested in education for staff to progress.

The leadership team understood the current challenges and pressures impacting upon service delivery and patient care.

The clinical leadership team were visible and approachable. From speaking with staff, it was clear that staff had confidence in working together and in leaders understanding issues and working better to improve them.

Vision and Strategy

Surgery

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders want to achieve in surgery and this is in line with the Trust vision. The service promoted training, and staff were aware of the vision for surgery and were able to share this with us during inspection.

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

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

Culture

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

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

The care and service delivered showed a strong team approach to work. Staff from all disciplines told us they felt valued in their roles and were very much part of the team. Staff we spoke with expressed pride and commitment in their work.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

Governance

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

Staff at all levels of the organisation understood what to escalate to a more senior person, and this happened for reporting low staffing levels. Ward managers told us that they have the option to report red flags due to low staffing levels. The number of red flags were reported monthly to the board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks, and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

There was a robust governance process related to risk with monthly risk meetings. The risks were escalated via the collaborative governance meetings and the directorate meetings. The collaborative board and the corporate risk review group oversaw the reported risks.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

Information Management

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

Staff had access to the IT equipment and systems needed to do their work and the trust's IT systems had received international recognition for how they helped improve the quality of care.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams. The trust had automated data collection systems which ensured monitoring performance was not over burdensome for front line staff.

Information governance systems were in place and ensured the confidentiality of patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the staff engagement group met monthly and this covered a wide variety of agenda topics in recent minutes we reviewed. We saw that staff survey questions had been updated to align with the NHS People Promise and that the Trust had asked additional questions regarding the awareness of Trust values.

There was a flexible working group which has a focus on providing more varied options of working to deliver care that will help to help retain staff and improve retention. There was an individual toolkit and a line manager toolkit developed within this to support requests for flexible working and encourage a flexible workplace.

There was a clear focus on engagement activities to develop a culture of inclusion. The Trust delivers quarterly 'Reciprocal Mentoring' group events and these have led to the launch of Discovery Events for staff from ethnic minority groups.

Learning, continuous improvement and innovation

Surgery

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

The Trust has a Trust Talent Management Strategy which has three levels drawing together core talent management interventions. Since 2018, the Trust have had 51 members of staff who have undertaken Level 7 Leadership Courses, of which 29 have obtained promotion since completing the course and only 2 have left the organisation.

Critical care

Good ↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

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

Nursing and medical staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning.

The trust set a target of 90% for completion of mandatory training. Within the critical care staff group, this had been achieved with 92% of staff completing mandatory training.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The trust set a target of 90% for completion of safeguarding training and 91% of the total critical care staff group had achieved this target. However, medical staff completion was below target at 81%.

There was a trust safeguarding policy which could be accessed via the intranet. There was a policy for rapid tranquilisation.

The trust had named lead nurses for adult and children's safeguarding as well as a safeguarding team who were available for advice.

Cleanliness, infection control and hygiene

Critical care

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

The units were visibly clean, tidy and dust free. Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient. Alcohol hand gel and hand wash facilities were available at each bed space.

The service generally performed well for cleanliness. Cleanliness audits scored between 87% and 100% in the previous 3 months before inspection. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff mainly followed infection control principles including the use of personal protective equipment (PPE). We observed staff carrying out hand washing prior to and after patient contact. However, three members of staff prepared medicine without wearing the required apron and gloves. We informed the trust of this who immediately instructed the critical care clinical educators to monitor and audit practice. Aseptic Non-Touch technique (ANTT) compliance was audited and training compliance for nursing staff from the last audit was 83.3%.

We found chemical substances on the shelving in sluices and the sluice doors were not locked. These tubs were required to be locked according to COSHH (Control of Substances Hazardous to Health' and under the Control of Substances Hazardous to Health Regulations 2002) recommendations. When escalated to senior staff the issue was immediately remedied.

Data on infection rates was also collected monthly for each unit and displayed in the areas we visited. This included information on MRSA, clostridium difficile, Pseudamonas, E. coli and methicillin-susceptible Staphylococcus aureus (MSSA). In the period April 2022 to October 2022, data showed that the infection rates for critical care were low. This was an improvement from our previous inspection.

The unit had 7 isolation rooms and the need for more of these was listed on the service risk register. At the last inspection, it was noted that although there was a process for identifying and managing the risk of patients with an infection when isolation rooms were not available, this was not logged as a risk at that time. However, this had been resolved.

Environment and equipment

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

The design of the environment followed national guidance for a critical care unit built prior to 2013. However, as noted at the previous inspection, there were no hand wash basins at each bed space. The lack of individual basins was due to the layout of the unit and managers had exhausted options to remedy this without a complete redesign of the unit. There were alcohol gels and hand wash facilities available at each bed space. The space around each bed in ICU 2 and ICU3 was sometimes restricted if there were multiple people in attendance.

There were curtains around each bed space that afforded privacy. These curtains were changed from blue to green if there were infection concerns for a patient.

Critical care

Staff carried out daily safety checks of specialist equipment. All staff received training in specialised equipment used in the intensive care unit to ensure safe practice. There were daily checklists that showed staff made checks on the equipment in use in the patient bed space.

The service had enough suitable equipment to help them to safely care for patients. Equipment servicing records showed that maintenance and upkeep was monitored and actioned.

Emergency equipment was available at each bed space such as tracheostomy safety boxes. There were resuscitation trollies centrally located on each unit. Daily checks of this equipment were completed and contents of the trollies were in line with Resuscitation Council (UK) guidelines.

We inspected a wide selection of consumable items in resuscitation trollies and storerooms in the different units we visited. We found all items were intact and within expiry dates.

Fire extinguishers were present on all inspected services and in date. We also saw that fire exits were checked and clear and the fire safety logbook and reference manual clearly stated who the fire safety advisor was. The fire safety policy was available to all staff and staff were aware of hospital fire procedures.

Theatres were closely located to the units providing easy access and there was central monitoring in place to allow oversight of patients.

The service had a family room with a sofa bed for overnight stays. However, this room had been used during the COVID-19 pandemic for staff well-being consultations and had not been reverted to its original use. The trust acknowledged on the risk register that better facilities were needed for accommodation and as a space for people to wait before visiting time.

Assessing and responding to patient risk

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

Effective practices supported all staff to seek appropriate support for patients whose conditions were deteriorating. There was a proactive approach to anticipating and managing risks to patients that used the service. Practices were embedded and staff understood their responsibilities.

Staff followed national guidance, assessed and documented patient risk on admission and then again 24 hours later using evidence-based tools. This included the malnutrition universal screening tool (MUST), venous thromboembolism (VTE) and pressure area assessment.

The unit had daily safety briefings which highlighted potential risks to patients. The agenda included points such as patient specific risks, capacity in the unit, staffing levels and a review of patients coming to the unit.

There was a coordinated approach to assessing and managing patient risk. An effective and highly trained critical care outreach team supported ward staff to respond to and manage the care of deteriorating patients safely.

Critical care

The critical care outreach team (CCOT) provided cover 7 days a week for 24 hours a day. The CCOT used a 'ward watcher' system to provide information and oversight of any unwell patients or patients who have moved from critical care to ward areas. The system identified any patients of concern, as well as any patients identified by the medical and surgical teams. There was a clear escalation policy in place for when patients had an elevated NEWS score. This was an improvement from our previous inspection.

As a major trauma centre, critical care was required to have a level 3 and level 2 bed available. Bed availability was discussed at site meetings and the unit aimed to keep 3 beds available each day for emergency admissions.

Staff we spoke with knew how to access mental health support. There was access to specialist nurses and crisis teams.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Managers told us that a risk assessment was completed for patients who needed a side room – this was not recorded in a standardised written proforma but as free text in medical notes. However, when staff were asked about this, they were generally unaware that this was the process.

Staff shared key information to keep patients safe when handing over their care to others. There was an all staff handover at each shift change and then individual bedside handovers from nurse to nurse after this. We observed completed daily bedside safety checks. Within patient records risk assessments and care bundles were completed, for example, for falls and moving and handling.

Medical staff completed their handovers separately. Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. There were 15 nurse vacancies at the time of inspection but recruitment was ongoing.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Roster and shift allocation of staff in critical care was managed by ward managers to ensure a balanced skill mix.

A clinical matron and head of nursing jointly led patient safety, quality, staff wellbeing and clinical governance across all three areas. Safecare (staffing) meetings were chaired by a clinical matron with support from ward managers to ensure a 24-hour site safe staffing plan. Any short notice staffing concerns out of hours were raised to the trust site team.

The ward manager could adjust staffing levels daily according to the needs of patients. Senior nurses continuously reviewed rosters throughout shifts to ensure that patients had the correct level of care. There was always a coordinator (one per 8 beds) on shift and an extra nurse who could flex between patients to cover demand.

Critical care

Nurse staffing levels followed and met national guidance, level 3 patients were nursed on a 1 to 1 ratio and level 2 patients were nursed on a 2 patients to 1 nurse ratio. This was an improvement from our previous inspection. There was also a healthcare support worker on each shift.

Planned and actual staffing numbers were displayed on each unit. Electronic rostering was in place which incorporated the safe care staffing tool. The senior management team told us staffing shortages would be reported on the incident monitoring tool.

Gaps in staffing were covered by moving staff between areas and staff working additional shifts; there was some use of bank staff. Agency staff were used very rarely. Support with staffing was also provided by senior nurses who may had planned to work non-clinically.

Staff reported incidents of staffing shortages and if there was any impact on patient safety.

Medical staffing

The service had enough medical staff to keep patients safe. The critical care services had a clinical director. There were 16.5 whole time equivalent consultants providing the medical cover across ICU2 and 3 and GCCU. There were 3.3 whole time equivalent vacancies for medical staff. Lack of Intensivists remained on the risk register.

During the hours of 08:00 and 18:00, there were between 3 and 5 consultants available dependent on whether this was a weekday or weekend. After 18:00, this number dropped to 2 consultants until 22:00. This met the GPICS standards of a consultant/patient ratio. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Overnight cover was provided by an on-call consultant who could attend within 30 minutes. The on-call consultant remained on site until 10pm.

We observed consultant wards rounds, and in the 10 patient records we reviewed, it was documented that twice daily consultant led ward rounds took place and that all patients had been reviewed by a consultant within 12 hours of admission.

The service had several advanced critical care practitioners who undertook a 2 to 3 year training program to work as advanced practitioners within critical care. Their role included patient assessment, practical procedures and drug prescribing.

Sickness rates for medical staff were low at 1.38%

Records

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

Patient notes were comprehensive and all staff could access them easily. Paper records were in use in all the areas we visited. Nursing and medical records were stored in a trolley at the end of each bed space or outside the room of those patients requiring isolation. Records were stored securely.

Critical care

Care bundles and pathways were in use for specific conditions or procedures. There was evidence in the notes we reviewed of assessments which focused on details other than physical health needs, for example, mental health conditions and emotional needs.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. Discharge information was thorough with clear escalation plans for individual patients.

Staff complete the safe patient transfer bundle for discharges to the ward document. This detailed pre-transfer checks to be completed, a handover and post transfer checks once the patient had arrived on the ward.

Medicines

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

There was no dedicated advanced critical care pharmacist. Following a resignation from post, the trust had struggled to recruit to the position. At the time of inspection, this was identified as a risk. After inspection, the trust advised that they had successfully appointed to this role. However, critical care pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records in 3 areas and saw that accurate records and checks were completed.

Fridge temperatures were monitored and recorded in line with trust policy. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

Arrangements were in place to ensure there were adequate supplies of emergency medicines and equipment. The GCCU had an electronic system for storing and issuing medicines that meant medicines usage was tracked and supplies continually monitored,

However, medicines were stored in a locked room on ITU2 and ITU3 but on open shelving rather than in a cupboard. The trust policy on medicine management stated that this was acceptable if there was an accompanying risk assessment. Managers were unable to furnish us with a risk assessment at the time of inspection. However, managers completed an updated risk assessment immediately after inspection and stated that this way of storing medicine was a temporary arrangement.

The storage area for intravenous and irrigation fluids on ITU2 was unsecured at the time of inspection. The area had a lockable door but this remained continuously open. Since inspection, the fluids were moved to a new locked storage location between ITU 2 and ITU 3.

Incidents

Critical care

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

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. Staff raised concerns and reported incidents and near misses in line with trust policy.

Safety huddles were established and took place as part of the nursing handover. Staff received feedback from investigation of incidents. Managers shared learning about never events with their staff and across the trust. There were learning from event bulletins for staff that had reviews of safety incidents and actions taken.

Managers for the service had sight of all incidents and all incidents rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Staff met to discuss the feedback and look at improvements to patient care.

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Critical care specific mortality and morbidity meetings took place weekly, which was in line with GPICS recommendations. Feedback from consultants we spoke with was this process was embedded within the service. All staff were invited to attend. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The unit's policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). Staff demonstrated awareness of the policies and knew how to access them.

Critical care

Staff followed nationally recognised care bundles. These included care bundles to reduce the risk of ventilator-acquired infections. These were all compatible with national standards practice and guidance.

The unit demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes for patients could be benchmarked against similar units nationally.

Critical care was not an outlier for the associated patient outcome parameters and invested considerably in using audit and research to improve the effectiveness of care and treatment.

Critical care managers carried out several local audits, which included; hand hygiene, aseptic non-touch technique and the environment. These audits were mandatory and set by the trust. We looked at these audits and saw compliance was good. Learning was undertaken from any poor performance. The critical care unit took part in a number of national audits to measure the effectiveness of the care and treatment provided. The unit also had an internal audit programme. Audits ongoing at the time of our visit were; delirium, oxygen prescribing and fluid balance monitoring. There was no lead consultant for audits following the retirement of the previous lead but there were plans to fill this vacancy.

The trust had a clinical and operational lead for LocSSIPs (Local Safety Standard for Invasive Procedures). The LocSSIPs were audited and critical care performed well. Of 7 audits undertaken in the 12 months prior to inspection, they had demonstrated 100% compliance in 5 audits and the lowest score had been 80%

The critical care unit had access to a physiotherapist who saw all patients that had been ventilated for more than three days as outlined in the guidelines for the provision of intensive care services (GPICS)2015.

However, the service leads were aware that further work needed to be done to provide care that was in line with NICE CG83 rehabilitation after critical illness. The service was challenged as funding had not been approved which would support full compliance. There had been bids to attain the capital investment needed but this was thwarted by other demands on the trust's budget.

Nutrition and hydration

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

Staff assessed patients for risk of dehydration and malnutrition using a nationally recognised tool. Staff took action, including accessing specialist support, to ensure patients nutrition and hydration needs were met. Staff fully and accurately completed patients' fluid and nutrition charts. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The unit scored 94% compliance between November 2021 and October 2022 following an audit of nutritional requirements and management of associated nutritional risks.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff and patients had access to specialist nutritional advice from the dietician team. The dietitian reviewed all patients requiring specialist feeding including nasogastric support and this met with the GPICS guidelines that 'there must be a dietitian as part of the critical care multidisciplinary team'.

Staff followed protocols and policies regarding enteral and parenteral feeding practice. A speech and language therapist was available to support patients with tracheostomies and those with swallowing difficulties. The speech and language therapist provided instruction to staff on how to support patients with swallowing difficulties with eating and drinking. There was no dedicated speech and language therapist attached to the critical care unit.

Patients had varied food choices and could select their meals through one of the catering leaflets. These leaflets offered several options for lunch and supper for each day of the week on a weekly rota and were associated to dietary codes. The leaflet also identified if a patient required mealtime support or if they were on a special menu or diet.

Pain relief

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

Patients' pain was well managed. Pain relieving medicines were prescribed and administered according to patients' pain levels. Staff prescribed, administered and recorded pain relief accurately. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after it was identified they needed it or they requested it.

Pain relief was discussed on ward rounds and reviewed by the pharmacy team.

In the 10 records we reviewed there was evidence of pain scores being completed and action taken in response to any indication a patient was experiencing pain. The trust used a pain scale which was recorded on the patient observation tool at the patient bedside.

We were provided with audit data relating to pain charts being present and pain assessment being undertaken following the administration of analgesia. The audits scrutinised whether there were completed pain assessment charts and if pain scores had been evaluated after analgesia was given. Compliance varied between 97% and 100% across the 3 units.

The patients and relatives we could speak with reported pain control being effective and that it was provided in a timely way.

Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes

The service monitored the effectiveness of care and treatment and used findings to improve them. They contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. Overall, the results of the data for September 2022 showed that the critical care unit had outcomes that were similar or better than other critical care units and were within national expectations. Despite having high acuity patients, ICNARC data showed that the service had lower than expected mortality rates.

Critical care

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

Pressure area care had been problematic as noted at the previous CQC inspection and the unit had reported high numbers of patients having pressure damage. This was attributed to patients deemed unstable to roll and the vulnerability of critically ill individuals. Nursing staff and the tissue viability team had undertaken audits and made changes to improve pressure care for patients. Numbers of pressure ulcers had decreased by 70% with the introduction of a pathway on assessing patients and actions to take. The team had instigated the use of repositioning wedges and trained staff how to use them. This was an improvement from our previous inspection.

The critical care team was actively involved in research. There was a lead nurse for audit in critical care. The unit was taking part in 16 clinical trials at the time of inspection. Some of the research projects underway, planned or recently completed were ProMISe, CRASH 3, Genosept, haemodynamic assessment of septic patients, the effect of exercise on patient fitness and quality of life after intensive care admission, amongst others.

The service had a lower than expected risk of readmission for elective care than the England average. The service had a lower than expected risk of readmission for non-elective care than the England average. The service was also a high performer in the national cardiac arrest audit.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data for staff working in ICU and CGU showed that 85% of staff had undergone a recent appraisal which exceeded the 80% target. There were plans to complete those which were outstanding.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. Registered nursing staff had an induction week then an 8-week supernumerary period. During this time support was provided by the clinical educator and a mentor. Training was provided covering a range of topics from body systems to stoma care and human factors.

The clinical educators supported the learning and development needs of staff. Clinical educators were in dedicated roles in line with GPICS recommendations. There were 5.43 whole time equivalent educators in post. They provided a variety of education and maintained central records for equipment training, steps and post-registration training on the units. All their planned and actual time was dedicated to their educational role. This was an improvement from our previous inspection.

The COVID-19 pandemic had meant that some education and training had been placed on hold. There was an educational recovery programme with actions and plans to catch up on missed education and competency training.

Critical care

All registered nurses in critical care are required to complete step one of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the units. Step 1 competencies have been designed to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor or practice educator. Data showed that 154 of 194 staff had completed step 1 competencies or equivalent. Of those staff, 59 of had completed step 2 and step 3 at university, obtaining the critical care award. This meant that 30% of nurses had a post registration award in critical care nursing which was not in line with the GPICS minimum standard of 50%. The educational recovery plan had a target to improve this.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Additional study days were provided by staff in areas such as surgery, hemofiltration and ventilation. There were identified link workers in each area, for areas such as blood transfusion and tissue viability. Staff praised clinical educators. Most staff had undertaken a study day in airway training organised by the team.

Doctors reported there were good teaching opportunities for medical staff on a range of conditions. There was a weekly consultant led teaching programme on a Wednesday and a middle grade teaching programme was in development. There was also access to a simulation centre to support training.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff of all grades and all disciplines worked together as a team to benefit patients. Doctors, nurses, healthcare professionals and administration staff supported each other to provide excellent care.

There were many examples of multidisciplinary working including the daily safety briefing, ward rounds which included input from a consultant, doctors, pharmacist, physiotherapist and as well as nursing staff.

There was a dedicated physiotherapist team who worked collaboratively with the nursing and medical staff to ensure that patients received the support they required. The physiotherapy team worked 7 days per week.

There was a lead physiotherapist and dietitian for critical care. Access to speech and language therapy and nurse specialists was available when required by referral. Pharmacist were present on the ward and microbiology staff could be contacted by phone.

There was no advanced critical care pharmacy provision which meant GPICS standards were not met.

The CCOT liaised with allied health professional as required as part of their role. They also ensured ward managers were aware of any unwell patients there may be on their wards and the plan of care.

All staff we spoke with told us there was a collaborative and supporting way of working in the critical care unit and everyone had their part to play and this was extremely evident during the inspection.

Seven-day services

Critical care

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

Critical care services were able to safely monitor patient outcomes and support care being delivered seven days a week.

The service had medical cover on site 24 hours a day and intensivists completed a ward round seven days a week. This was in line with 'NHS Services, Seven Days a Week, Priority Clinical Standard 2: Time to first consultant review': All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital.

Staff on wards could call for support from the critical care outreach team 24 hours a day, 7 days a week.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight. There was no dedicated occupational therapist, but referrals could be made if a patient required one.

Speech and language therapy was offered Monday to Friday. There were a low number of speech and language therapists available within the trust which reflects a nationwide shortage of this staff group.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

There were guidelines in place to support patients withdrawing from drugs or alcohol. Staff told us the pharmacy department and consultants would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

A range of patient information leaflets were available for patients and families and the units had many displayed boards promoting an array of health-related topics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Critical care

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff demonstrated good understanding of the mental capacity act and deprivation of liberty safeguards. Capacity assessments were recorded in patient records.

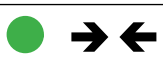
Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff clearly recorded consent in the patients' records.

Staff were aware of the process if a patient required any form of restraint. Staff told us where possible this would be avoided, and we observed staff comforting patients to stop them pulling at tubes rather than using mitts. Where mitts were in use, we found evidence of capacity assessments being completed, care plans were in place and there was evidence of ongoing assessment. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

In the records reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. These are used to measure the agitation, sedation or delirium levels of a patient. Where appropriate these had been completed and appropriate actions taken.

The falls assessment chart included a screening tool for dementia. This was completed as appropriate in the records we reviewed.

Is the service caring?

Good 

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

Compassionate care

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

Compassionate care was embedded in all staff working in the critical care unit. Our observations and everyone we spoke with confirmed this. We saw patients being comforted and cared for by staff on the unit and visitors afforded equal consideration. We observed sedated and unconscious patients being communicated with by nursing and medical staff in a compassionate way. All staff introduced themselves by name, told the patient who was accompanying them and explained what was happening to them.

Staff provided care in a respectful manner that maintained patient dignity. Staff drew bay curtains to have private conversations or examine the patient.

Although there was no room for a relative to sleep in overnight, families were supported if there was a need to be present.

Critical care

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We spoke to 4 patients and their relatives and all stated that they were aware of what was happening with regards to their care and things had been explained to them in a way that they understood. We saw a number of 'Thank you 'cards from patients and their relatives displayed on notice boards throughout the areas we visited – one stated: ''generous caring staff who would do anything for patients''

Emotional support

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

The unit promoted the use of patients' diaries. These are an ongoing record of a patients stay in critical care, written for the patient. It is a daily record of what happened to them during their stay, including showing how their condition changed, who came to visit them and what was going on in the outside world whilst they were in the unit.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

All relatives we spoke to made comments on how well they had been supported by staff in the critical care unit. One relative we spoke to said they felt overwhelmed with the care and treatment that they and their loved one had received since they had been admitted.

There was a multidisciplinary approach to support the patient emotionally on the unit. This was provided by allied health care professionals, medical, nursing and domestic staff. We watched as staff talked with patients in a supportive manner.

Managers and staff offered emotional support to each other and had debriefing sessions when applicable. The unit had been impacted by loss of valued staff through illness and senior leaders acknowledged this, providing support where able. At the height of the Covid-19 pandemic, psychologists were available for staff who needed well-being advice and support and an advert was out to secure a dedicated psychologist for the department.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

We observed staff explaining to patients and their relatives the care and treatment that was being provided. Medical ward rounds were conducted not just in front of patients and relatives but involving them, making all information and decisions transparent and inclusive.

Critical care

Patients and their families could give feedback on the service and their treatment via a survey. This feedback was difficult to glean given the nature of illness in critical care but the service was looking at new ways to improve this. The last friends and family test survey had only 4 responses. Administration staff were to be trained to help harness patient, friend and family views. However, patients gave positive feedback about the service in various ways. There were many thank you cards displayed and compliments received.

The critical care unit had built a garden for patient and staff use since the last inspection. Staff had worked to raise funds and recruit help to create an outdoor space as a tranquil facility. The garden had been used in recent months to host a birthday party for a long stay patient.

During Halloween, staff had organised a pumpkin carving competition on the unit and a patient was asked to choose a winner.

Staff went out their way to look after patients and aid their rehabilitation. One patient liked a particular newspaper so this was collected for them each morning. If patients enjoyed particular radio programmes or foods, for instance, staff accommodated these requests.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

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

Patients received 1 to 1 or 2 to 1 nursing care, depending on their needs. A doctor was available at all times and patients were seen regularly throughout the day.

There was no follow up clinic for patients who had been discharged from critical care which denied patients the opportunity to speak to the staff that had looked after them. The service had follow up meetings at the request of inpatients, however these were unfunded, and we were told they ran on 'goodwill'.

The use of a patient diary helped understanding of what had happened during their stay and patients were supported psychologically for a period following their staying critical care.

Service leads understood the need for a flexible service which could change and adapt to the fluctuating demand for critical beds. This meant at times of severe pressure, there were staff with the required skills to continue to deliver a quality service.

The service was involved in the regional critical care operational delivery network.

Critical care

Arrangements were in place to manage patients with complex long-term weaning problems and the service had access to a home ventilation team.

The Butterfly scheme and unit champions were used to support those patients living with dementia.

There had been a room for relatives to stay in but this was no longer in use. The waiting area for relatives and visitors was small. Visitors spilled into the corridor when numbers were high.

Meeting people's individual needs

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

Support was available for patients with physical and learning disabilities. Staff made reasonable adjustments to meet the needs of patients with a learning disability or who were living with dementia and their family members.

Initiatives to enhance the care of those with a learning disability were in place. Hospital passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individuals during difficult periods.

There was a good awareness amongst staff of the delirium that patients experience as a result of their treatment in the critical care environment. The unit was committed to humanising the environment and took measures to control noise levels and lighting to normalise the care environment.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

Staff supported patients and those close to them during referral, transfer between services and discharges. Staff always informed patients of possible changes to their care before it occurred. Before discharges staff informed the patient and their family of where they were to be discharged to and what expectations to have of the services being provided. Staff said this was particularly important as some patients reported a feeling of abandonment due to the reduction of 1 to 1 or 2 to 1 care given on the units.

There were restricted visiting times and visitors were required to book a time slot before they went to the unit. This system was intended to ensure the department was not overcrowded. Staff discretion was used when a patient might require the presence of family or loved ones outside of these times. There were imminent plans to change this system to better meet the needs of patients and their families.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available. Physiotherapy staff learned Makaton when they had a patient who used this language to communicate.

Staff could access bariatric equipment to care for patients as required.

The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas. Although there was no Rehabilitation After Critical Illness (RACI) provision, the outreach team provided 21 hours of ward-based

Critical care

RACI service to patients who had stepped down from critical care. They had also introduced 'Call 4 Concern'. This patient safety service for inpatients, families and friends was available if someone was concerned about a noticeable change or deterioration in a patient's condition. They also offered emotional support to patients and their families who had recently been discharged from the unit.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Admissions to the unit included elective admissions (post-operative patients), emergency admissions from all other specialists within the trust and requests and transfers into the service from other hospitals. Emergency admissions counted for more than 70% of patients seen in critical care.

Patients were reviewed in person by a consultant in intensive care within 12 hours of admission to the unit. We reviewed ten patients' notes and all patients had been reviewed in person by a consultant in intensive care medicine within 12 hours of admission to intensive care. This was in line with Guidelines for the Provision of Intensive Care Services, 2015.

Cancellation of surgery because of lack of critical care beds happened in low numbers most months. Records showed that for the 6 month period prior to inspection, there were 25 cancelled planned surgical procedures. The critical care unit aimed to block out 3 beds per day so that they had capacity to take emergency admissions.

Since the last inspection, the hospital now had a post anaesthetic care unit (PACU). This was a much-needed service which had taken pressure off the critical care units. Some elective cases that required an extended period of recovery but did not necessarily need to be in critical care went to PACU. There were plans to increase the size of PACU.

The trust did not record patients delayed in recovery while waiting for a critical care bed following planned surgery but managers told us that this happened infrequently. Over the period May to October 2022, 6 patients were cared for in theatre recovery whilst waiting for admission to critical care. They had an average wait for admission to the unit of 6.2 hours. The shortest delay was 1 hour 15 minutes and the longest was 13 hours.

From 15 August 2022 to 8 November 2022, critical care bed occupancy at the trust has ranged from 79% to 93%. This is compared to a regional average with a range of 67% to 74% and 72% to 75% average for national comparators.

During the same period, the percentage of critical care beds occupied by patients with Covid-19 ranged between 1.4% on 7 August to 9.8% on 23 October. Data as at 7 November shows 7.2% of critical care beds were occupied by patients with Covid-19.

Over the last 12 months, there were 59 re-admissions to critical care. In the most recent month, October 2022, there were 3 re-admissions. Level 3 to Level 2 and back to Level 3 within 48 hours counted as a re-admission to the Level 3 unit and general ward and back to the critical care unit within 48 hours was also counted as a re-admission to the unit.

Managers monitored patient transfers and followed national standards. Staff aimed not to move patients between wards at night. At the time of inspection, critical care was not an outlier for out of hours moves.

Learning from complaints and concerns

Critical care

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

The service received a low number of complaints. Managers investigated complaints and identified themes. For the 12 month period prior to inspection there were three complaints about critical care. We reviewed the complaints and saw that apologies were made and actions addressed then implemented in a timely manner.

There was information on the unit and website to advise people how to complain and provide feedback. Staff understood the policy on complaints and knew how to handle them. Staff said discussing concerns with relatives and patients meant staff took action to resolve any issues before concerns escalated to become formal complaints.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Critical care had managers with the right skills and abilities to run the service providing high quality care. Leaders had an inspiring shared purpose and aimed to deliver and motivate staff to succeed. Managers were eager to harness and retain talent so invested in education, to retain nursing staff and to succession plan.

There was a lead consultant and a head of nursing providing leadership for critical care and the CCOT. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.

The clinical leadership team understood the current challenges and pressures impacting on service delivery and patient care.

There was strong medical leadership on the units. From our observations and from speaking with staff, it was clear that staff had confidence in the nursing leadership in the different units. The clinical leadership team were visible and approachable.

Vision and Strategy

Critical care

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a vision for what leaders wanted to achieve in critical care in line with the overarching vision for the trust. The service was forward looking, promoted training and clinical research and encouraged innovations.

The vision was to be a high quality critical care unit and a centre of excellence for education and training.

There were 2 ongoing strategies. The first was a 12-month strategy to stabilise the service after it had undergone a turbulent time both during and after the Covid-19 pandemic. The second was a 5-year strategic plan to strive, embellish and be at the forefront of critical care provision and research.

Staff told us that they were dedicated to the delivery of the highest quality of care to critically ill patients which is a statement on the trust website for critical care. This suggested that staff had a shared and communal vision.

The management team were vocal about the areas needing attention in critical care and had strategies in place for innovation going forward. They highlighted a number of priority recommended actions which included workforce retention, to introduce a rehabilitation after critical illness service and the prioritisation of wellbeing and development across all staff groups.

Culture

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

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

The care and service delivered in the critical care unit showed a strong cohesive team approach to work. Staff from all disciplines told us they felt valued in their roles and were very much part of the team. Staff we spoke with expressed pride and commitment working for the critical care unit.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

The service had been identified as the most popular critical care training unit in the region by the education establishments that fed into this trust.

Governance

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

Critical care

Critical care was part of the perioperative and critical care medicine services collaborative. This collaborative met monthly.

The critical care unit had robust, well established and effective governance processes. The departmental structure was clearly laid out, staff understood the hierarchy and were clear about their roles and responsibilities.

The critical care unit had a consultant lead for clinical governance. Clinical governance meetings were monthly and fed into the monthly general critical care directorate meetings.

In these meetings, all aspects of governance were discussed including quality issues of safety, risk, clinical effectiveness, and patient experience. An action plan was produced after every meeting and progress reviewed at the following meeting. We reviewed 3 sets of these minutes and any lessons learned and actions taken in response to incidents and audits were documented. It was clear how this information was then shared with staff at unit level.

Mortality and morbidity meetings were also monthly. At these meetings, simulation exercises were used to promote understanding and learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a systematic process, involving staff of all roles and grades, in reviewing and improving the service. This included identifying risks and planning to reduce the level of risk. There was a rolling agenda of meetings to improve quality and patient safety.

There was a robust governance process related to risk with monthly risk meetings. The risks were escalated via the critical care governance meetings and the directorate meetings. The collaborative board and the corporate risk review group oversaw the reported risks.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating. There were 22 open risks and 7 of these risks were deemed high. The high risks related to workforce issues, a lack of isolation rooms, storage and compliance against standards. All risks had a risk owner, a target for completion and a date for review.

Information Management

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

There were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.

Critical care

The trust was typically a paper based organisation but in the process of transitioning to new digital technology. The critical care unit was at the project planning stage to move to the new technology and this was on track to be introduced to the unit in 2023. Some patients had 3 paper pharmacy records if they had moved between wards within the trust. This issue was hoping to be rectified once electronic prescribing arrived.

There were effective arrangements to ensure that data or notifications were submitted to external bodies. The unit took part in local and national audits, including the Intensive Care National Audit and Research Centre (ICNARC). The unit had a dedicated ICNARC clerk who collated all relevant information and submitted the evidence to ICNARC every quarter.

Critical care held information on the trust website though at the time of inspection, this was under review and being updated.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders engaged with national and regional critical care networks. There were similarly strong links with other units in the hospital offering neurological, cardiology and paediatric critical care. The clinical lead was part of the Tees Valley critical care workstream.

There were networks that staff could join including a Black, Asian and Minority Ethnic (BAME) group. Feedback had been received from staff from ethnic minority groups felt overlooked for promotion and did not always feel included. The trust had developed a reciprocal mentoring programme for staff from ethnic minority groups that several critical care staff participated in so that issues could be shared, voiced and understood.

Information was displayed throughout the critical care unit on notice boards. There was information on all aspects of critical care, including staff in the unit, patient and relative feedback plus specialist boards for staff education and development.

Staff had access to a closed social media page which was used to share information. There was staff engagement by recognition and reward of their work. The physiotherapy team had introduced a ‘rehab legend of the week’ to acknowledge staff who excelled in assisting with therapy tasks.

There were social occasions planned for staff to foster good working relationships. Bowling, white-water rafting and air trail days for staff had taken place in July, August & September 2022.

Learning, continuous improvement and innovation

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

The service was involved in the regional critical care operational delivery network.

Critical care

The service had an established cohort of employed advanced critical care practitioners (ACCP's) and others were in training. They supported the medical workforce in general critical care areas.

Information provided showed the service was a desirable location for trainees with high rates of success.

There was a well-established mortality and morbidity review process, this also involved other services within the trust and looked at complex cases which had been managed well to share good practice. Simulation exercises were used at these meetings as well as MTD meetings.

There were 5 registered nurses undertaking the Professional Nurse Advocate (PNA) programme. This training was designed to equip registered nurses with the skills and knowledge to support the mental health and wellbeing of fellow colleagues and improvement of patient care.

There was a critical care outreach nurse dedicated to the provision of safe discharge for patients with tracheostomies. Work was being undertaken with community nursing staff on tracheostomy training.

There was ongoing work and training with medical wards to avoid oesophagectomy patients having to stay unnecessarily on the critical care unit. Studies had shown that a large proportion of post-operative oesophagectomy patients did not require ICU level support but were routinely managed there.

Critical care was exploring the feasibility of a trainee nurse associate programme in collaboration with a local university.

Critical care was undergoing STACQ (South Tees Accreditation for Quality of Care). They wanted to achieve diamond accreditation having previously been awarded a lesser award. This accreditation programme involved peer reviews, scrutiny of data sets, visual inspection and patient feedback gathered over six months.