University Hospitals of North Midlands NHS Trust

Inspection report

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Ratings

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

University Hospitals of North Midlands NHS Trust provides a general acute hospital services for 1.1 million people in Staffordshire, South Cheshire and Shropshire. The trust provides a full range of hospital services including urgent and emergency care, critical care, medical care, surgery, end of life care, maternity, gynaecology, and outpatients' services. Services for children and young people are provided at the Royal Stoke University Hospital and County Hospital. In addition to these services, the trust is also a tertiary centre on the Royal Stoke University hospital site for trauma, cardiology and spinal care. The trust also provides specialised services for three million people across a wider area, including neighbouring counties and North Wales. These specialised services include cancer diagnosis and treatment, cardiothoracic surgery, complex orthopaedic surgery, laparoscopic surgery, the management of liver conditions, neurosurgery, neonatal intensive care, paediatric intensive care, renal and dialysis services, respiratory conditions, spinal surgery, trauma and upper gastrointestinal surgery.

The trust employs over 11,000 staff. Services are provided at:

- The Royal Stoke University Hospital – 1,100 current inpatient beds.
- The County Hospital – 197 current inpatient beds.

University Hospitals of North Midlands NHS Trust was formed in 2014, integrating the University Hospital of North Staffordshire with Stafford Hospital (Mid Staffordshire NHS Foundation Trust). The County Hospital, previously known as Stafford Hospital, was part of Mid Staffordshire NHS Foundation Trust. In 2013, the trust was put into administration by Monitor and Trust Special Administrators were appointed to run the trust and determine its future. The trust has had a history of financial challenges and was in financial special measures until autumn 2020.

The trust had experienced significant challenges over the past 18 months due to the Covid-19 pandemic. The trust had treated over 7,106 Covid-19 positive patients, of those 1,517 were Covid-19 related deaths**.** Staff were redeployed from substantive roles to care for the most acutely ill patients and support staff in critical areas across the trust. Services had to be redesigned and moved at short notice.

Our findings

At the time of our inspection, the number of patients admitted to the trust with Covid-19 had significantly reduced.

We carried out a short notice-announced inspection of the following acute services provided by the trust and inspected two core services because we had concerns about the quality and safety of services. These were:

- Urgent and emergency care at the Royal Stoke University Hospital.
- Medicine at the Royal Stoke University Hospital.

We also carried out two focused inspections as part of our continual checks on the safety and quality of healthcare services. These were:

- Medicine at County Hospital. This was a focused inspection on the safe, effective and well-led key questions.
- Surgery at County Hospital. This was a focused inspection of safe and well-led key questions.

Following our inspection, we served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement.

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

We did not inspect some services previously rated requires improvement because this inspection was focused only on services where we had concerns or had not inspected for some time. We are monitoring the progress of improvements to the services and will re-inspect them as appropriate. Services previously rated as requires improvement and not inspected this time include:

- Urgent and emergency care at County Hospital.
- Outpatients at County Hospital and the Royal Stoke University hospital.

In rating the trust, we took into account the current ratings of the four services not inspected this time.

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

The trust had made improvements since our last inspection but further work was needed to improve the rating.

We rated caring as outstanding, well led as good, safe, effective, and responsive as requires improvement. Well-led is the overall trust-wide rating, not an aggregation of services ratings. This was an improvement since the last inspection.

We rated medicine at the County Hospital as requires improvement.

We rated surgery at the County Hospital as good.

We rated urgent and emergency care at the Royal Stoke University Hospital as requires improvement.

We rated medicine at the Royal Stoke University Hospital as good.

Our findings

The trust did not always have enough staff to care for patients and keep them safe.

The service attempted to control infection risk; however, staff did not always comply with recommended practice. Staff did not always assess all risks to patients and therefore could not act on them. Staff did not always maintain good care records.

There were significant handover delays for patients arriving by ambulance and for those who self-presented to the emergency department.

Further improvements were needed to ensure that patients with mental health needs had their risks assessed and managed across the trust.

When patients could not make decisions about their own care and treatment, mental capacity assessments and best interest decisions were not always made in a timely manner.

The service did not always manage safety incidents well and we were not assured that staff reported all patient safety incidents and near misses in line with trust policy.

However:

Staff provided care and treatment that was based upon national guidance and standards. Managers monitored compliance against these standards and took action to address any concerns. Patients received pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and managed services and all staff were committed to improving services continually.

Staff treated patients with compassion and kindness. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

The trust board was cohesive and had the appropriate range of skills, knowledge and experience to perform its role. Board members understood their roles and were able to challenge appropriately.

The trust collected reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements.

While the trust has managed considerable challenges during the significant impact from the COVID-19 pandemic, the senior team had persevered with the roll out of the Improving Together programme with the aim to encourage teams to embrace change and drive improvement.

How we carried out the inspection

Our findings

We carried out this inspection on 24 and 25 August and 5 and 6 October 2021. We visited areas relevant to each of the core services inspected and spoke with several patients and staff, as well as holding three focus groups. During the inspection, we visited the frail elderly assessment unit, acute medical unit, respiratory ward, the general medicine wards and all areas of the emergency department at the Royal Stoke University Hospital. At County Hospital, we visited ward one (general medical ward), ward 15 (care of older people) and the Acute Medical Unit (AMU). We also visited the theatre department, including the recovery areas, ward 8 (general surgery), and the elective orthopaedic unit at County Hospital.

We spoke with 179 staff members of various speciality and profession including, consultants, doctors, nurses, healthcare support workers, pharmacists, patient experience, domestic staff and administrators.

We spoke with 25 patients and reviewed 61 patient records in total across both sites.

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

Outstanding practice

We found the following outstanding practice:

The Royal Stoke University Hospital:

Urgent and emergency care core service:

- The department had recruited operating department practitioners (ODPs) to the ED. They were responsible for the checking and oversight of the resuscitation equipment and supported the anaesthetist's and resuscitation teams in the event of a patient requiring intubation. They were identified as a positive addition as their support to the anaesthetist's ensured a swifter process for ensuring critically ill patients were given the vital care and treatment required.

County Hospital

Medicine care core service:

- On ward 15 training in clinical holding was made available to staff. This approach to care is particularly beneficial in care of older people and reduced the reliance for security staff to be called to support patients when they become agitated and distressed.

Surgical care core service:

- The ENT Head & Neck Service introduced ‘Telescopic Referrals’ which enabled around 1600 patients with cancer diagnosis to be identified and treated quickly. Specialist nurses conducted video examinations of the throat which freed up time for consultants to review higher risk referrals. All patients received an expert opinion with days of being referred by their GP.

Our findings

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 nine legal requirements. This action related to urgent and emergency care core service at the Royal Stoke University Hospital and medicine care core service at County Hospital.

The Royal Stoke University hospital

Urgent and emergency care core service:

- The trust must ensure that there are enough suitably qualified, competent, skilled and experienced medical staff on each shift to deliver safe and effective care and treatment. **Regulation 18 (1)**.
- The trust must ensure they provide patients with a first assessment within 15 minutes of arrival to the ED in line with the conditions placed upon their registration. **Regulation 12 (1) (2) (a)**.
- The trust must ensure that patients are risked assessed appropriately, in a timely way and provide mitigation for risks when identified. **Regulation 12 (1) (2) (a) (b).**
- The trust must ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**.
- The trust must ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1).**

County Hospital

Medicine care core service:

- The trust must ensure risks associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12(1)(2)(a)(b)**.
- The trust must ensure nutritional risk assessments and care plans are completed in line with their policy. **Regulation 12(1)(2)(a)(b).**
- The trust must ensure patients consistently receive timely swallow assessments. **Regulation 12(1)(2)(a)(b).**
- The trust must ensure Mental Capacity Act assessments are consistently completed in a timely and responsive manner. **Regulation 11(1)(2)(3).**

Action the trust SHOULD take to improve:

Trust wide

Our findings

- The trust should ensure it reviews and investigates significant incidents in a timely manner and in line with trust policy.
- The trust should ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with trust policy.

The Royal Stoke University hospital

Urgent and emergency care core service:

- The trust should ensure that measures are in place to keep patient records secure.
- The trust should ensure there is a recovery process in place to ensure all staff complete mandatory training and essential to role training.
- The trust should ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided.
- The trust should consider how they can improve information management for certain patient groups.
- The trust should consider how the current layout of the department is impacting on the safe running of the department.

Medicine care core service:

- The trust should ensure that it continues to work toward meeting trust targets for all mandatory training.
- The trust should ensure that all wards display up to date audit results such as results from hand hygiene audits.
- The trust should ensure medical wards are provided with adequate storage space.
- The trust should ensure patient records are kept in a structured and consistent format so that staff can easily access them.
- The trust should ensure complaints are managed in a timely way.
- The trust should ensure that waiting times from referral to treatment and arrangements to admit, treat and discharge patients to be in line with national standards.

County Hospital

Medicine care core service:

- The trust should ensure that it continues to work toward meeting trust targets for all mandatory training.
- The trust should ensure all serious incidents are investigated effectively and in a timely manner to reduce the risk of future harm.
- The trust should consider taking action to ensure key information about patient's care is consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound.
- The trust should consider making the speech and language therapy service provision equitable across County Hospital.
- The trust should continue to work towards the provision of a full multidisciplinary seven-day service at the County Hospital site.

Our findings

Surgical care core service:

- The trust should ensure that medical staff are up to date with all mandatory training.

Is this organisation well-led?

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

- Leaders had the experience, capacity, and capability to ensure that the strategy could be delivered and risks to performance addressed
- The leadership was knowledgeable about issues and priorities for the quality and sustainability of services and understood what the challenges were and acted to address them.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action.
- The board understood the challenges that staff were facing and worked to support colleagues and led in a compassionate way. Staff were focused on the needs of patients receiving care.
- The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately.
- Leaders and teams used systems to manage performance. Senior staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The trust collected reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements.
- Leaders and staff 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.
- All staff were committed to continually learning and improving services. The trust was implementing a quality improvement programme to empower staff to make improvements in care for patients. Leaders encouraged innovation and participation in research and strived to influence improved patient outcomes.
- There were governance processes in place to identify issues which enabled the board to know where the risks are and take action to make improvements which should deliver sustainable change.
- Financial governance processes were robust, and oversight was provided by established committees reporting into the board.
- The work on the digital strategy, staff engagement and plans to engage with patients was impressive.
- The trust board and senior leadership team displayed integrity on an ongoing basis. Staff side representatives told us they viewed the senior team as approachable, in touch with front line staff and listened when staff raised concerns.

However:

- There were processes in place to identify learning from incidents and complaints but further work is required to ensure timely review, response and a consistency to drive improvement and outcomes for patients.
- There was a system for staff to raise concerns and the trust was completing further work to check that this was effective and that all staff felt heard.

Our findings

- There were mixed views on the visibility of the executive team.
- Staff views were sought, and we saw evidence of how patients and public views were considered, however further work is needed to ensure the voice of patients is heard especially those in hard to reach communities.
- The middle tier management level was viewed by some staff and senior leaders to be less communicative, some information shared with middle management was not always escalated to senior teams and information was not always shared with front line staff.

Leadership

Leaders had the experience, capacity, and capability to ensure that the strategy could be delivered and risks to performance addressed. Compassionate, inclusive and effective leadership was sustained through a leadership strategy and development programme. There was effective selection, deployment, support processes and succession planning. The leadership was knowledgeable about issues and priorities for the quality and sustainability of services, understood what the challenges were and acted to address them.

The trust board was cohesive and had the appropriate range of skills, knowledge and experience to perform its role. Board members understood their roles and were able to challenge appropriately.

Non-executive directors gave a clear and consistent account of their role within the unitary board. The non-executives had a range of experience and backgrounds including leadership within the NHS; the chair was the only member of the board with a formal accountancy qualification. The chief nurse and medical director were new in post, but all roles within the senior leadership team were substantive offering stability in the team.

The trust had a lead for mental health and equality, diversity and inclusion. There was still work to do to ensure that people with mental health needs consistently received the care that they needed and that policies reflected national practice. The chief operating officer was the executive lead for LGBT and was active in this role.

There were effective systems in place to ensure that people were fit for the role that they were employed for.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. There was further work needed to ensure that actions in urgent and emergency care led to the required improvements.

There was a programme of board visits to services and most staff fed back that leaders were approachable. Some senior executive staff undertook clinical shadow shifts and participated in the Covid-19 vaccination programme by administering vaccines to staff. Senior leaders did weekly ward visits, regular walkabouts throughout the trust and clinical shifts where appropriate. However, during the core service inspection, some staff told us they did not think the executive team were visible, this was not the same for all departments.

Staff side representatives told us they viewed the senior team as approachable, in touch with front line staff and listened when staff raised concerns.

Leadership development opportunities were available, including opportunities for staff below team manager level. However, the Covid-19 pandemic meant the suspension of programmes with only a limited number of sessions having been completed. Succession planning was in place throughout the trust and was led by the Transformation and People Committee.

Our findings

We consistently heard very positive staff reflections of their confidence in the chief executive. We found there was a good balance of approach and expertise between chief executive and chair. Each understood the boundaries of their roles, though were equally clear how to maximise the impact of their collaborative partnership.

Non-executive directors gave a clear and consistent account of their role within the unitary board. The non-executives had a range of experience and backgrounds including leadership within the NHS.

The senior leaders were committed to spending at least one day per week at the County Hospital site.

Vision and Strategy

The trust 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 referred to working with providers within the wider health economy to improve patient pathways. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision for what it wanted to achieve and the strategy in place was due to be reviewed in the forthcoming year due to the COVID-19 pandemic and restoration phases.

There was a clear statement of vision and values, driven by quality and sustainability. It had been translated into a robust and realistic strategy and well-defined objectives that were achievable and relevant.

The vision, values and strategy had been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy was aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population

The trust vision was developed to set a clear direction for the organisation to become a “world class centre” of “clinical and academic achievement and care”. “One in which our staff all work together with a common purpose to ensure patients receive the highest standard of care the place in which the best people want to work”.

The clinical strategy was under review at the time of inspection with a planned completion for December 2021 to allow time for the newly appointed chief nurse and medical director to contribute.

The strategy linked to a business plan summary which highlighted eight key areas for improvement. The strategy was also aligned with professional standards, the improving together programme and outlined staff wellbeing as a priority.

Most staff within divisions were aware of the trust strategy and how they fitted into achieving the overall strategy. They were also aware of the overarching priority to restore services following the COVID-19 pandemic. The trust had plans for further training to ensure all staff understand the vision and strategy.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services.

Local providers and people who use services had been involved in developing the strategy. Senior leaders engaged with patient groups, local MPs and the clinical commissioning groups to discuss changes to clinical services such as the reopening of maternity services at County Hospital.

Our findings

The trust had planned services to take into account the needs of the local population. We heard how the trust planned to introduce a comprehensive process to address health inequalities but felt this was not replicated across the wider system.

The executive team was clear around the importance of quality and recognised and spoke clearly about strategic uncertainties within the integrated care system. Executive and non-executive directors recognised the need to work as a system to drive forward future improvements for patients. This was also reflected in the strategy

There was further work to do on reviewing and developing the mental health strategy. Whilst improvements had been made in the care of patients with mental health needs in Urgent and Emergency Care, these had not been extended across the trust.

Culture

There was a mixed perspective from staff regarding feeling respected, supported and valued. Staff were focused on the needs of patients receiving care. The trust was at the start of its equality and diversity agenda in daily work and provided opportunities for career development. The trust promoted an open culture where patients, their families and staff could raise concerns without fear, however not all staff felt comfortable raising issues.

Some staff told us that development was not always given enough priority. Equality and diversity were not consistently promoted, and this caused some workforce inequality. Staff, including those with protected characteristics under the Equality Act, did not always feel they were treated equitably. However, there was some focus on encouraging staff from BAME backgrounds to develop and progress as leaders. The trust had a local BAME leadership programme which specifically targeted groups of people who evidence suggested were less likely to access traditional leadership programmes.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. Four of the indicators relate specifically to workforce data; four are based upon data from the national NHS Staff Survey and one considers BAME representation on boards. The WRES seeks to highlight differences between the experience and treatment of BAME staff in the NHS, with a view to closing the gap in those metrics. The trust equality and inclusion workforce had four main priorities for 2021- 2024 with 11 indicators for medical staffing.

The percentage of BAME staff in the trust total workforce had increased from 17.4% in 2020 to 18.6% at 31st March 2021. From the 2020 NHS Staff Survey, 26.3% of the 665 BAME staff who responded to the survey reported experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months, compared with 29.2% the previous year.

The trust recognised staff success by staff awards and through feedback. We heard how the chief operating officer had written a letter to a staff nurse thanking her after hearing how she had safely managed a difficult night shift with reduced staffing.

To gather the views and experiences of staff working at the trust we conducted an online survey. The survey started in August 2021 and was available for two weeks. We received 1,646 completed responses. We noted that 69% felt this organisation actively promotes equality, diversity and human rights for all staff: 63.7% of staff agreed or strongly agreed

Our findings

that staff with protected characteristics under the Equality Act are treated equitably in this organisation:52.2% felt that the organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. 31.6% personally experienced harassment, bullying or abuse at work from managers; 71.5% said they know how to raise a concern through the speak up process.

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. For the 2020 survey results, the trust had a response rate of 44.2%. This was similar to the benchmark average.

Staff networks were in place promoting the diversity of staff. The trust had several active network groups which helped to engage diverse staff groups including LGBTQ+, BAME and staff living with a disability. These fed into the equality, diversity and inclusion group. This group then took the lead in reviewing, developing, promoting and monitoring the trusts approach to equality and diversity in employment; However, staff we spoke with felt that parts of the equality and diversity agenda were not fully owned and assigned enough importance by the board. We heard during the inspection mixed thoughts around the impact of these efforts to promote equality, diversity and progression planning for BAME staff. We saw that protected groups were engaged and included in the development of strategy, policy and practice. An example of this was the development of a transgender policy.

The trust worked appropriately with trade unions.

The trust had appointed a Freedom To Speak Up Guardian (FTSUG) and provided them with sufficient resources and support to help staff to raise concerns. The number of cases had increased year on year to 123 this year from 61 the previous year. The trust had launched a “Speaking Up” charter which the Chief Executive and staff side representatives had signed this. The FTSUG had a non-executive lead who was viewed as very supportive and regularly met with the non-executive directors to provide a summary of ongoing themes and areas of concern. Regular reports were provided to board to ensure oversight of themes and actions needed.

The trust applied Duty of Candour (DoC) appropriately. We reviewed seven complaints and found all of them to contain correct DoC processes.

Staff had access to support for their own physical and emotional health needs through occupational health. During the Covid-19 pandemic the trust had invested significantly in staff wellbeing. Prior to the inspection, the trust had run a two week staff wellbeing event which allowed teams to “stop and pause” and partake in social and team events such as cake baking, free ice creams and painting groups.

New appointments to the trust board included colleagues from an ethnically diverse background in both executive director and non-executive director positions.

Prior to the inspection we heard that serious allegations of bullying, harassment and discrimination had been made. The trust had commissioned an external review to look across the trust at what action needed to be taken. There was also to be a further survey of staff.

Governance

The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

Our findings

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Non-executive and executive directors were clear about their areas of responsibility.

The trust used a framework for reporting and measuring quality in frontline services. This was called the care excellence framework (CEF) and it had been developed and designed internally. The framework contained information from clinical observations, patient and staff interviews, and benchmarking. There was an internal accreditation system around this framework which helped to provide assurance from ward to board around key areas. The accreditation system operated an awards structure which was based on evidence provided by each area. These awards ranged from bronze to platinum.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed.

The trust was working with third party providers effectively to promote good patient care. We heard that relationships with the two local mental health service providers was strengthening. A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements.

The board assurance framework focused on strategic risks in line with the trust's strategy, links were also evident between some of the strategic risks and defined corporate risks. Risk owners at executive level were responsible for providing quarterly updates on mitigating actions through the board of directors meeting and regular assurance was sought through other internal committees of the board.

There were multiple pathways of engagement to share medicine safety risk up and down the organisational structure. Innovation was encouraged to improve medicine optimisation and support the trust strategy.

The trust had been under scrutiny from regulators because of its financial position. It was removed from financial special measures in autumn 2020. There was evidence of strong financial governance discipline. The board signed off all business cases for investment in revenue or capital of over £1m. Cases had documented approval by relevant executives and divisional directors. There was evidence that cases were updated and strengthened following rigorous scrutiny by non-executive directors to give greater assurance that specific, measurable achievable, relevant and timely (SMART) objectives would be met; even though in consequence investments might be delayed. The Audit Committee reviewed breaches of financial instructions and action taken. Although financial control discipline appeared well-embedded, the Chief Financial Officer described the steps he was taking to further strengthen assurance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They predominately 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.

Our findings

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. We reviewed seven complaints and found delays with investigation and responses with all seven. The trust target for answering complaints was 40 days, but this target was routinely not met. The senior team acknowledged work was required to improve this.

Clinical specialty risk registers were generally well maintained, and risks were escalated in line with the trust's policy.

We reviewed 10 serious incident investigations and noted the investigations were thorough and evidenced duty of candour had been applied. However, we noted some investigations were delayed and took many months to complete.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. Senior staff told us that staffing levels was the highest risk and this was reflected in the board assurance framework.

The trust board had sight of the most significant risks and mitigating actions were clear. The board focus was strategic risks with corporate risks not cited by the board.

There were plans in place for emergencies and other unexpected or expected events.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. For the financial year 2020-21 the Head of Internal Audit had given the trust significant assurance on the operation of internal controls with minor improvements required. The external auditor had given an opinion on the accounts that was qualified for technical reasons relating to inability to test stock levels in March 2020 during the pandemic. The Audit Committee Chair described how the committee and board gained assurance not only from auditors' reports but also from audit regulators

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. There was evidence that cases were updated and strengthened following rigorous scrutiny by non-executive directors, even though in consequence investments might be delayed.

The trust was to receive a lower share of system financial resources, leading to a need to become more productive and efficient in its use of resources.

The trust had processes to manage current and future performance. There was a process to identify, understand, monitor and address current and future risks. Performance issues are escalated to the appropriate committees and the board through clear structures and processes.

Clinical and internal audit processes were well established and had positive impact on quality governance, with clear evidence of action to resolve concerns. Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care is understood.

Our findings

Information Management

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

The trust had a rich supply of data with effective information technology systems to support this, which included financial performance. Reporting included a wide range of performance indicators and used statistical process control analysis, identified special cause variation and supported data quality assurances.

The trust was aware of its performance through the use of key performance indicators and other metrics. This data fed into a board assurance framework.

The Caldicott guardian worked closely with the senior information risk owner (SIRO) and processes were in place to ensure data was protected and requests for access to patient records were handled lawfully.

There was a strong ambition to improve existing platforms and develop new ones to support efficient pathways and delivery of patient care in particular electronic patient records and prescribing systems.

There was an emphasis on designing technological solutions with a focus upon the health inequalities in the geographical area in particular access to online booking and clinic appointments which may not be easily accessible for some members of the hard to reach communities.

The trust learned from data security breaches. There had only been one incident in 2021.

The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant. Leaders and staff received information to enable them to challenge and improve performance.

Data or notifications were consistently submitted to external organisations as required. There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems were used effectively to monitor and improve the quality of care.

Engagement

Leaders and staff 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.

Patients, staff and carers were able to meet with members of the trust's leadership team and Non-Executives to give feedback. A patient story was included in every board meeting. We observed the board members actively listening to a patient and their family. All board members displayed empathy and were open to feedback.

The trust was engaged with the local integrated care system with a clear focus on integrated place arrangements. The executive team recognised the importance of wider partnership working to secure sustainability of clinical services. There was partnership wide working across two integrated care systems (ICS).

Our findings

Friends and Family Test (FFT) data was shared with all departments as well as the patient experience group. The trust generally received a good amount of responses, predominately within inpatients, emergency departments and outpatients. In August 2021, 98% would recommend inpatient services.

The trust sought to actively engage with people and staff in a range of equality groups.

The trust had a structured and systematic approach to staff engagement. The senior team held "UHNM" live events fortnightly and actively encouraged the use of social media for direct messaging.

External stakeholders said they received open and transparent feedback on performance from the trust.

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 and strived to be influences on improved patient outcomes.

The trust actively sought to participate in national improvement and innovation projects. There was a focus on success with innovation and technological solutions to problems, and to improve patients care and outcomes.

Digital technology innovation was embedded throughout the trust and the executive team were clear this was a way to improve patient pathways.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. We heard how staff had been involved in developing an app to enable booking of COVID-19 vaccinations.

The trust had a planned approach to take part in national audits, accreditation schemes and shared learning, and was actively participating in clinical research studies. The trust's ambition was to increase clinical research opportunities and further strengthen relationships with the local universities.

The service was transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population to design improvements to meet them.

Effective systems were in place to identify and learn from unanticipated deaths. We reviewed eight mortality case files and found all showed timely review and appropriate issues were raised and disclosed when required.

There were organisational systems to support improvement and innovation work. The trust had begun staff training in improvement methodologies and used standard tools and methods. A robust roll out programme had started across the trust to train all staff in the "Improving Together" programme.

Leaders were able to demonstrate learning from safeguarding reviews, incidents and complaints to improve patient practice.

Those leading on root cause analysis investigations had received relevant training to ensure incidents were investigated thoroughly and actions identified.

Our findings

From June 2021 to August 2021, the trust received 154 complaints across all services and 2,535 plaudits. Reports were provided for divisions, as well as the quality governance committee which focused on broader themes.

The trust had 48 accreditations, which ranged across medicine, surgery, children and young people and other clinical services.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Dec 2021	Requires Improvement →← Dec 2021	Outstanding ↑ Dec 2021	Requires Improvement →← Dec 2021	Good ↑ Dec 2021	Requires Improvement →← Dec 2021

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.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Royal Stoke University Hospital	Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Outstanding ↑ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021
The County Hospital	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Good ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021
Overall trust	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Outstanding ↑ Dec 2021	Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Requires Improvement ➔➔ Dec 2021

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 The Royal Stoke University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Dec 2021	Good ↑ Dec 2021	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021
Services for children & young people	Requires improvement Feb 2020	Good Feb 2020	Outstanding Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Critical care	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018
End of life care	Good Feb 2018	Requires improvement Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Surgery	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Urgent and emergency services	Requires Improvement ↑ Dec 2021	Good ↑ Dec 2021	Good ↑ Dec 2021	Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Requires Improvement ➔➔ Dec 2021
Maternity	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Outpatients	Good Feb 2020	Not rated	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Overall	Requires Improvement ➔➔ Dec 2021	Good ↑ Dec 2021	Outstanding ↑ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021

Rating for The County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Good Feb 2018	Good Feb 2018	Good ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021
Services for children & young people	Requires improvement Jul 2015	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015
Critical care	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015
End of life care	Good Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Surgery	Good ➔➔ Dec 2021	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021
Urgent and emergency services	Requires improvement Feb 2020	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020
Maternity	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Outpatients	Requires improvement Feb 2020	Not rated	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Overall	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Good ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021

Royal Stoke University Hospital

Newcastle Road
Stoke On Trent
ST4 6QG
Tel: 01782715444
www.uhnm.nhs.uk

Description of this hospital

The trust provides a full range of hospital services including urgent and emergency care, critical care, medical care, surgery, end of life care, maternity and gynaecology, and outpatients services at both hospitals. Services for children and young people are provided at Royal Stoke University Hospital and County Hospital.

In addition to these services, the trust is also a tertiary centre on the Royal Stoke site for trauma, cardiology and spinal care.

Royal Stoke Hospital: The Royal Stoke Hospital is a large acute hospital in Stoke on Trent. They offer several secondary care services including medical care, maternity, surgery and children and young people services. The hospital is also a regional trauma centre and offers direct major trauma care to patients from across the region and north Wales.

The Emergency Department (ED) at the Royal Stoke Hospital is open 24 hours a day, seven days a week. The trust is a major trauma centre and receives patients by helicopter as well as land ambulance. The helipad where patients were brought in was outside the green ambulance entrance. Due to the COVID-19 pandemic, the department had changed the layout to adhere to recommended infection prevention and control guidance. The department now consisted of:

- Six triage cubicles.
- Seven trolley spaces in the ambulance assessment.
- High risk ambulatory with five treatment rooms
- Medium risk ambulatory with four treatment rooms and four trolley's.
- Medium risk majors with 15 cubicles and one side room.
- High risk majors with 16 enclosed cubicles and three side rooms.
- Medium risk resuscitation (resus) with eight enclosed cubicles. One bay is set up as a trauma bay and one set up for paediatric patients.
- High risk resus with 10 enclosed cubicles. One cubicle was reserved for paediatric patients.
- Children's ED had one triage, one escalation room, separate waiting rooms (high and medium risk), four cubicles, two treatment rooms and three escalation bays.

Our findings

At the time of our inspection, patients with minor illness, injuries or ailments were redirected to alternative treatment facilities. There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider and therefore did not form part of this inspection.

During the inspection, we visited the emergency department. We spoke with 48 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with eight patients. During our inspection, we observed care and treatment and reviewed 26 sets of patient records.

We also carried out a short notice announced inspection of medicine core service because of several serious incidents relating to falls and pressure ulcers had been reported to us.

Medical services at Royal Stoke Hospital were last inspected in 2019 where it was rated as requires improvement overall. Please refer to our previous trust and location reports for details of regulatory action taken.

During our inspection, we visited the frail elderly assessment unit, acute medical unit, respiratory ward and general medicine wards.

We spoke with 60 staff including, doctors, allied health care professionals, health care support workers, ward managers, sepsis leads, matrons, nurse practice educators, discharge coordinators, a safeguarding lead, a mental health lead, a chief dietitian, a clinical lead for speech and language therapy, head of therapies, the acting associate director for medicine, the medicine divisional chair and the deputy associate chief nurse for medicine. We also spoke with ten patients about their care and treatment.

We reviewed the care records of 12 patients and reviewed staff training records, and governance records, such as minutes of meetings, audit information and relevant policies and procedures.

Medical care (including older people's 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 but did not make sure everyone completed it.

Medical and nursing staff received mandatory training, but medical staff did not always keep up to date with it. Medical and nursing staff were respectively 45% and 53% compliant with advanced life support training, 44% and 77% compliant with adult basic life support and 33% and 77% compliant with moving and handling (level one), The trust target for compliance with mandatory training was 95%. However, the opportunity for staff to access training may have diminished due to pressures on the services relating to staff off sick or self-isolating, those staff who remained in work covering for colleagues, getting used to new ways of working or learning new skills having transferred to other teams. Managers were aware of these gaps as they monitored mandatory training and alerted staff when they needed to update their training. However, plans were in place to address training gaps.

The mandatory training was comprehensive and met the needs of patients and staff. Topics included advanced life support, adult basic life support, safe use of bed rails, blood transfusion awareness, end of life care, complaints, moving and handling, infection prevention control, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), equality and diversity and fire safety.

Some staff had completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This formed part of the mandatory training programme.

Mandatory training was delivered through both e-learning and face to face training. Staff could complete their e-learning during their working day if they had spare time to do so, however many staff said they completed it in their own time from home. Feedback was varied as to whether staff could claim their time back. Quality nurses alerted staff by email when they were due to complete mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse but they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust target for compliance with safeguarding training was 95%. All nursing staff were compliant with their safeguarding training.

Not all medical staff had completed training specific for their role on how to recognise and report abuse. Medical staff were 75% compliant with Safeguarding Adults (Level 1 - 3 Years), 59% compliant with level 2, 77% compliant with

Safeguarding Children (Version 2) (Level 1 - 3 Years) and 62% compliant with Safeguarding Children (Version 2) (Level 2 - 3 Years). This did not meet the trust target of 95%. Managers were aware of these gaps as they monitored mandatory training and alerted staff when they needed to update their training. Plans were in place to address training gaps. Staff could give examples of safeguarding issues they would look out for such as unexplained bruising or financial abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff professional standards of practice and behaviour were underpinned by values of equality and diversity. This meant that staff treated people as individuals, avoided making assumptions about them, recognised diversity and individual choice, and respected and upheld their dignity and human rights.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff demonstrated detailed awareness of the principles of safeguarding and their responsibilities. For example, where patients had complex social care needs or staff identified potential safeguarding risks at home, they liaised with the safeguarding team and other multidisciplinary colleagues to ensure patients were protected.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could contact the safeguarding team for advice and support. They provided advice, training and support for all areas of safeguarding.

Staff accessed safeguarding policies on the trust's intranet and requested further support from the trust's safeguarding team if necessary. Safeguarding posters were on display throughout the department with useful contact numbers for staff to access support.

Staff followed safe procedures for children visiting the ward. Only the children of patients admitted to the department could visit. Children were always accompanied by an adult.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All clinical areas were visibly clean. Staff spoke highly of domestic and housekeeping staff, and they were present across the department on the day of our visit. This meant staff could request timely deep cleans and decontamination.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All the areas we visited showed cleaning was up to date. Cleaning audit data supported this.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff appropriately used personal protective equipment such as aprons and gloves. We saw these were readily available, which staff confirmed. Staff were 'bare below the elbow' in accordance with the trust's infection prevention and control policy. Posters encouraged visitors to use hand gel and to wash their hands before entering clinical spaces. Clinical staff observed the trust's bare below the elbows policy and followed good hand hygiene guidance, including between patient examinations and when entering clinical areas. Staff observed aseptic non-touch technique (ANTT) guidance when carrying out procedures and consistently and correctly used PPE.

Medical care (including older people's care)

Staff followed procedures to manage COVID-19. For example, staff completed COVID-19 risk assessments for all patients and recorded these in their notes. Patients were triaged on admission to identify those at higher risk. Staffing, pathways and personal risk assessments were also carried out.

Staff carried out a range of infection prevention control (IPC) audits. The audit results we reviewed varied. For example, we reviewed hand hygiene and PPE audit results completed on 2 July 2021 on ward 76B and ward 81. These showed full compliance. The PPE audit completed on AMU on 8 August 2021 showed 50% compliance, however during our inspection we found no concerns.

Managers put action plans in place to address areas of non-compliance.

The infection prevention and sepsis team did 'walk abouts'. The main purpose of IPC walk rounds was to improve the trust's health care outcomes through the identification, prevention and mitigation of patient and staff harm.

IPC risks were escalated when necessary. For example, following a walk about on a medical care ward the associate chief nurse / deputy director (infection prevention and sepsis) emailed the infection prevention and sepsis team to express their disappointment that there was 'still quite a bit of dust evident, despite it being flagged several times previously. They asked how to escalate from a governance perspective as this was 'not acceptable from a patient safety perspective'. Cross site monthly medical divisional governance meetings were held. A cross site approach facilitated shared problem solving and learning. Minutes of these meetings showed effective governance and oversight. The medical division's governance meetings linked into the quality assurance committee and audit committee that met regularly to discuss quality, safety and performance issues. These committees understood their role in monitoring quality, safety and performance within the service.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to identify when an item of equipment had been cleaned was ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally 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. Patients said staff generally answered call bells quickly. Some patients said they had to wait longer than they wished, however acknowledged staff were very busy and doing their best on the wards.

The design of the environment followed national guidance. However, corridors were often cluttered with equipment. Staff told us this was due to lack of storage space. Keeping the hallways uncluttered is critical in fire and other emergency scenarios, as they may require that patients and staff be evacuated quickly where visibility is already reduced. Although staff completed regular environmental audits, actions were not always actioned by the dates identified.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation equipment each day in all areas of the wards. This was in accordance with the trust's policy. Our checks confirmed this. All equipment conformed to the relevant safety standards and were up to date with electrical testing.

The service had suitable facilities to meet the needs of patients' families. However, there was an absence of side rooms on Ward 126 and 127. This meant staff could not always isolate infectious patients in a timely manner. However, trust were in the process of purchasing pods for the bays.

The service had enough suitable equipment to help them to safely care for patients. For example, staff said they had access to bariatric equipment and pressure relieving equipment.

Staff disposed of clinical waste safely. Staff stored, handled and disposed of sharps in line with the national guidance. For example, staff labelled sharps disposal containers.

The department followed 'The Control of Substances Hazardous to Health Regulations' (2002) (*COSHH) guidelines which* is the law that required employers to control substances that are hazardous to health.

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. The national early warning scoring system was a simple, quick-to-use electronic tool, staff used based on routine physiological observations. The scoring of these observations provided staff with an indication of the overall status of the patient's condition. Prompt action and urgent medical review when indicated, allowed for appropriate management of patients at risk of deterioration. Audits we reviewed confirmed staff escalated deteriorating patients when necessary.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. This was evidenced in the patient files we reviewed. We reviewed the most recent performance report for the division (June 2021). This showed staff exceeded the 95% compliance target with venous thromboembolism (VTE) risk assessment compliance.

Staff knew about and dealt with any specific risk issues. Staff identified their top risks were falls and pressure ulcers. Managers had put action plans in place to address risks and shared these with staff. The wards were working with the corporate nursing team to reduce falls, we found falls were reducing because of trust initiatives. Initiatives such as low beds, cohorting patients together and the early review of test results were constantly employed. The medical wards were also in the process of organising a pilot for motion alarms.

Staff we spoke with were aware of how to escalate if they had concerns that a patient may have sepsis after taking routine observations. A trust wide sepsis team worked with patients with sepsis. Staff were aware of what to do in the event of an incident such as a cardiac arrest; for example, contacting the relevant site team immediately.

There were information boards displayed around ward risks such as PPE and falls.

The service had 24-hour access to mental health liaison and specialist mental health support. The mental health liaison team formed part of the acute care pathway providing assessment and rapid access as appropriate. It provided a seven-day single point of access for all inpatients.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The mental health liaison team formed part of the acute care pathway providing assessment and rapid access as appropriate. Mental health team based at the Royal Stoke site completed all the relevant assessment and documentation for all mental health patient admitted to the hospital.

Staff shared key information to keep patients safe when handing over their care to others. Handovers and ward rounds we observed ensured safe continuity of information between shift changes and improved communication with patients and families.

Shift changes and handovers included all necessary key information to keep patients safe. This included the patient's diagnosis, anything the team needed to know about them and their treatment plan.

Staffing

The service had 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, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Although staffing fill rates we reviewed varied, managers followed processes to ensure safe staffing. A trust wide paper outlined the work that was to be undertaken to support nursing recruitment and workforce redesign. It identified what could be co-ordinated centrally with input and support from all areas as well as action to be taken by the medical division to meet specific 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.

Managers ensured an appropriate number of staff were available at all times across the continuum of care, with a suitable mix of education, skills and experience to ensure that patient care needs were met and that the working environment and conditions supported staff to deliver quality care.

The ward manager could adjust staffing levels daily according to the needs of patients. Robust escalation policies provided a source of clarity for staff at times of increased pressure and risk around inpatient staffing levels. This included contacting the matron of the day, site managers out of hours and advertising shifts through communication channels such as social media and emails and recruiting bank staff.

We reviewed the latest divisional performance report provided to us by the trust (June 2021), this showed the number of nurses and healthcare assistants matched the planned numbers in areas we visited.

The service had reducing vacancy rates. There were 27.09 registered vacancies and 14.09 nonregistered vacancies. With new staff starters taken into consideration, the vacancy rate was 24.09 whole time equivalents. Over the last two years UHNM had been successful in the recruitment of nurses with the vacancy factor fluctuating between 7% - 10% with some seasonal fluctuation and the retention rate was good when compared with national peers at 7% to 8%.

The service had low turnover rates. The turnover rate at the time of our inspection was 1.11% The trust had a process in place to reduce turnover rates. For example, band two and band five nursing staff could transfer to a differing area in the trust at the same banding without having to go through the full recruitment process. This process supported career development and succession planning.

Medical care (including older people's care)

The service had high sickness rates. The trust target was 3.39%. As of July, it was 5.84%. During the first two waves of the pandemic, COVID-19 absences increased significantly. As COVID-19 restrictions were lifted, COVID-19 absences started to increase again. Managers put action plans in place to address this risk. For example, absence management assurance meetings continued to take place within the directorates. These involved joint meetings between human resources (HR) with matron's and ward managers to go through long term and frequent absences by specialty for assurance they were being managed in line with policy.

The dedicated HR advisor for medicine was having regular meetings with line managers to support on sickness management.

The service had low and/or reducing rates of bank and agency nurses used on the wards. The trust had processes in place to address the use of bank staff. For example, rosters were created in advance which had been successful in reducing agency usage.

Managers limited their use of bank and agency staff and requested staff familiar with the service and 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 and adjusted staffing levels and skill mix and gave locum staff a full induction.

Medical staffing was identified on the risk register. Processes were in place to mitigate this risk. For example, there were recruitment processes for hard to recruit to posts, directorate and divisional management teams monitored staffing levels and directorate and divisional management meetings took place to discuss staffing reports.

Managers could access locums when they needed additional medical staff. Managers told us they used locums familiar with the service.

Managers made sure locums had a full induction to the service before they started work. They received appropriate induction for their roll including induction in local clinical protocols.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The trust matched or exceeded the England average in relation to consultant, middle career and registrars. For junior doctors, the trust was at 16% and the England average was 20%.

The service always had a consultant on call during evenings and weekends. For example, six consultant geriatricians participated in the acute medical rota in the evenings and weekends and consultants provided a referral service for older people on all medical and surgical wards.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and stored securely, however they were not always easily available to all staff providing care.

Patient notes were comprehensive, but staff could not access them easily. We reviewed a sample of twelve patient records across medical wards. Records, including prescription cards, were paper based except for vital sign monitoring

which was recorded on an electronic system. Generally, records contained relevant information to keep patients safe. However, nursing records were not maintained in a structured and consistent format on the wards we visited, which meant staff may have to hunt for a specific piece of information, trust were in process of updating their electronic system to prevent further delays, confusion when accessing records.

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

Records were stored securely. Trolleys containing patient paper notes were kept in front of the nursing reception bays and were never left unattended by staff.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Any support given was recorded on a drug chart. The drug chart included: name and date of birth. name, formulation and strength of the medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Reviews were evidence based and included a comprehensive review of a patient's medication, taking into consideration all aspects of their health. The balance between the benefits and risks of and alternatives of taking medicines were considered.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. This was in line with Health Building Note (HBN) 14-02 which provides best practice guidance on storage facilities for medicines (including controlled drugs) in clinical areas.

Staff followed current national practice to check patients had the correct medicines. For example, staff checked the patient's names before administering medications. Controlled Drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, administered and recorded following best practice procedures which included daily checks by two nurses.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. These were shared through a variety of communication channels such as the communication folder, team meetings and email.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. No patients whose charts we checked had been prescribed any medicines to control their behaviour.

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.

Medical care (including older people's care)

All staff knew what incidents to report and how to report them. Staff were familiar with the incident reporting process and could provide examples of the types of events they would report, such as patient falls, pressure ulcers and medicine errors. We viewed a sample of incidents reported between March 2021 and May 2021. Staff reported between 833 and 887 incidents.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff knew how to reports incidents though the incident reporting IT system. Incidents reported included falls, pressure ulcers and staffing issues.

The service had no never events on any wards. This showed staff followed national guidance on how to prevent them.

Managers shared learning with their staff about never events that happened elsewhere. Managers shared feedback through a variety of channels such as huddles, handovers, emails and a communications folder.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents had been reported and recorded in the previous 12 months in line with policy.

Staff understood the Duty of Candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff understood they should always be open in an honest and timely fashion and patients and relatives were to be asked if they had any questions, they would like answered in an investigation. Duty of Candour was a standing agenda item in governance meetings. This showed managers had oversight.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared feedback through a variety of channels such as huddles, handovers, emails and a communications folder.

Staff met to discuss the feedback and look at improvements to patient care. Team meetings, handovers and huddles took place. Incidents and learning from them were discussed and feedback.

There was evidence that changes had been made as a result of feedback. For example, following a recent root cause analysis (RCA) into a patient fall, staff were offered extra training with beds and how to adapt them into chairs for patients. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers completed a RCA to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. We reviewed the previous three RCAs completed by the service. They looked at what, why and how it happened. They identified areas for change and developed recommendations, with the aim of providing safe patient care. Involvement and support for patients and relatives formed part of the RCA process.

Managers debriefed and supported staff after any serious incident. Staff said managers offered them support throughout the pandemic. We heard examples of managers visiting staff at home and being available outside of their own work hours.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Medical care (including older people's care)

Safety thermometer data was displayed on wards for staff and patients to see. The safety thermometer data showed the service achieved harm free care within the reporting period. We reviewed the data from August 2020 to July 2021 which confirmed this. As of June 2021, for Harm Free Care (new Harms) the result was 98.4%. This was a slight increase from 96.3%, however the division continued to exceed the national target of 95%.

Staff used the safety thermometer data to further improve services. Action plans were put in place to address areas of concerns and shared with staff.

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. National Institute for Health and Care Excellence (NICE) guidance was incorporated into trust policies and standard operating procedures and the implementation of this guidance was monitored. For example, the trust monitored its compliance with the NICE guidance on, 'falls in older people' and 'pressure ulcers: prevention and management'. Staff followed care pathways that detailed the care and support people needed for specific treatment. These care pathways ensured people received care and treatment in line with current best practice guidance.

The trust relied on a suite of clinical policies in conjunction with the collection of National Institute for Healthcare and Excellence (NICE) Guidelines to provide a benchmark for wards and departments to comply with during each stage of the patient's journey.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff used the SBAR (Situation-Background-Assessment-Recommendation) technique which provided a framework for communication between members of the health care team about a patient's condition. This always included a patient's mental health needs.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients said they received food regularly and that the trust catered for specialist nutrition needs such as gluten free meals. Menus we reviewed confirmed this.

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

Nurses carried out a nutritional assessment of each patient on admission using the malnutrition universal scoring tool (MUST) and updated this through periodic observations depending on the medical need of the patient.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. In all patient records we reviewed the MUST score was up to date and staff had documented evidence of escalating a patient's care to a dietitian or speech and language therapist (SALT) when more specialist support was needed.

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. Staff used a 1-10 scale when asking patients about their level of pain.

Patients received pain relief soon after requesting it. Patients we spoke with said they received timely pain relief and that staff regularly asked them if they were experiencing pain.

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 relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. This included the Sentinel Stroke National Audit Project (SSNAP), the national lung cancer audit, national audit of inpatient falls and heart failure audits. The most recent SSNAP audit showed the rust was within the top performing Trusts

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. We reviewed national audits including SSNAP, lung cancer audit and the national audit of inpatient falls. Where areas were identified as needing improving action plans were put into place.

Managers and staff used the results to improve patients' outcomes. For example, in the lung cancer audit to improve the number of patients seen by a clinical nurse specialist, all current vacancies were be reviewed and filled where necessary. Following the national audit of inpatient falls an area for improvement highlighted was to 'Embed the Role of falls champions in all clinical areas and to 'Promote and Encourage Cascade Training by Falls Champions within their own Clinical Areas'

From March 2020 to February 2021, patients at the trust had a lower-than-expected risk of readmission for elective admissions and a higher-than-expected risk of readmission for non-elective admissions when compared to the England average. The readmission rate for medical care at the time of our inspection was 12.3%.

The quality and safety oversight group discussed the overall standardised readmission rate and comparison with peers. They reported that overall, it was within expected range.

From April 2020 to March 2021, the average length of stay for medical elective patients at the trust was 5.0 days, which is lower than the England average of 6.5 days. For medical non-elective patients, the average length of stay was 4.8 days, which is lower than the England average of 5.7 days.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, staff prioritised patient pathway audits to report outcomes at each stage of the patient pathway including documentation, risk assessments, consent, invasive procedures, monitoring and deterioration and discharge.

Managers used information from the audits to improve care and treatment. For example, Since the previous care excellence framework visit to the frail and elderly assessment unit wards, the quality nurse had taken overall responsibility for completion of the action plan. The update included 'the unit have introduced a system whereby one member of staff must always be in the bay to reduce the number of falls. To improve compliance with fridge temperature monitoring, it was now the ward clerk's responsibility to complete the daily checks.

Managers shared and made sure staff understood information from the audits. Medical staff carried out their own clinical audits such as an audit on smoking history taking. An action point from the audit included putting posters in the wards reminder staffs of smoking history taking and cessation and available stop smoking cessation services. Improvement was checked and monitored.

The service was accredited by The Joint Advisory Group on Gastrointestinal Endoscopy **(**JAG). JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

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. The trust ensured the right people, with the right skills, were in the right place at the right time.

Managers gave all new staff a full induction tailored to their role before they started work. This provided new starters with a structured and supportive method of introduction to the trust and department. It communicated the trusts strategic directions, policies and procedures to and included an introduction to their role and their immediate work area. The trust process for locum doctors included a local induction checklist to follow when a locum first started work. The trust also provided them with an induction pack containing essential information.

A career pathway had been developed and was used for unregistered staff. All newly qualified staff had access to a preceptorship programme and specific learning opportunities to support them in their role.

Managers did not consistently support staff to develop through yearly, constructive appraisals of their work. As of July 2021, compliance with appraisal rates in the division was 82%. The trust reported that the appraisal rate was consistently below the target of 95%. More recently the rate showed special cause variation. There was a drop below the mean from March 2020 to May 2020 due to the first covid-19 wave and it was reducing again during the second COVID-19

wave. Actions had been put in place to address non-compliance. For example, communication to the division on new pay progression requirements for all staff under 'Agenda for Change' to be 100% compliant to receive increments. Managers continued to be reminded that holding appraisal conversations with staff remained especially important for discussions around the impacts of Covid-19 on individuals as well as being a means of facilitating support mechanisms.

The clinical educators supported the learning and development needs of staff. Quality nurses offered bite-sized learning sessions. These broke down information into small, manageable chunks instead of subjecting staff to long, uninterrupted sessions. Training was chosen based on learning needs identified through processes such as audits.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us these were kept in the communication folder for them to refer to anytime.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were mostly responsible for their own continued professional development (CPD) in line with the revalidation requirements.

Staff had the opportunity for learning through clinical skills workshops and leadership sessions and staff could apply for formal courses through the training needs analysis process. For more experienced staff the offer of CPD was less structured and area dependent leading to inconsistencies in competencies and opportunities across the organisation.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, all new nursing assistants without a care qualification were to enrol on a nursing apprenticeship within six months of commencement, the trust supported 20 nursing assistants onto Nursing Associate apprenticeships, 10 nursing assistants onto a Registered Nurse Apprenticeship Programme and 30 nursing assistants onto a Registered Nurse Top up Apprentice programme.

For example, a ward clerk had been offered to shadow the head of discharges as part of her development goals to become a discharge coordinator.

Managers made sure staff received any specialist training for their role. Nurses adopted link or champion roles in specialist subjects. This included clinical and non-clinical subjects, such as infection control, learning disabilities, tissue viability and safeguarding.

Managers identified poor staff performance promptly and supported staff to improve. Managers referred underperforming staff to the quality nurse who offered training and support to them. Quality nurses also identified staff who may need extra support through audits.

Managers recruited, trained and supported volunteers to support patients in the service. We spoke with one volunteer who spoke highly of the department, staff and patients.

Multidisciplinary working

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

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, staff of different grades and specialities attended daily board rounds. Board rounds are a summary discussion of the patient journey. The purpose was to improve patient safety and patient journey through the hospital by ensuring that multidisciplinary plans for all patients were clear, up to date and all staff ununderstood their responsibility in relation to each patient's care plan.

Different groups of health and care staff who were members of different professions such as nurses, doctors and allied health professionals, worked together to make decisions regarding the treatment of individual patients and service users.

Staff worked across health care disciplines and with other agencies when required to care for patients. Each elderly ward had a team of staff which includes consultant geriatricians, specialist registrars, speciality doctors, foundation doctors, GP trainees, core medical trainees, advanced nurse practitioners, senior clinical nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians and pharmacists, lead nurses, specialist assessment nurses and social workers. Some staff are dedicated to a specific ward and are thus able to provide a continuous and seamless service for the patient.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff could access the trust mental health liaison team. This was for people with mental health needs in an acute general or community hospital setting. They were commissioned to respond to referrals from wards within 24 hours.

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. Allied health professionals (physiotherapists, occupational therapists and speech and language therapists) covered core hours between 8.30am to 4.30pm from Monday to Friday. In addition, the physiotherapy and occupational therapy service was available on an ‘on-call’ basis over night; and could offer support at weekends for more urgent cases such as in the respiratory speciality. Radiography services were available 24 hours a day.

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 displayed healthcare literature. For example, the respiratory wards displayed information about smoking cessation.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Nurses gathered information concerning the patient's individual physiological, psychological, sociological, and spiritual needs. The assessment identified current and future health care needs of the patient. The alcohol screening and referral tools and smoking cessation tools were completed for all patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

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 measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff applied the Mental Capacity Act appropriately. For example, staff had assessed and recorded mental capacity before applying for Deprivation of Liberty Safeguards. This provided assurance that patients were not being deprived of their liberty unlawfully.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff recorded patients' consent for procedures and treatment in patients' records. We saw staff gaining verbal consent to undertake tasks with patients, such as providing personal care or taking vital monitoring readings.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff completed 'best interest' paperwork following a capacity assessment which had identified that a patient did not have capacity to consent to an aspect of their care or treatment.

Staff made sure patients consented to treatment based on all the information available. Staff sought patient's permission before they received any type of medical treatment, test or examination. This was done based on an explanation by a clinician.

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. Staff clearly recorded consent in the patients' records and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance as of 31 July 2021 was 95%.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us if they had concerns about a patient, they would discuss with the safeguarding team.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Matrons reviewed a selection of patient records during their daily department review. If concerns are identified around assessing patients for capacity, this is discussed with the team or individual caring for the patient. The hospital mental health liaison team assessed all patients admitted to the hospital and provided support for all staff and patients 24/7 with additional support and advice from the local mental health hospital.

Is the service caring?

Good 

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

Compassionate care

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

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff ensured curtains were properly closed when carrying out examinations or offering personal care.

Patients said staff treated them well and with kindness. Staff were empathetic understood their needs. and showed patients respect and dignity.

Staff followed policy to keep patient care and treatment confidential. We saw staff asking patients for their consent before they touched them in any way, knocking or speaking before entering the space or room patients were in and making sure curtains, screens or doors were properly closed before attending to patient's needs. Patients we spoke with also confirmed this.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. This was evidenced through our observations and feedback from staff, patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff requested the priest visit a patient who had been given bad news. Care plans reflected individual 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 Chaplains were available to give spiritual, pastoral and religious support to patients, their visitors and staff, whether they have or do not have a particular faith it. The purple bow scheme programme helps staff provide extra support when required to patients receiving end of life care, such as offering refreshments, keeping noise to minimum and checking if relatives or carers may need any additional support. Relatives and carers are also offered a card acknowledging that end of life is approaching, and that staff would like to accommodate any requests they may have, for example, open visiting, overnight stays, wanting to play certain music and spiritual/religious needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw staff comforting and reassuring patients distressed. Staff used curtains to maintain dignity when necessary.

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 could access mental health support for patients through the trust wide mental health team. This included support for neurological conditions such as dementia as well as mental health conditions.

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. They said staff communicated clearly with them and allowed them to ask questions.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Relatives were able to stay overnight, particularly with patients who were vulnerable or at the end of life. Pull out beds were available for this purpose. Located by most patient beds; comfortable reclining chairs were available for patients or relatives to use.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust used a range of different surveys as a source of feedback directly from patients, services users and NHS staff about the care that they receive or provided. These were used to check progress and improvement and to hold themselves to account for the outcomes they achieved.

Staff supported patients to make advanced decisions about their care. Staff held discussions with patients and/or relatives and carers to gain consent when patients had 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in place.

Staff supported patients to make informed decisions about their care. Staff followed the ReSPECT process This created a personalised recommendation for a patents' clinical care and treatment in a future emergency in which they are unable to make or express choices.

Patients gave positive feedback about the service. Patients we spoke with described staff as caring and kind. We reviewed the most recent divisional performance report provided to us by the trust (June 2021). The friends and family test (FFT) were suspended nationally but staff still collected feedback through paper forms. Within the medicine division, inpatient ward recommendation score had dropped to 93%. This was below the 95% target rate.

We reviewed the patient experience report from July 2021.The inpatient response rate was 20%. The percentage of inpatients likely to recommend the service was 97%.

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. Different patient pathways were available to minimise the number of patients being admitted to the medical care wards in the hospital. The acute admissions unit was a short-stay department that was linked to the emergency department but functioned as a separate department. It acted as a gateway between the patient's general practitioner, the emergency department, and the wards of the hospital.

The Medical Assessment Unit (MAU) was an essential part of the larger medical unit. Patients were usually sent to this unit from the emergency department and from their GPs. Depending on the treatment required, patients were either discharged and free to go home or transferred to a specialised ward.

Medical care (including older people's care)

The frail elderly assessment unit provided on-going acute medical support towards a timely and safe discharge for patients. This may be to community home based services or bed-based services, dependent on the patient's needs.

The trust put plans in place to safely care for all patients who needed hospital care including those with COVID-19. COVID-19 patients were being cared for in areas where they could receive the care they need, keeping other patients safe from any infection. The trust was able to quickly open a dedicated COVID-19 ward when there were more patients needing hospital care.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. From 1 January 2021 to 27 August 2021, there had been no mixed sex breaches on Royal Stoke Medical Wards. We did not observe any breaches during our inspection.

Facilities and premises were appropriate for the services being delivered. Staff delivered care and treatment in clean wards, suitable for the intended purpose. These were adequately maintained and, appropriately located.

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. The trust provided a seven-day single point of access for all inpatients and people who attend the emergency portals at the Royal Stoke and were admitted to the inpatient areas.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients were referred onto health and social care professionals, such as occupational therapists, physiotherapists, speech and language therapists, dieticians and social workers appropriately. This meant that people received specialist assessments and treatments to meet their health and social care needs.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted.

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. Staff could contact the trust learning disability nurse to provide specialist healthcare and support to vulnerable people with mental health, learning disabilities, autism and dementia, as well as their families and staff teams, to help them live a fulfilling life. The wards we visited were aware of reasonable adjustments needed to be made for patients' living with learning disabilities and that they could contact the liaison nurse if they were experiencing any problems with communicating with relevant services – particularly if multidisciplinary team (MDT) meetings were required.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff recorded details about a patient who could not easily share information about themselves. It helped staff understand the person's cultural and family background. important events, people and places from their life.

Staff used reminiscence interactive therapy activities (RITA). This was an all-in-one touch screen which offered digital reminiscence therapy. It encompassed the use of user-friendly interactive screens and tablets to blend entertainment with therapy and to assist patients (particularly with memory impairments) in recalling and sharing events from their past through listening to music, watching news reports of significant historical events, listening to war-time speeches, playing games and karaoke and watching films.

Ward walls displayed posters containing information relevant to visitors and patients. For example, posters showed visiting times, staff names, leaflets for carers and details of the car parks. The trust provided communication support for service users and carers whose first language was not English. This included British Sign Language (BSL). The trust could also produce written information in braille and in large print documents.

The service had information leaflets available in languages spoken by the patients and local community. Information on NHS Choices was now accessible to users who would like to view the site in alternative languages using the translation tool. The new NHS Choices auto-translation service provided people with the ability to translate thousands of pages of information on NHS services, over 800 leaflets on conditions and treatments and health and wellbeing advice.

Patients were given a choice of food and drink to meet their cultural and religious preferences. During our inspection, we saw separate specialist menus, and a variety of food to cater for individual choices and tastes.

Access and flow

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 not always 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 referral to treatment compliance time as of August 2021 was 61%. This was lower than the England average of 66.5% in August. However, trust was similar to the Midlands average of 60.4%.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The division recorded on their risk register they were unable to deliver the open/incomplete referral to treatment times (RTT) standard (92%) or locally agreed target at divisional/ specialty level. Mitigation was put in place. For example, RTT performance was managed weekly with directorates in planned care assurance meetings.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, ‘delayed transfer of care’ patients meant a patient was ready to leave a hospital but was still occupying a bed. Staff told us delays could occur when patients were being discharged home and awaiting a care package to be out in place first or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. The trust had processes in place to address this area of risk. For example, they completed long stay reviews and of discharge planning encouraging the development of proactive planning for discharge rather than reactive last-minute planning for discharge and patients were risk assessed before being placed as outliers onwards. For example, the acute medical unit was where patients were assessed, investigated and treated for urgent medical problems.

Although we heard anecdotal feedback regarding concerns about the care of outlier patients, managers told us they made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Senior managers told us there were three consistent locums and one of them was consultant of the week to manage the

medical outliers. Standard operating procedures were in place. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. For example, patients had their care pathway reviewed by relevant consultants. A medical outlier is a hospital inpatient who is classified as a medical patient for an episode within a spell of care and has at least one non-medical ward placement within that spell. Managers worked to minimise the number of medical patients on non-medical wards. Managers had processes in place.

Managers monitored that patient moves between wards/services were kept to a minimum. The division listed all ward moves between 22:00 and 08:00 by ward, CQC core service and by month for the most recent 12 months. The highest number of moves took place on the emergency assessment unit (201) over the previous 12-month period.

Managers worked to keep the number of cancelled appointments to a minimum and when patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers and staff worked to make sure that they started discharge planning as early as possible. The trust operated a track and triage team who are made up of social workers and therapists based on site and a discharge facilitator based on each ward who was responsible for completing the patient profile, keeping this updated and chasing things like housing issues, house cleans to ensure that the patient could be discharged if safe to do so. They also had dedicated wards for patients deemed ‘fit for discharge’, where patients were transferred to from other wards. The patient profile is a pen picture of the patient which includes all personal details including next of kin, home circumstances, current care arrangements and current functioning ability on the ward. This was completed digitally and was a live document that was updated frequently and accessed by the track and triage team who arrange the care package required for the patient to leave hospital. This team ensured that patients moved to the right service based on health and social care needs with moves to beds as exceptions.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff worked with other services to plan hospital discharges. Dedicated discharge coordinators were in post on the wards we visited. Staff told us the discharge planning was started on admission. Discharge coordinators worked with other services to gain and share information to facilitate patients discharge from hospital including GP’s relatives and care homes.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Staff used a process called Red to Green. This was an initiative that helped turn patients' 'red days' into value-adding 'green days' which help to facilitate a safe discharge from hospital. A green day is when the patient has received an intervention that supports their journey.

Staff supported patients when they were referred or transferred between services. Staff followed the principles of person-centred care for people before and during a hospital stay and at discharge.

Managers monitored patient transfers and followed national standards. Staff transferred patients when they needed access to a specialist or procedure not available at the trust. This would involve trust staff clearing the transfer with the physicians at the hospitals where they practice

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.

Medical care (including older people's care)

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. One patient we spoke with spoke of their experience of making a complaint directly to the patient and liaison service (PALS) team. They said their complaint was dealt with promptly and efficiently and that the rest of her stay was safe and caring.

The service clearly displayed information about how to raise a concern in patient areas. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to advise patients on how to make a complaint in line with the trust's policy and procedure.

Managers investigated complaints and identified themes, however not all complaints were managed in timely way. We reviewed the divisional performance report for June 2021. There were 78 complaints closed within the last 3 months (April – June 2021). Of those:

- 17 were not upheld,
- 37 were partially upheld,
- four were awaiting a decision, and
- 20 were upheld.

There were 23 complaints opened on the trust electronic incident system during June 2021, an increase of seven compared to previous reporting period.

- Fifty percent of these relate to clinical treatment,
- 19% to communications,
- 14% to patient care,
- 9% to admissions, discharges and transfers,
- 5% to values and behaviour, and
- 5% to trust administration.

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. Staff told us managers shared learning through a variety of communication channels such as the communication folder, huddles, handover and emails

Is the service well-led?

Good 

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

Medical care (including older people's care)

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.

Leadership was based on a triumvirate leadership model. This meant operational and clinical leadership worked to support the trust's sustainability, and to effectively engage more fully in external partnerships.

Staff told us local managers were visible on the wards, including the ward managers and matrons. During our inspection, we saw leaders were present on the ward and staff approached them for advice and support. Visibility of managers above the matron level varied between wards, however we learnt of examples of senior managers engaging with staff. For example, the directorate management team now ensured they spent a day a week in the acute medicine office to increase visibility and collaborate working and drop-in sessions with the directorate management were held to focus each month on the topic of the month, e.g., 'your job, your manager'.

Staff felt the chief executive was visible and driven by improving the quality, safety and experience of care for patients.

Strong clinical leadership provided role models to aspire to.

The trust had systems in place to grow capability and competencies of our clinical and managerial leaders at all levels. The 'Connects Leadership Development Programme' and prospectus were designed to provide opportunities for all staff at all levels to meet their potential.

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.

The trust had created a set of values and promises which were developed by staff, patients and carers. The values were: 'Together, Compassion, Safe and Improving'. We observed these values underpinned everything staff did.

Staff could nominate each other to the values recognition team for demonstrating any of the trust's four core values. When staff received all four awards, they received a heart badge.

The division's strategic plans were in line with integrated care systems (ICSs). This evidenced that senior leaders and managers worked effectively with the wider health economy.

Culture

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

Staff displayed a culture that put patients first, promoted trust, respect and equality and were sufficiently open and transparent such that staff felt able to challenge each other, regardless of status, without fear and were encouraged to come forward when difficulties arise

Medical care (including older people's care)

The pandemic had created a climate of empathy, compassion and support between staff at all levels. Staff morale was patient focused and positive.

Systems were in place to recognise staff for displaying the trust's values. Staff could nominate their colleagues under the values recognition scheme. We also saw that staff were nominated for external awards by their colleague.

Governance

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

The trust had implemented a ward accreditation system called the integrated Care Excellence Framework (CEF) of measurement, and clinical observations around the CQC key questions to help us to track their progress. This included an award system for each key question and an overall award for the ward/department based on evidence. The awards ranged through bronze, silver, gold and platinum and those reaching the platinum standard were invited to a board meeting to receive their certificate; However, this was suspended during the pandemic and trust had recently re-introduced this.

The acute medical team participated on the 'Improving Together and Shared Governance Initiative'. Taking a shared-governance approach to leadership ensured staff of all levels were involved in having a say and managing the environment in which they work.

A combination of structures and processes at and below board level led on trust-wide quality. This ensured required standards were achieved and where substandard performance was identified action was taken. For example, team meetings took place and matrons attended monthly directorate governance meetings, which fed into divisional meetings. We reviewed minutes of clinical governance meetings. These were effective and encompassed quality assurance, quality improvement and risk and incident management. For example, complaints and incidents, staffing and risks were discussed and reviewed

A trust policy relating to how patients detained under the Mental Health Act (MHA1983) were managed when an inpatient on a medical ward was now in place. The trust now provide training for staff on how to appropriately manage detained patients to ensure their rights were maintained.

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.

A risk register was in place and was monitored and updated through governance meetings. This mostly reflected the risks we found and what staff told us during our inspection. The risk register is part of the process of recording how the trust managed the risks in their organisation. Each risk identified was recorded on a register that summarised: a description of the risk, its cause and impact, the existing controls for the risk, an assessment of the consequences and likelihood of the risk happening with the existing controls, the risk rating: low, medium, high or very high and the overall priority of the risk.

Staff attended regular morbidity and mortality (M&M) meetings as an opportunity for learning and reflection. These provided a forum for staff to explore the management details of cases wherein morbidity or mortality occurred.

Medical care (including older people's care)

Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

The division's leaders' leaders had oversight of the key information and risks to ensure they oversight of quality and safety within the division. The triumvirate team produced a quality performance report monthly. Agenda items included complaints, friends and family test data, sepsis screening compliance and duty of candour.

Information Management

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

The wards we visited displayed local 'care excellent indicators' dashboards which demonstrated results from internal quality checks. However, not all wards displayed up to date audit results such as results from hand hygiene audits. However, this may have been due to the additional pressures of the pandemic.

The senior leadership team produced their performance data through charts known as a Statistical Process Control (SPC) chart. They plotted the trust's data like a run chart every week so they could see whether you were improving, if the situation was deteriorating, whether their systems were likely to be capable to meet the standards, and also whether the process was reliable or variable.

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 reviewed the most recent divisional performance report provided to us by the trust (June 2021). The friends and family test (FFT) were suspended nationally but staff still collected feedback through paper forms. Within the medicine division, inpatient ward recommendation score had dropped to 93%. This was below the 95% target rate.

We reviewed the patient experience report from July 2021.The inpatient response rate was 20%. The percentage of inpatients likely to recommend the service was 97%.

Staff engagement surveys were carried out and action plans were put in place to address areas of risk. For example, it was identified that 'our teams state that there are not enough staff to be able to do their jobs properly". Actions put in place included 'ongoing recruitment throughout the last 12 months and shift by shift review of nurse staffing'.

The trust hosted a trust staff awards celebratory night. This was to celebrate outstanding contributions made by staff over the past year across nine award categories.

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.

Medical care (including older people's care)

We saw many examples of staff successes to be celebrated. For example, in the older adult division, Ward 76a won the most discharges for midday in June and there was a good celebration of nutrition week in collaboration with the nutrition team. The initiative 'Time to Eat' and 'Mealtime Monitor' had been introduced in the frail and elderly assessment unit (FEAU).

In the gastroenteritis team, the liver team launched "Hepatitis C test and treat days" in the community; the test and treat bus had clinic rooms with a liver scanner, and the Hepatitis C tests consisted of a finger prick. Results only took an hour.

Quality nurses aided and supported the bedside nurses in meeting regulatory measures to improve patient outcomes.

The AMU practiced shared governance. This gave staff collective ownership to develop and improve practice, to ensure patients received caring, safe and confident care. For examples had introduced a system to report faulty equipment more simply and promptly to reduce time wasted in looking for working equipment; The trust aimed to roll this out throughout the medical awards.

Since our previous inspection, the trust had introduced a trust wide policy relating to how patients detained under the Mental Health Act (MHA; 1983) were managed when an inpatient on a medical ward, we found the policy needed to be updated as some of the wording within the policy were not up to date and did not follow the latest NICE guidelines. The trust provided training for all staff on how to appropriately manage detained patients to ensure their rights were maintained.

We found a culture where ideas did not only come from management, staff were encouraged to provide feedback on ways to improve the trust from a frontline perspective. Staff felt empowered to put forward ideas and suggestions for improvements through quality improvement initiatives.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training. Staff told us the mandatory training had been suspended during the pandemic however staff had now been encouraged to complete the electronic learning modules. Information shared with us after the inspection showed 98% of nursing and clerical staff had completed their mandatory training, with nurse practitioners and nurse educators recording 100% compliance. There were still delays with face-to-face training for skills such as life support. Information provided by the trust showed 80% of eligible staff had completed adult immediate life support (ILS) training and 0% (three staff members) had completed their advanced life support training.

In addition to the mandatory training requirements, staff also completed additional training which was essential to their roles. Subjects included (but not limited to) infection prevention and control, manual handling, conflict resolution and equality and diversity. The compliance target was the same as mandatory training (95%), compliance for these subjects ranged between 72% to 100%.

Not all medical staff received and kept up to date with their mandatory training. Information received after the inspection showed 79% of medical staff had completed their mandatory training. This was below the trusts own target of 95%.

Staff again identified the challenges over the past few months and demand on the service had led to compliance with training dropping below the trust target. Subjects which required face to face training were one of the most impacted subjects. Information showed 48% of medical staff had completed their mandatory advanced life support training and 50% of the medical staff required to complete basic life support had done so.

The mandatory training was comprehensive and met the needs of patients and staff. The training was a blended mix of electronic learning and face to face learning. Where training compliance had fallen below the target compliance, we were not informed of or provided on request, any specific recovery plans on how this would be improved.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The department employed registered mental health nurses who were preparing additional training for staff. So far this had been delivered to band six and seven nurses but were planning to roll this training out to all staff in the department. Nursing and administration staff also completed dementia awareness training. Information showed 95% of staff had completed this training. Medical staff were not required to complete this training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us nurse educators were returning to their role within the department and they also maintained oversight of training compliance and requirements for staff.

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 staff received training specific for their role on how to recognise and report abuse. Most training modules achieved the target compliance of 95%. However, only 77% of staff completed safeguarding level three training and 93% of staff had completed their prevent awareness training.

In addition to the formal training staff were required to complete, staff also completed additional exploitation awareness training as this was a concern relevant to the local area.

Medical staff received training specific for their role on how to recognise and report abuse. However, several staff were still required to complete the training which meant compliance levels fell below 95% for all aspects of safeguarding training. Compliance ranged between 83% (which was recorded for safeguarding level one training) and 29% (which was recorded for prevent awareness training).

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Policies and procedures were in place to support staff when identifying abuse, harassment and discrimination. They also provided staff with guidance on how to manage these incidents appropriately.

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. Staff were able to confidently discuss examples of safeguarding concerns which they had identified and escalated. Staff were aware of the main safeguarding concerns relating to their local population.

Staff followed safe procedures for children visiting the department. Children and their parents were appropriately directed to the paediatric emergency department where there was a separate checking in process.

There was a process in place for staff to follow if parents or carers left with the child prior to being seen. The process directed staff to a suitable outcome should they be able to contact the parent or carer. However, if there were safeguarding concerns and staff could not contact the parents or carers, the process only required staff to update the discharge letter and trust electronic system. There was no reference to staff escalating their concerns to the trust safeguarding team and/or local authority.

Cleanliness, infection control and hygiene

The service attempted to control infection risk. However, there was confusion around measures which were supposed to be in place. Staff mostly used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Urgent and emergency services

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Recent audits demonstrated 100% compliance with cleanliness across the department.

Staff followed infection control principles including the use of personal protective equipment (PPE) however we found some concerns around what staff were required to use. We found the department had been organised into green (low risk) and red (medium to high risk) areas, in accordance with current COVID-19 guidance. Although these areas had signs to indicate the risk level of the area, staff were not always confident on which personal protective equipment (PPE) they should be wearing. Staff told us they had been informed by the Infection Prevention and Control (IPC) Team that once in a red (medium to high risk) area, FFP3 (filtering face piece) masks should be worn as well as a visor, although the type of mask used was only advised as optional. However, we observed many staff within the red areas who were wearing surgical face masks with no visors. We asked senior members of staff what their expectations were around PPE in red areas who confirmed FFP3 masks and visors should be worn by all and staff should challenge those who were not in the correct PPE. Whilst being shown around the department, we asked staff what PPE we were required to wear, and we were informed our surgical face masks were appropriate unless going closer to where patient care was being provided. This demonstrated there was not a clear local policy around PPE in the department. We raised this with a member of the IPC team whilst on site who informed us, they would investigate our concerns.

The department had a green majors area situated between two red areas (red resus and red majors). We observed staff leaving doors between red and green areas open as well as staff using the green majors as a thoroughfare to get to the red areas. This is not in keeping with current guidance and potentially increased the risk of transmission to staff and patients.

Within the reception area, there was a navigator who met patients coming in and asked them questions in relation to COVID-19. Depending on their answers, the navigator identified the correct pathway for them to take. The reception area had chairs taped off to encourage patients to adhere to social distancing whilst waiting to be seen. There was also a separate entrance and exit for patients, visitors and staff to use. During our inspection, although the reception became increasingly busy, we observed most patients were trying to adhere to the measures put in place by the department. However, when patients were not socially distanced from each other, we did not see staff attempting to address this. Patients were advised to wear a mask if possible, however we observed several patients who were not wearing masks or wearing masks incorrectly (not covering their nose). Again, we did not observe any staff members addressing any of these concerns.

Staff told us they had many patients coming through the department during the height of the pandemic who had were confirmed COVID-19 cases. In a response to the IPC risk these patients posed, the trust had made the decision to start placing doors on cubicles. At the time of our inspection, both red majors and resus had doors on their cubicles and green resus was in the process of having doors placed on the cubicles. Staff told us from an IPC point of view, this had been a positive move, although acknowledged this had caused risks from other perspectives. When aerosol generating procedures (AGPs) had been completed in these rooms, staff were now able to close doors and reduce the risk to others in the area. We observed signs on the doors where staff were required to document when AGPs had been conducted so staff knew when the room was deemed safe.

Staff adhered to the World Health Organisations (WHO) five moments for hand hygiene. We observed staff completing hand hygiene at the point of care. Within the paediatric red triage area, portable hand wash basins had been provided for staff due to there being no running water. These were regularly cleaned and maintained by the domestic staff.

Staff cleaned equipment after patient contact however, we did not observe any consistent labelling system in place to demonstrate when it was last cleaned.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well. However, the current layout of the department had expanded which caused concerns.

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

The original design of the environment followed national guidance. However, due to the pandemic, the department was expanded to allow them to adhere to COVID specific requirements which had meant reconfiguring areas. The department now covered a substantial area to enable adherence to social distancing and enabling the green and red pathways. Within the red paediatric waiting area, CCTV cameras had been implemented to enable staff to observe them. Paediatric red triage bays had been provided in an area which was considered for temporary use. This area did not have plumbed in suction, oxygen or water and had also been fitted with CCTV to enable observation of the area.

Within the red resus and red majors' areas, doors had been placed on the cubicles which were not see through. This had impacted on the ability to maintain direct observation of patients. Clear (see through) doors were also being placed on green resus cubicles which were considered more appropriate by staff from an observation point of view, however staff identified the doors were rather narrow which they considered could be an issue during some of the resuscitation/ trauma calls.

The department had one designated room available for patients attending with significant challenges to their mental health. This room met the specific requirements as advised by the Psychiatric Liaison Accreditation Network (PLAN). Staff told us this was not used frequently as most patients would also have physical health needs which required them to be seen with the cubicle areas. Cubicles within the green major's area were still open and staff had good observation and oversight of these patients. However, patients who were in the cubicles within red majors were no longer in the direct observation of staff due to doors. Although the doors had windows within them, staff told us they had concerns about the visibility of these patients. We asked for risk assessments in relation to mental health risks for adding doors to cubicles, however we were informed formal risk assessments had not been completed.

Staff carried out daily safety checks of specialist equipment. We sampled a selection of equipment in the department and found they were serviced, cleaned and regularly checked.

The service had suitable facilities to meet the needs of patients' families. There were three rooms available for families to use when their relative had been admitted and were significantly unwell. These rooms were away from the main areas and were used to deliver bad news in a confidential and dignified manner. They were also adjacent to a viewing room when a patient had passed away for families to spend some time with their relatives.

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

Staff disposed of clinical waste safely. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with legislation and local policy.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed a selection of risk assessments for each patient. They removed or minimised risks and updated the assessments. However, we identified additional risks to patients which were not always assessed and therefore mitigation could not be implemented. Staff identified and quickly acted upon patients at risk of deterioration.

Within the reception area, a controller met patients at the door to identify if their concerns related to COVID-19 by asking some key questions. Once assessed for risk, the controller directed them to the reception desk. We observed most patients were being booked in at the reception desk within five minutes of arrival to the department, as recommended by RCEM (2017) (Royal College of Emergency Medicine) initial assessment of emergency department patients. At the time of our inspection, the department did not routinely audit this measure.

We found the department was still challenged when meeting the standards around the 15 minutes from arrival to first assessment. The challenges observed were both around patients who were self-presenting as well as those who were brought in by ambulance. At the start of our inspection on 24 August 2021, we found patients arriving by ambulance had their first review within 15 minutes in the RAT area of the department. However, after more ambulances arrived at the department, the assessment times started to rise. Patient notes reviewed at this point showed patients had their first assessment between 17 to 25 minutes after arrival.

Patients who self-presented to the ED had their initial assessment performed by the navigator who sat beside the reception staff. At this point the nurse would identify which stream the patient required. Times from patient arrival to their first assessment by the navigator varied during our inspection between three minutes to 50 minutes. Despite the length of time it took for the navigator to complete the initial assessment, we did not see any evidence of harm during our inspection. There were processes in place to ensure patients with potentially life-threatening/high risk conditions were seen urgently. Information requested after the inspection did not identify any harm had occurred to any patients in the last 12 months as a result of delay in initial assessment.

Staff provided examples of when they used the chest pain pathway and ensured patients received timely care and treatment.

The navigator was able to stream patients to other services using safe processes and provided clear clinical rationale. Other streams available for the navigator included the onsite urgent care centre, other urgent care/minor injuries units and primary care. At the time of our inspection, all patients who would usually have been reviewed in minors (minor injuries and ailments) were being advised to attend alternative locations. This had been well advertised however staff told us they still had several patients who attended for minor concerns. If they were unable to be seen elsewhere due to personal circumstances, staff would see them at the department.

Since our last inspection in 2019, the department no longer cared for patients in the corridor as this was identified as a significant risk. A new standard operating procedure (SOP) had been implemented jointly with the ambulance trust to keep patients on the ambulances until a trolley was available. Unfortunately, this had meant there was several ambulances which were located outside the department waiting to bring the patient in throughout the day. At the start of our inspection on 24 August 2021, there were three ambulances waiting to bring patients in. This fluctuated throughout our inspection with the highest number of ambulances waiting to bring patients in at one point reaching 14. Although staff had received a handover of concerns by the ambulance staff and the patients were under the responsibility of the emergency department, the KPI for handover of these patients was recorded from when the patient was finally taken into the department.

Urgent and emergency services

During the two days of our inspection ambulance handovers and activity was recorded as follows:

- There were 169 patients brought in by ambulance to the department on 24 August 2021. Of these patients, 13.3% waited between 30 to 60 minutes to be handed over to staff which was higher than the England average of 11.3% on this day. In addition to this, 10.7% of patients waited over 60 minutes to be handed over to staff which was higher than the England average of 6.1% on this day.
- There were 150 patients brought in by ambulance to the department on 25 August 2021. Of these patients, 15.6% waited between 30 to 60 minutes to be handed over to staff which was higher than the England average of 11.2% on this day. In addition to this, 11.2% of patients waited over 60 minutes to be handed over to staff which was higher than the England average of 6.2% on this day.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS2) and Paediatric Early Warning Score (PEWS) when performing observations to identify the potential risk for deterioration. Observations were recorded within patient records and required staff to escalate patients to medical staff when concerns were identified. We reviewed 26 sets of notes and found all patients had either a NEWS2 or PEWS score recorded. Whilst patients were in resus, regular monitoring occurred to ensure patients remained stable. Staff printed these observations out once the patient moved out to evidence their condition. Where patients had scored highly on either NEWS2 or PEWS, we saw evidence of review by a more senior clinician in accordance with the escalation procedure. The frequency of observation performed on patients whilst in ED was determined on their condition and previous score. Staff were confident in identifying if a patient's condition had deteriorated and would complete additional observations if deemed appropriate.

Patients being held on ambulances had observations completed by the staff from the rapid assessment and treatment (RAT) area. The nurse and doctor covering the RAT (of registrar grade or above) tried to review the patient together, however if this was not possible at the time, the nurse would do the initial assessment and then escalate to the doctor if there were concerns. On going monitoring of the patient was completed by the ambulance crew until there was a cubicle available for the patient. If the ambulance staff had concerns, they were required to escalate to the ED staff.

Staff completed some risk assessments for patients on admission / arrival, using a recognised tool. All patients were routinely risk assessed for falls, pressure sores and manual handling on initial admission into the department. Where risks were identified measures were put in place to mitigate the risk. Where patients were identified as a falls risk, stickers were placed on their notes to indicate this. However, we did review one set of patients notes where the patient was reported to have fallen prior to attending ED. The falls risk assessment had not been completed and no sticker was placed on the notes. We also asked staff what additional measures were put in place for patients identified as a falls risk who were in cubicles with doors. Staff told us they would try to maintain observation of the patient through the windows in the doors, however they were aware of the limitations of this. Intentional rounding/comfort rounds were performed on patients in the department, patients who were a falls risk were placed on a more frequent rounding than patients who were not a falls risk.

Staff told us only patients who were due to be admitted from ED were risk assessed for the risk of venous thromboembolism (VTE). However, we observed patients who were within the department for extended lengths of time (one patient was around 22 hours and another patient for 19 hours) who had not undergone a VTE assessment as they had not been admitted, despite being at potential risk.

Staff knew about specific risk issues however they were not always dealt promptly. All staff were aware of the risk of sepsis for patients and had training on managing patients with sepsis. We reviewed five sets of notes where a sepsis

screen was indicated, however we found only two out of the five had been completed and treatment given. Staff had documented in one set of notes that the sepsis screen had not been completed due to the patient being held on the ambulance. Information shared after the inspection showed the department regularly audited their sepsis performance. Results showed the department were improving in performance and were now 90% compliant with all actions.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff worked closely with the local mental health trust. The department had also employed four registered mental health nurses (RMNs). The pathways for patients with mental ill health had improved since the department employed their RMNs, which meant patients were provided with the right support. We reviewed the notes of two patients who attended with mental ill health and found they had been seen promptly and had plans in place for ongoing support.

Staff shared key information to keep patients safe when handing over their care to others. When handing patients over to other departments or wards, staff supported their verbal handover with a written handover document.

Shift changes and handovers included all necessary key information to keep patients safe. However, we observed a medical staff handover and found details of current demand within the department was not sufficiently covered. Staff did not go into detail around patients waiting to be admitted or transferred.

Nurse staffing

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

The service did not always have enough nursing and support staff to keep patients safe. The department was budgeted for 223.89 whole time equivalent (WTE) nursing and healthcare assistants. However, information showed they currently had 207.6 WTE staff in post, leaving a vacancy rate of around 9%. This included an over fill of 3.67 WTE for band two staff and 0.83 WTE of band seven staff. Despite having a 9% vacancy rate, senior staff told us this did not appear to impact staffing shifts on a day to day basis usually, however when higher rates of sickness were reported during the pandemic, this was when the vacancy became more apparent. An additional 12.8 WTE staff were due to start in the department in September 2021 which would improve the staffing for nurses and healthcare assistants.

The service met the Royal College of Paediatrics and Child Health (RCPCH) standards of ensuring there was always at least two registered children's nurses on every shift. Staff told us they tried to ensure there were four registered children's nurses on each shift although at times this had reduced to three nurses due to sickness. The department had 35 registered children's nurses employed in the department.

Recruitment was a rolling process which had previously been managed by the education lead. However, senior staff told us they were hoping to bring this back into the senior nurse's responsibility to enable a better handle on staffing as well as being able to communicate with the ED team better about staffing going forward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior staff told us they rostered 25 registered nurses per shift which was based on national guidance and previous demand. However, when required staffing levels

were met staff were regularly taken from the department to support other areas in the hospital. Although senior staff understood there may be a need throughout the hospital, especially during the pandemic, this had left the department vulnerable at times. Senior staff had escalated their concerns verbally to the senior leadership team; however, they did not always complete an incident report to support their concerns.

The department manager could adjust staffing levels daily according to the needs of patients. Staffing was monitored throughout the day and managers attended meetings three times per day in relation to staffing and capacity. If additional support was required in the department, this was escalated during these meetings and where possible, additional resources were supplied. In addition to this, senior staff had identified a requirement within triage to uplift the staffing for this area. A paper had been submitted to the senior leadership team in relation to this which had so far been met with a positive response.

The number of nurses and healthcare assistants did not always match the planned numbers. Senior staff told us their usual staffing was down by one or two members of staff, however there had been shifts where they only had 16 registered staff members. During these shifts, to ensure the department was safe, they would have to reduce capacity. These concerns were escalated to the senior leadership team at the time; however, staff did not always complete incident reports to document the risk experienced. We reviewed staffing rotas from 31 May to 25 July 2021 and found there were only two day shifts and two night shifts where actual matched planned staffing numbers. Most shifts were down between one to four members of staff, which leaders told us had been manageable although with the increase in demand, was beginning to be a struggle. However, we found there were 13 day shifts and eight, night shifts where staffing fell to levels leaders considered challenging (more than five staff below the planned staffing rates).

The service had low and reducing vacancy rates. At the time of our inspection, there was a vacancy of 20.79 WTE in the nursing workforce. However, there were plans for 12.8 WTE staff to commence work in the department. Band five nurses had the largest vacancy of 9.81 WTE.

The service had reducing turnover rates. There was a slight rise in numbers of staff leaving in February 2021, however this had stabilised since this. Staff told us those who had left had mainly been down to following career development opportunities.

The service had a high sickness rate. Staff told us of significant sickness rates throughout the pandemic as well as additional staff isolating. Information received following our inspection showed the service were still experiencing significant staffing sickness. The nursing team reported 9.6% of staff sickness in July 2021 which is the highest recorded rate since January 2021. There was also significant sickness amongst the nurse practitioners in the department who reported 8.7% staff sickness in July 2021 which is the highest recorded rate since October 2020.

Managers limited their use of bank and agency staff and requested staff familiar with the service and had a lower rate of bank and agency usage. We were told despite requesting staff from various agencies, the uptake of the shifts was not as high as expected. Managers had escalated this to their senior leadership team and were seeking a resolution to the problem.

Managers made sure when bank and agency staff completed shifts in the department, they received an induction and understood the service.

Urgent and emergency services

Medical staffing

The service did not always have 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 however they were not always able to ensure the right skill mix was provided on each shift. Managers gave locum staff an induction when present for shifts.

The service did not have enough medical staff to keep patients safe and did not always match the planned number of staff. There were currently 20 WTE consultants in the department. They provided 24-hour consultant cover as part of their major trauma consultant cover requirement. There were four consultants who covered the paediatric department who had training in paediatric emergencies and were on the GMC speciality register.

The current consultant establishment enabled them to provide three consultants between 8am to 4pm, four consultants between 4pm and 12am and one trauma team leader overnight on site. Information provided after the inspection showed there were 13 out of 31 days where the day shift had a vacant consultant post and 20 days where there was a vacant consultant post on a late shift. In addition to this, there were two days when the department had two vacant consultant posts on a late shift.

There were six military consultants in post at this department. Managers told us the support they provided was well received. However, they were aware of the requirements of these doctors and the possibility for short notice deployments. There were processes in place to manage any gaps in the rota when this occurred. Manager were usually given sufficient notice to plan for cover for military staff deployments.

There were concerns around the number of middle grade doctor's night-time cover. There were 34.83 WTE middle grade doctors on the establishment in the department. Senior staff told us they tried to provide four doctors of ST4 (specialist trainee) and above with three usually being adequate to provide safe cover in the department. However, there had been shifts when they were only usually able to provide two members of staff in the evening, with some occasions only one member of staff working in the department overnight. The doctor's rota for August 2021 supported what we were told. There were 11 shifts where only two middle grade doctors were present and an additional four shifts where only one middle grade doctor was present on shift. During six of these shifts, additional junior doctors had been rostered to work to try and provide additional support. Many medical staff we spoke with during our inspection raised concerns around the senior cover overnight and believed this was unsafe in such a busy department.

After the inspection, we raised our concerns with the trust and asked for further assurance on how this would be managed. Information received did not provide us with the assurance that this risk to the department would be managed immediately. However, we acknowledged the department were putting plans in place to manage this in the future by increasing medical staffing numbers.

Junior doctors- there were 43.16 WTE junior doctors working in the department. Information reviewed after the inspection showed there were large numbers of vacancies on the August 2021 junior doctor's rota, with only one day demonstrating a fully staffed rota. The number of vacancies ranged between one member to three members of staff per individual shift. There were staff vacancies across most shifts with only the 2pm to 11pm shift, both weekdays and weekends reporting no staff vacancies. Concerns were raised by staff around the heavy junior doctor's rota as well as the lack of adequate breaks on long 12-hour shifts.

The service had reducing vacancy rates for medical staff. Senior staff told us they were officially three consultants down from their establishment however a paper had been submitted for an additional four consultants. Although there was

optimism around funding for additional consultants, senior staff believed they were unlikely to receive full funding as requested. The Children's business unit had recently appointment a new paediatric consultant for the trust. Staff told us the consultant had an interest in emergency medicine and would therefore be providing some support for the paediatric department.

The service had low turnover rates for medical staff. Information received showed only those medical staff who were on rotation or locum left the service.

Sickness rates for medical staff were low. Current sickness rates were recorded as 2.8% in July 2021 which was RAG (red, amber, green) rated green (good) by the trust. Information indicated sickness rates had been stable since January 2021 when they were recorded as 5%.

Managers could not always access locums when they needed additional medical staff. There was difficulty filling shifts with locum staff at this trust. This had been discussed with the senior leadership team and were seeking resolution to this situation. In addition to this, senior staff told us they had more difficulty filling shifts with locum doctors than they did for nursing vacancies.

Managers made sure locums had an induction to the service before they started work when locums attended for shifts in the department.

The service did not always have a good skill mix of medical staff on each shift however, they were aware of this and reviewed this regularly. Where staffing was short within some of the doctor's grades, the department would try to reinforce the numbers of medical staff by adding additional junior staffing to the rotas. This meant the skill mix would not always be appropriate for that shift.

The service always had a consultant on call during evenings and weekends. There was a trauma team leader onsite throughout the evening with an additional consultant on call for telephone advice if required. Although the consultant on call was not required to attend in person, senior staff told us if the department required additional support, they would attend.

Records

Staff did not always keep detailed records of patients' care and treatment and they were not always stored securely. However, records were clear and easily available to all staff providing care.

Patient notes were not always comprehensive however, all staff could access them easily. We reviewed 26 sets of notes during our inspection. All notes we reviewed were easy to access and the documentation which was within them was clear and the responsible person had signed, printed their name and dated. We also saw some staff had stamps with their registration details (pin numbers for GMC or NMC). We found there were some good examples of comprehensive notes with clear plans in place for the patient. However, we also found there were some which had minimal information contained within them despite their appearing to be a plan for the patient to be admitted. Staff told us when doctors reviewed patients and decided a bed within the medical wards was required, electronic referrals were immediately completed. When questioned why there was no evidence of any review being documented to support a referral, staff were unable to explain this.

When patients transferred to a new team, there were no delays in staff accessing their records. We observed staff preparing patients to move to other areas within the hospital which included photocopying their ED records so this could accompany them.

Records were not always stored securely. We found notes within majors and ambulatory were stored in trolley's which were not locked. Notes for patients who were still being cared for on the ambulance were stored by the computer where patients were booked in. Although staff were around to question unauthorised people reviewing the notes, they were not stored securely.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. A pharmacist is based on the unit from 9am to 5pm weekdays to support the safe prescribing of medicines. Patient group directions were used to improve patient access to pain relief during triage.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. There had been several initiatives during the COVID-19 pandemic to improve access to medicines and the safe use of medicines. Trauma grab bags had been instigated to speed up access to medicines, reduce stock holding and continuation of treatment as bags were able to follow patients if they transferred from the unit. Anticipatory medicines packs to support the prescribing and supply of medicines at end of life had been introduced. A new booklet had been produced to support the prescribing of treatment following an overdose with Paracetamol.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines and prescriptions were stored securely. All areas had ready access to medicines to treat hypoglycaemia.

Staff followed current national practice to check patients had the correct medicines. The unit-based pharmacist supported the checking of patients' medicines on admission. Funding had been secured for a pharmacy technician to support this work, allowing the pharmacist to focus more on clinical and prescribing activities. Staff had information about patient's recent or regular medicines through the Summary Care Records.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. There were 272 medication related incidents between July 2020 to June 2021. Most of these incidents (224) were recorded as no harm to patients with the remaining 48 recorded as low harm.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us they rarely used medication to restrain patients due to the high proportion of concerns being related to illicit drugs. They were therefore reluctant to administer additional medication to help calm patients down due to the potential interaction this would have. Information requested showed there had been six occasions over the last six months where staff used medication to calm patients who were acting violently and aggressively towards staff.

Incidents

The service managed patient safety incidents which were reported well. Staff were aware of what constituted an incident and near miss, however they did not always report them. Managers investigated incidents raised well 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. However, staff did not always raise concerns and report incidents and near misses in line with trust policy. Information reviewed showed the service raised 5,351 incidents

between July 2020 and June 2021. Most of these incidents were classified as no harm (4,865) and low harm (458). Despite a significant number of incidents raised during this time, staff told us there had been areas of concern and incidents which they identified which they had not raised as an incident report. One example which staff did not always report was low staffing numbers. Staff told us incidents which had a direct impact on patient care and potential harm was always reported.

The service had reported no never events in the last 12 months. If appropriate, managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. We reviewed examples of serious incident investigations which had been completed and found managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

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. Senior staff were able to describe the process for undertaking, and when to formally undertake the duty of candour. There was a trust policy in place which directed staff as to when to implement duty of candour and how this should be completed formally which all staff were aware of.

When staff reported incidents, they told us they received feedback from investigation of the incident. They also had feedback from other serious incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. During handover, important learning and feedback from incident investigations amongst other important issues was discussed. Staff told us they used the same brief during handover for a week to ensure all staff were made aware.

Staff were able to discuss changes that had been made as a result of incident investigations and feedback. One example discussed was around patients who undergo an ECG (electrocardiogram). Staff told us there had been a theme in incidents around ECGs and reviewing these. Changes had been made as a result of investigation into the incidents to ensure patients were kept safe and had the right care and treatment they required. Another example discussed was in relation to paracetamol overdose and the introduction of a patient passport to support management of this.

Managers debriefed and supported staff after any serious incident. Staff reflected on some difficult cases they had experienced within the department and the support they had received from their managers. When a serious incident involving a child occurred, all staff told us these seemed to be one of the most difficult and where support and debriefing was welcomed.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff however we did not see this shared with patients and visitors.

The service continually monitored safety performance. Matrons were required to complete regular checks on the department for safety performance using the trusts Care Excellence Framework. The results of this were fed back to the nurse in charge at the end of the review. Any significant findings were included in the handover to the department for that week.

Staff used the data on safety performance to further improve services.

Urgent and emergency services

Is the service effective?

Good ↑

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

Evidence-based care and treatment

The service mostly 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. We saw that the department implemented relevant clinical guidelines from the National Institute for Health and Care Excellence (NICE) and other relevant professional bodies such as the Royal College of Emergency Medicine (RCEM). Information around policies, guidance and standard operating procedures (SOP) was mainly found on the trust intranet. However, we also saw some laminated posters related to new procedures, policies or SOPs around the department for staff to refer to.

Pathways had been developed for staff to follow to ensure patients received safe and effective care. Examples discussed of positive pathways in place which were evidence based were for stroke and cardiac patients. However, we identified concerns around the lack of an effective frailty pathway. Staff were unable to identify what pathway was in place for frail and elderly patients who attended the department. Members of the trust's frailty team rarely reviewed patients in the department and would often wait for them to be admitted.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The mental health pathways had been developed based on national guidance and legislation to ensure the rights of patients were protected and patients received safe and effective care in a timely manner.

At handover meetings, staff did not routinely refer to the psychological and emotional needs of all patients, only those where this information was related to their presenting concerns.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Hydration stations were provided around the department and staff encouraged patients to drink water. There was also a café and vending machines available for patients to use. Patients told us staff had offered food and drink to them whilst they had been waiting in the department, however most patients we spoke with preferred to use the café.

During our inspection, we did not observe any patients attending the department who required specialist nutrition, however staff told us they would ensure they met patient needs if required.

Staff fully and accurately completed patients' fluid charts where needed. However, we did not observe any patients who had their nutrition monitored during our inspection.

We did not observe any nationally recognised screening tools used to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff would refer patients for additional input if identified as required on admission from patient history.

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. Staff used a pain scale of zero to 10 when assessing pain, with zero being no pain and 10 relating to severe pain. Pain was assessed during comfort rounds which were tailored to each patient. Alternative pain assessment methods were used for patients who were unable to communicate with staff.

Patients received pain relief soon after it was identified they needed it, or they requested it. We reviewed a set of notes where the patient had cried out in pain. Staff reacted immediately to the patients cries and provided suitable pain relief.

Staff prescribed, administered and recorded pain relief accurately. We did not observe any concerns around the timeliness of administering medications to patients. Additional pain relief was prescribed for patients who may require this in addition to routine pain relief, and we saw where staff had provided this for patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved some good outcomes for patients.

The service participated in relevant national clinical audits. The department were signed up to participate in the Royal College for Emergency Medicine (RCEM) audits. The most recent RCEM audit they had participated in was this current year's fractured neck of femur audit. They had participated in the previous audits for 2019/20 which included mental health (self-harm), assessing cognitive impairment in older people and care of children in ED.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. However, where outcomes did not meet the required standard or expectation, the department identified recommendations and implemented actions to learn and improve. In the most recent audit, staff identified concerns around knowledge of the fractured neck of femur pathway as well as the effective administration of a FICB (fascia iliaca compartment block). Results showed 57% of eligible patients received a FICB. Although this was just over half of the eligible number of patients, this was an improvement from the audit completed in 2016 where only 18% of eligible patients received one. To improve the care and treatment patients received, the staff identified additional training was required for all doctors and a block trolley was set up to aid staff to complete this. We also reviewed action plans related to the RCEM audits from 2019/20 which highlighted areas to improve within the department.

Managers and staff used the results to improve patients' outcomes. An example of an audit which had gone on to implement actions to improve patient's outcome was around paracetamol overdose. At the time of the audit, 60% of patients either had partial treatment or serious omissions of treatment which was recommended. However, the actions

implemented following this has seen an improvement in the treatment provided to patients. One example of an action implemented was around the paracetamol overdose passport. Staff told us this had significantly improved the management of patients following an overdose, although this was only anecdotal at the time as the re-audit was yet to be conducted.

Managers and staff told us they carried out a comprehensive programme of repeated audits to check improvement over time. Audit activity had reduced during the pandemic due to the workload and capacity, however over time routine audits were being reimplemented, and repeated audits to complete the audit cycle were now underway. One area staff were keen to explore through audits was around the attendances to the department where patients could have been seen elsewhere. As well as audits for the numbers of patients being sent back to the department following their initial stream to the onsite urgent care centre (UCC).

Managers used information from the audits to improve care and treatment. Examples were provided by staff where this had occurred.

Managers shared and made sure staff understood information from the audits. Feedback from relevant audits was included in the weekly handover information as well as bulletins produced with key points.

The service had a lower than expected risk of re-attendance than the Midlands and the England average. The department recorded a 7% reattendance rate in June 2021 which was lower than the Midlands average of 8% and England average of 8.2% at that time. This had been constantly lower than both since June 2020.

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 were also required to complete the trust's induction programme when starting.

Managers generally supported staff to develop through yearly, constructive appraisals of their work. Appraisals had recently started back up again following a period where they were suspended due to the pandemic. Staff told us they ensured appraisals were meaningful and not just a tick box exercise. Information shared with us showed at the time of our inspection showed:

- 80% of nursing staff at the department had received their appraisal.
- 92% of administration staff had received their appraisal.
- 86% of nurse practitioners, nurse educators and advanced nurse practitioners had received their appraisal.

We did not receive the information for all medical staff in relation to appraisals, however 88% of the emergency medicines management department had received their appraisals.

The clinical educators supported the learning and development needs of staff. There was a nurse educator in the department who took the lead on training for staff. However, during the pandemic, the nurse educator was requested to work elsewhere as part of the pandemic response plan. The member of staff had recently returned to the department and would therefore be re-establishing a thorough training programme for all staff to participate in.

There were no formalised team meetings held in the department at the time of our inspection. However, managers made sure staff were aware of any important messages and learning from incidents or complaints through a weekly handover document. This ran all week to ensure all staff had the opportunity to receive important information. In addition to this, there were private social media groups for staff to communicate with each other.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any additional and specialist training for their role.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. This was usually discussed during appraisals, however managers had open door policy and encouraged staff to come and discuss any developmental requirements.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us staff from Human Resources (HR) were extremely supportive to all involved when areas of poor performance was identified.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, there were challenges for the staff in the department when working with other teams across the trust.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Huddles were held throughout the day to discuss the patients within the department and plans in place for their care and treatment. They were also an opportunity to review the demands on the department and flex staff around to hot spot areas of activity.

The service had recruited operating department practitioners (ODPs) to work in the department. They were responsible for checking and maintaining the resuscitation equipment. They also supported the anaesthetists and resus teams in the event of a patient requiring intubating. All staff were positive about the support the ODPs gave and value of the ODPs to the MDT of the department.

We were aware of challenges staff faced when working with staff from other specialities. Staff told us they had a good relationship with the medicine directorate and had a smoother referral process for them. Patients awaiting a bed within a medicine ward or department, were reviewed by the medicine team in the department. This had meant there were some delays for some patients who were waiting to be seen by a consultant. However, staff told us there were some considerable challenges when trying to refer patients to other specialties. This meant there was a risk of patients remaining in the department for longer and delaying other patients from being seen.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff told us the relationship between the local mental health trust had significantly improved and this had enabled patients experiencing mental ill health to go directly to the mental health facility for review and assessment. When patients attended the department, there was swift review by Mental Health Liaison Team (MHLT) once the patient had been referred and a plan implemented for patients to keep them safe.

Urgent and emergency services

We observed a positive relationship between staff from the department and staff from the ambulance trust. Staff were working cohesively towards providing safe and effective care for patients and had adapted well to the new process.

Seven-day services

Most 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.

There was a pharmacist based in the department between 9am to 5pm on the weekdays. Outside of these times and weekends staff accessed the on-call pharmacist support for the trust.

Staff did however identify an area of concern around the SDEC (same day emergency care) provision as this closed at 8pm with referrals not accepted after 6pm. This was around the time activity increased and staff told us they had a significant number of patients who would be suitable for this pathway. Although this provision met the seven-day provision, this was not providing the recommended 12 hours cover, with staff believing this service would help with flow concerns in the department if it was opened for longer.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support in the department.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were provided with information leaflets and staff signposted them to organisations for additional support where required.

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. However, we were not assured medical staff completed training around capacity and deprivation of liberty safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us the training they received around mental capacity had enabled them to develop the knowledge and competence to identify when a patient may be lacking capacity and how to assess the patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in patients' records. We observed staff obtaining formal consent for treatment (when specific tests and investigations were required to be completed) and explained all details thoroughly for patients to understand. We also observed staff gaining informal consent when taking patient observations.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We did not observe any patients who were unable to consent for themselves, however staff were aware of the process to undertake should they require it.

Urgent and emergency services

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff in the paediatric department were aware of the Gillick Competence and Fraser Guidelines and were able to discuss examples where Gillick Competence had been considered for some of the patients reviewed. Fraser Guidelines were not as commonly used in the department due to the specific nature of when this is usually considered.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information provided after the inspection showed 96% of staff had completed this training which was above the trust target of 95%.

We were not assured medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We requested training data following our inspection but did not receive information to demonstrate medical staff completed this training.

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. There were four staff employed in the department who provided additional support to others when providing care and treatment for patients with mental health concerns. They had provided additional training around legislation and best practice when providing care to patients with mental ill health. When additional support was required, staff were supported by the mental health liaison team.

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. Staff told us the use of Deprivation of Liberty Safeguards was rare within the department, however, were aware of the correct process to follow and the documentation to complete should a patient require this.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us if they had concerns about a patient, they would discuss with the safeguarding team.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Matrons reviewed a selection of patient records during their daily department review. If concerns are identified around assessing patients for capacity, this is discussed with the team or individual caring for the patient.

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed the interaction between staff and patients and found staff treated them with compassion and were considerate of their needs. When providing personal care to patients, staff ensured curtains were drawn to maintain the dignity of the patient.

Patients said staff treated them well and with kindness. We spoke with eight patients and despite one patient voicing their dissatisfaction about the amount of time they had been waiting, all patients spoke highly of the staff and the care they provided them.

Staff followed policy to keep patient care and treatment confidential. However, when patients booked in and were seen by the navigator, there was a risk of confidential information being heard by others. Staff tried to maintain confidentiality as best as the could by lowering their voices if this could occur. Due to the activity and the use of masks by staff, this did impact on communication which meant staff most of the time had to raise their voices rather than lower them.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff providing respect and compassionate care to patients who had attended due to mental ill health. There were times when staff found the circumstances challenging but ensured the care and treatment provided was always kind, dignified and non-judgemental.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Cultural and religious needs were well understood, and staff ensured any specific cultural needs would be considered whilst in the department. Staff also told us there was good access to various religious leaders to support patients of all faiths.

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. At the time of our inspection, patients were still encouraged to attend the department alone due to the impact of the pandemic. Staff were aware of the additional impact this had on both the patient and their relative's emotional well-being and tried to compensate for this where possible.

Staff mainly supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. However, we observed two occasions where patients were left visibly upset and distressed with staff not attending to them. We saw one patient who was visibly upset in the waiting room area and many staff had walked past with no interaction. We observed another patient who appeared distressed, who had been placed in the middle of the waiting room in a wheelchair by a member of staff. Both patients were out of the eyesight of the staff behind the desk and staff had walked past both patients. We spoke with both patients to ensure they were ok and asked a member of staff to help them.

Staff demonstrated empathy when having difficult conversations. Staff told us this was an important part of their role due to the types of patients and incidents they experienced in the department. There were quiet areas where they held difficult conversations with relatives which could also be used if delivering bad news to patients.

Urgent and emergency services

Understanding and involvement of patients and those close to them

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

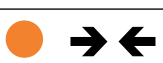
Staff made sure patients and those close to them understood their care and treatment. We observed some positive examples of discussions with patients around their care and treatment. Staff always made sure patients had understood what they had discussed and were happy to explain further if the patient requested.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff communicating with a range of patients, each time personalising it to them. One example was a member of staff communicating with a child, this was conducted in a way which held the child's attention enabling the member of staff to complete a full and meaningful assessment. Within the feedback shared with us by the department, many patients had indicated staff had communicated with them on a level they understood.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service collated feedback through the friends and family test (FFT) as well as through their own feedback system. The FFT results for July 2021 showed 70% of patients had a positive experience at the department. This was consistent with results from previous months. Other feedback comments demonstrated patients were happy with their care and treatment with personal thanks being mentioned to individual staff members. Patients had found their care 'excellent' 'amazing' 'respectful' and 'exceptional' amongst other positive phrases. The main concern in the feedback was around the time it took for patients to be seen, however this never appeared to impact the treatment provided by staff when patients were eventually seen.

Staff supported patients to make advanced and informed decisions about their care. Our observations during the inspection and review of the feedback provided by patients supported this.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that tried to meet the needs of local people and the communities served. However, they were challenged in delivering their plans due to issues with the wider system and local organisations.

Managers tried to plan and organise services, so they met the needs of the local population, however there were significant challenges within the wider system. All staff we spoke with, with no exception told us they had concerns around the number of patients who attended the service who did not need to be seen at an emergency department. To reduce the activity at the department, processes had been implemented to direct patients with minor injuries and ailments to other services including a local minor injuries unit as well as the other emergency department at the County location. Although this had improved the provision to manage the more serious concerns and sicker patients, this was

now no longer the case due to an increase in the number of patients attending this department each day. Staff told us there had been an increase in the number of patients who were either referred to the department by their GP (with or without being physically seen, with or without a referral letter) as well as patients who could simply not get an appointment with their GP and therefore attended the department to be seen.

Once at the department, the navigator tried to stream patients to alternative resources including the onsite urgent care centre (UCC), the local MIU or Country department if considered to fit the minor's pathway or even back to their own GP. Where patients were referred by their GP with a letter of referral, staff would direct some patients straight to the speciality within the hospital if capacity allowed. However, there were still challenges around this system with some patients refusing to access other alternative treatment options and some of the facilities redirecting back to the department due to being unable to accept the patient. Staff told us this still impacted the department and impacted the ability to assess patients within the 15-minute key performance indicator (KPI). Also, when patients refused to access alternative treatment options, this would add to the overall waiting time to be seen for treatment.

The department had received several external reviews to identify what, if any potential improvements could be made. Despite identifying the challenges around the wider system, at the time of our inspection staff told us there had been no further plans put in place in response to these reviews to improve the responsiveness of the department.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Where patients were allocated cubicles near the opposite sex, staff would ensure the dignity of both patients was maintained.

Facilities and premises were appropriate for the services being delivered. However, the changes which were made in response to the pandemic had meant the floor space of the department was vast now and some areas had been reconfigured to accommodate other patients. This had meant some of the signage which was present was no longer valid to the current layout of the department.

The waiting areas had been reconfigured to adhere to social distancing requirements for COVID-19. Several seats were taped off to prevent patients being closer than two metres. Although we observed several patients standing in the main reception whilst waiting to be seen due to all seats being taken, we did not observe any patients waiting outside of the department who had self-presented. We did not see any signs with maximum numbers of patients allowed within the waiting room itself, however within other areas of the department we saw signs identifying the maximum number of people allowed in them at one time.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The support for patients with mental ill health had improved significantly since the department employed four registered mental health nurses. Staff also told us they had good support from nurses who specialised in learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had electronic systems in place where alerts were inputted for patients who required additional support or specialist intervention. This included, but was not limited to; high volume users, patients with learning difficulties, homeless patients, patients with care plans or care orders in place, patients with known infection control complications, patients known to be violent or aggressive and patients known to have been a victim of domestic violence. This enabled staff to put interventions or actions in place early whilst they visited the department. One staff member told us they were being given the responsibility to review all the current patients on the system who were considered frequent attenders

Managers monitored and took action to minimise missed appointments. There were imminent plans in place to create a kiosk in the reception area for NHS 111 patients who came to the department with appointments. Staff were hopeful that this would improve the flow and responsiveness of the department.

The service was unable to relieve pressure on other departments due to the significant pressure they faced.

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. Staff were welcoming of relatives and carers attending the department with patients who had additional needs.

The department was not designed to meet the needs of patients living with dementia. Although the decoration of the department was plain and not overwhelming to a patient's sensory functions, signage was not consistent with recommended dementia friendly standards. The layout had caused staff to place several paper signs in the department which were not consistent in layout with no consideration for pictorial inclusion. However, with the addition of the doors to the cubicles in red resus and majors, staff commented on the positive impact this had due to the reduction of noise.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff continued to use the butterfly system and contacted the specialist nurses for advice and support if required. Staff also told us there was a box containing distraction objects for patients living with dementia and patients with a learning disability. However due to the pandemic, the box had not been used as frequently due to restrictions on the use of such items from an infection prevention and control perspective.

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

The service had information leaflets available in languages spoken by the patients and local community, however not all of these were displayed at the time of our inspection.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. All staff spoke positively about their access to interpretation services. As a last resort, staff told us there was also a translation application which could be used.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patient's we spoke with preferred to access the onsite coffee shop and vending machines if they required any food or drink.

Staff had access to communication aids to help patients become partners in their care and treatment. We observed a range of tools to help staff communicate with patients. Staff were especially used to using communication tools in the paediatric department.

The paediatric department had access to a play specialist who would entertain the children. However, the department had stored all toys away due to the current policy in relation to the pandemic. Whilst children were waiting to be seen, there were televisions in both the red and green waiting areas which played age appropriate shows.

Urgent and emergency services

Access and flow

People could access the service when they needed it however, they did not always receive care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Staff told us the activity within the department had increased 40% since March 2021 and now reflected the attendance numbers they saw pre-pandemic. Information from the trust showed there was 111,218 attendances between August 2020 to July 2021. In July 2021, there were 10,371 attendances to the department which had been a consistent figure since April 2021.

Following the previous inspection in 2019, the department had worked hard to ensure patients were no longer cared for in corridors. To prevent this from occurring again, the department worked with the ambulance trust and produced a SOP for them both to work from where patients would be cared for until a cubicle became available. This meant ambulances would be held outside for a period of time, waiting to handover the patient physically to the department staff. During our inspection, nationally accessible information showed 10.7% of ambulances waited over 60 minutes to physically handover their patients on the 24 August 2021. On the 25 August 2021, 11.2% of ambulance waited over 60 minutes. This was higher than both the England average and Midlands average on both days. A Hospitals Ambulance Liaison Officer (HALO) was deployed to the department on both days to try and manage the backlog of ambulances at the department. The number of ambulances queuing during our visit fluctuated between three and 14. Staff told us there were over 70 ambulances which had waited for a significant period throughout the day on 24 August 2021. During the second day of our inspection, we spoke with staff on one ambulance who had been waiting for over two hours to bring their patient into the department. The patient had been escalated for conveyance to hospital by their GP, despite the GP not physically reviewing the patient. The patient was on an end of life care pathway and staff were concerned they were deteriorating fast. At that point, the staff in the RAT area were yet to review the patient. We escalated this to the consultant who was reviewing patients, they told us the patient was next to be seen.

Average time from arrival to initial assessment was the same as pre COVID-19 pandemic at 24 minutes (this was the same for ambulance attendances and those who self-presented). This was outside of the recommended 15 minutes. Information shared by the trust showed during July 2021 57% of patients had their initial assessment within 15 minutes. From the records we reviewed, this was in line with what we found during the inspection.

The recommended time take from arrival to treatment was 60 minutes, however the department were failing to meet this. In June 2021, the average time it took for patients to receive treatment was 92 minutes. The trust's performance had improved between November 2020 to March 2021, however since this, the performance was deteriorating and the department was now recording the highest time to treatment since pre COVID pandemic.

The department had a television which showed patients the waiting times for the department as well as how many patients were waiting to be seen. On the first day of our inspection at 9.23am, the television was displaying there were 83 patients waiting to be seen in the department and the waiting time to be seen was already over four hours. According to nationally accessible information, 67% of patients were admitted, transferred or discharged within four hours of attendance This did not meet the 95% national standard and was below the England average of 78% and Midlands average of 72%.

Managers and staff tried to make sure patients did not stay longer than they needed to. However, information showed in June 2021 on average patients were in the department for 200 minutes which is higher than the England average of 177 minutes. The 95th percentile of total time in the department was 652 minutes which was also above the England average of 539 minutes. This appeared to be increasing again after a sharp drop in February 2021 and is in line with what staff told us about the increasing picture of activity at the department and the challenges for patients to be admitted.

The number of patients who were waiting over 12 hours from decision to admit to admission appeared to be rising. In June 2021 there were two recorded patients who had waited over 12 hours in the department for a bed within the trust. This had risen to 15 patients in July 2021. During our inspection we found there were two patients who had been waiting over 12 hours from the decision to admit who were still awaiting admission at the time. One patient had been waiting for 19 hours whilst the other patient had been waiting for 22 hours. During our inspection, staff told us they were experiencing significant challenges across the trust from a flow point of view which meant patients were spending longer in the department. During our inspection, the department had declared themselves as level four, the highest on the escalation trigger reporting system. Staff attended frequent bed meetings to update and escalate concerns and challenges they faced. We observed one bed management meeting and found staff tried to work together to identify potential beds where patients from the department could move to. Staff were also updated with the potential moves throughout the day and a plan agreed for staff to work towards.

The number of patients leaving the service before being seen for treatments was rising. In June 2021, 7% of patients attending the department left before being seen. This was higher than the England average of 5% and the Midlands average of 5.2%.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Staff supported patients when they were referred or transferred between services. The service moved patients only when there was a clear medical reason or in their best interest. The navigator provided patients with the information they required when they were streamed to other services. Patients were only streamed to other services if their clinical conditions were assessed as being safe to do so.

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. We observed one patient who wanted to raise a complaint. The matron for the department went to meet with the patient to hear their views.

The service clearly displayed information about how to raise a concern in patient areas. Staff also verbally gave patients information on how they could complain should they have concerns that required raising.

Staff understood the policy on complaints and knew how to handle them. We observed staff implementing the complaints policy during our inspection.

Urgent and emergency services

Managers investigated complaints and identified themes. There were 80 complaints submitted about the department between July 2020 to July 2021. Staff investigated these thoroughly and discussed themes and trends with all who work within the department. The top three areas of concern raised through complaints was around diagnosis (16 complaints), lack of patient involvement in care/decisions (eight complaints) and poor attitude (five complaints).

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. Managers used the handover to feedback any key learning from complaints.

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 improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced and had plans on how to manage them. 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. However, there was a disconnect between the leadership within the department and the senior leadership team for the trust.

The emergency department was part of the medical directorate. There was a triumvirate in place to lead the department. The clinical director and the matron were relatively new in their posts; however, both had worked in the department previously and were aware of the challenges the department faced. They identified they had done a lot to try and improve the department and were proud of how far they had come, however they were aware there were still areas which needed attention and were working to prioritise these.

Most staff we spoke with were positive about their local managers and told us they were supportive, approachable and visible.

Concerns were raised during the inspection over the interaction between the leadership of the department and the executive team. Staff felt disconnected from the trust leadership and executive team and they felt the executive team did not understand what was happening on the site. Staff said they rarely saw members of the executive team. We observed an incident during our inspection where the leads for the department were directed by a member of the executive team by email to start offloading ambulances immediately due to the number of ambulances being held outside. Staff felt this was inappropriate, unsafe and were unhappy that the executive team had not visited the department to identify the challenges they were faced with. In addition to this, the leadership team told us they were not involved in some key meetings where there was focus on the department including A&E delivery board.

Urgent and emergency services

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.

Staff had a good awareness of the trust values and felt these was embedded in their practice. They demonstrated how they worked together (as a team), showed compassion for their patients, always aimed to provide safe care and treatment and a safe environment for their patients and all had a desire to continually demonstrate ideas and ways of improving.

The department had a vision which was in line with the trusts vision. The vision remained to provide an emergency care service which met the needs of the community. However, in order to do this, the department had to work with the wider health economy and ensure patients received the right care, at the right place, at the right time. The strategy focused on three streams of work:

- Community services which built on existing clinical networks
- Secondary care which will look at improving patient outcomes by becoming more efficient and effective.
- Tertiary and specialised services which concentrates on the major trauma side of the department.

Culture

Most staff felt respected, supported and valued by their immediate leaders and peers. 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.

Most staff we spoke with told us they felt valued, supported and respected by their leaders and by their peers. However, there was a consistent message about the lack of support from above their immediate leaders. Patient care was at the heart of all staff and they were committed to providing a safe and positive experience for patients whilst in the department.

Managers were aware of the impact the pandemic had on staff and that staff in some areas were close to burn out. Some staff had been recommended to enquire about further support for their health and well-being. Staff were aware of the well-being support that had been implemented by the trust and knew their own local managers were supportive of them accessing these. The department also had a well-being team who were responsible for providing well-being support for staff. Some initiatives put in place for staff was ‘bring in breakfast’ which appeared to have been well received by staff. Fundraising had also enabled the team to provide staff with a well-being room where staff could go for a quiet moment. There were also plans in place for a family fun day for staff. Staff felt their well-being mattered to their local managers.

Staff told us there was an ‘open door’ approach to all managers and leaders in the department. If there were any concerns, staff felt they were able to raise them without fear of reprisal. Some staff told us they were actively encouraged to speak up if they had concerns. Staff were also aware of the Freedom to Speak Up Guardian and knew who their guardian was at the trust. Medical staff however did have concerns around their work rotas, teaching being regularly cancelled and the lack of senior support on night shifts. Staff were aware of their guardian for safe working and how to escalate concerns, however they had not escalated their concerns to them. The GMC 2021 survey had indicated

there was lower satisfaction for local training which supported the concerns raised during our inspection. Workload also scored low; however, this was consistent with previous results. The largest concern identified on the survey amongst medical staff in the department was around the handover process, however we did not receive any feedback around this.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. We reviewed incidents where the duty of candour had been applied and found no concerns with how the service had completed this.

Governance

Leaders mostly 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. However, we had had concerns around the challenges the department leads had escalating important issues to the executive team.

Staff at all levels were clear about their roles, responsibilities and accountabilities. The department had allocated a band seven nurse as the lead for governance. Key learning and performance related issues were discussed during the handovers. The same key information was discussed during each handover for one week to ensure all staff received the information. Additional methods of communicating key governance issues were in place including private social media chat groups and the trust emailing system. Notices were occasionally put up in the staff areas of the department for staff to read.

Staff from the department attended monthly emergency medicine directorate clinical governance meetings. These meetings were chaired by the clinical director for the department and had multidisciplinary team attendance. These meetings discussed key governance issues including (but not limited to) incidents, complaints, risks and clinical effectiveness and audits. These meetings covered both the adult and paediatric departments and demonstrated where aspects from both departments had been raised for escalation to the board. This was the main governance meeting where members of the department were required to attend. Staff attended other internal governance meetings including the non-elective improvement group and mortality and morbidity meetings. Any learning or actions would be escalated and discussed at the department's main governance meeting.

There were regular meetings throughout the day to discuss the flow and capacity within the hospital. Staff from the department participated in these meetings and escalated the pressure level within the department. From these meetings, the trust was able to accurately assess the pressures they currently faced and take appropriate action. On the first day of our inspection, the trust was reporting a pressure level of four. When the hospital reaches this level, the full hospital policy is usually implemented. However, staff told us this did not happen as there were always beds ring fenced in specialist areas which were never admitted into, despite the challenges faced.

Staff from the department were not invited to attend the accident and emergency delivery board meeting as well as other key meetings which were centred around the department. This was a significant concern as staff were aware of the potential for misrepresentation of the challenges they were facing as well as key decisions being made without their

voices or improvement ideas being heard. Staff gave us an example of where a new process had been discussed at a meeting with the ambulance trust where they had not been invited. The decision at the meeting was to go ahead with this process, however this had not been communicated with the department and caused considerable concern about patient safety and staff pressures.

Staff from the department joined the trust's mental health governance meetings which were chaired by the trust's lead for mental health. Any specific incidents or concerns raised in the department were escalated within this meeting and any feedback cascaded back to the all staff in the department. Staff also participated in meetings with external organisations to ensure the care and treatment provided for patients with mental ill health was safe and effective.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. However, we found risks within the department which were not on the risk register. They had plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.

Leaders were mainly aware of their risks within the department, however we identified areas of risk which had not been entered on to the risk register. Staff told us of their concerns around the new approach to caring for patients who were held on ambulances. Although all agreed this was better than the previous measures of corridor care, due to the increasing demand and staffing risks, this at times made the staff unhappy about the additional responsibility over the patients in the ambulances. During interviews with the leads of the department, this aspect of risk had not been escalated, however we were told that it would be.

In addition to the risk above, we were also concerned about the potential risks the non-see through doors posed due to the reduced visibility of patients. Staff were aware of the reduced risks these doors provided from an infection prevention and control (IPC) aspect but could not articulate if additional risks such as falls and those with known mental ill-health had been considered. We found information within governance meeting minutes which had identified a potential link with the doors and increased number of falls in the department, there was a proposal for getting quotes for replacing the doors with see through doors. We requested information following our inspection around this. No formal risk assessment had been completed for additional risks as the primary focus had been on reducing IPC risks, especially around COVID-19. We were informed that they intended to complete a risk assessment for these doors following our inspection.

Staff had commented on the expansion of the department and how this was seen as a risk. This was not annotated on the risk register despite several staff seeing this as a risk. Although this was necessary to accommodate patients safely during the pandemic, staff believed this was not sustainable for much longer due to staffing concerns. It was also difficult for the EPIC (emergency physician in charge) to maintain oversight over all areas due to the current layout of the department.

There were 20 risks on the department risk register. The main risks on the department risk register were in relation to medical staffing and the lack of being able to achieve the key performance standards due to demand on the service. These were the main risks which leaders were able to articulate, however when asked for the top five risks, not all leaders were able to identify them. They were able to discuss new and emerging risks identified in the department which were being escalated. This included concerns around the management of patients presenting with heart conditions. The clinical director had an upcoming meeting with risk management to manage this risk appropriately.

Medical staff was one of the top five risks identified on the register. This had been escalated to the trust level risk register due to the severity of the risk. However, we found the description around the risk did not identify the specific risks identified with middle grade staffing levels on night shift. We were therefore not assured the board were directly sighted on the level of risk the department faced due to a lack of medical staff.

As leaders were not invited to participate in some key meetings about the department, it was evident there were decisions made about the department which they did not contribute to.

An update of the department's performance was regularly provided to the trust board. The most recent board meeting was held 4 August 2021. The information presented identified the increase in demand and the challenges this presented.

Information Management

The service collected data and analysed it although staff shared concerns over this. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required. The information systems in place were integrated and secure, however staff believed there were ways to improve information management for certain groups of patients.

Staff had access to information they needed to carry out their roles effectively with policies and procedures available on the trust's intranet.

Some staff had raised concerns about the systems in place to collect reliable data for the department although no specific examples were given at the time. One member of staff indicated it was more of an analysis challenge for the data collected in the department. Many examples were discussed where data was being collected for the purpose of showing how pressurised the department was with the intention of sharing during meetings with external organisations.

There was a television in the waiting area which displayed information on the number of patients waiting to be seen and the time patients were expected to experience when waiting for treatment. This information was updated on a fine minute cycle.

The department did not currently have a visual screen in place to enable an oversight of the patients in all the different areas of the department.

Staff raised concerns around the lack of access to information systems for patients known to the local mental health team. Staff had requested the trust enable them to have read only access to help with decision making in the department, but the trust had not enabled this. Staff told us RMNs (registered mental health nurses) not having access to the mental health notes for patients who are high volume users was a concern and hindered their management in the department.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. There was some collaboration with partner organisations to help improve services for patients.

Staff within the department participated in the staff survey. We requested information in relation to the results for the department, however we were not confident the results solely applied to the department. The results however showed the main concerns were around the demands on staff at work and not being able to complete their jobs to the best of

their ability. Within the information shared by the trust, only 24% of those responses believed they had realistic time pressures and only 35% believed there were enough staff in the organisation to do the job properly. In addition to the action plan in place, the divisional lead had also written to all staff to inform them of actions they were taking in response to the staff survey.

The department had a well-being lead who was a senior nurse. They ran drop-in sessions with all staff to discuss any concerns or challenges which they had. These had been well received and well attended as staff believed their concerns were taken seriously.

Staff told us the well-being group had a process in place where they provided buddy systems to new staff from overseas. Staff would take the new starters out to show them key amenities within the local area to help familiarise themselves with the area. The feedback from this had been extremely positive and the new staff appreciated the efforts of staff to help them.

Patients, the public and other external organisations were engaged with to receive feedback about the current status of the department. Feedback from patients was usually through the Friends and Family Test survey as well as additional locally received feedback. The department had recently invited to external organisations in to review the department and provide feedback on how they could improve the service. Both had acknowledged the external pressures the system was under which had resulted in several patients attending the department who were not considered an emergency.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, not all staff felt their ideas were listened to when it came to quality improvement.

Since the previous inspection in 2019, staff were committed to improving the service they provided. Staff were locally encouraged to produce ideas on how the service could be improved. Leaders were receptive to the ideas and would often trial these locally before consideration for permanent implementation was given. Leaders told us the ideas staff came up with were impressive and demonstrated a desire to improve patient experience. Despite this feedback from staff, the results of the staff survey had identified low numbers of staff believing they could be involved in deciding on changes and able to make improvements in their work.

Staff were continually trying to improve the management of patients who attended the department at the 'front door'. Since the last inspection, they had implemented a system where senior nurses now streamed patients. However, the department were still challenged with the volume of patients attending who did not require emergency care and the time taken from attending the department to their first assessment. New initiatives were due to be implemented after our inspection which aimed to improve the flow of patients attending who were not considered to require emergency level care.

The focus on mental health within the department and improved pathways and working with the local trust who provided the mental health provision had been noted during this inspection and was an improvement from the previous inspections. Staff leading on this within the department were passionate about improving patient experience for those experiencing mental ill health.

The department had tried to provide improvement and innovation within the service by employing operating department practitioners to support the anaesthetists during trauma calls. Staff we spoke with found this a positive change and valued their input when critically ill patients were brought into the department.

However, there were challenges faced when staff identified and submitted ideas of how issues such as flow could be managed throughout the trust, which would ultimately improve the flow in the department. One idea raised was to increase resources within the AEC so this could be a 24-hour service, seven days per week. This would reduce the blocking of trolleys in the department as there would be an improvement of flow out of the department. This unfortunately had not been taken on board as a potential improvement plan at the time of our inspection despite staff believing this would significantly improve flow.

County Hospital

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www.uhnm.nhs.uk

Description of this hospital

The trust provides a full range of hospital services including urgent and emergency care, critical care, medical care, surgery, end of life care, maternity and gynaecology, and outpatients services at both hospitals. Services for children and young people are provided at the Royal Stoke University Hospital and County Hospital. In addition to these services, the trust is also a tertiary centre on the Royal Stoke site for trauma, cardiology and spinal care.

County Hospital: The County Hospital is a smaller hospital site in Stafford. This hospital provides services including medical care, elective surgery, outpatients and diagnostics, and a paediatric minor injuries unit.

We carried out a focused inspections of surgical and medicine core service at County hospital. Focussed inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Surgery services at County Hospital were last inspected in 2015 where it was rated as requires improvement overall. We did not inspect effective, caring and responsive. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

We also carried out a focused inspection of medicine at County Hospital because several serious incidents relating to falls and pressure ulcers had been reported to us. Medical services at County Hospital were last inspected in 2017 where it was rated as requires improvement overall.

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 ensured nursing staff completed it. Medical staff did not always manage to complete mandatory updates within the targets the trust had set.

Nursing staff received and kept up-to-date with their mandatory training. Training was a combination of face to face training and online learning and included sepsis training and infection prevention and control. Managers provided them with time to complete it, and displayed compliance progress on wallcharts for staff on ward 8 and the elective orthopaedic unit. Both wards had met their targets on the day we inspected.

We reviewed a snapshot of compliance data on 26 August 2021 and found nursing staff met their target of 95% with most of the mandatory courses. Where these were not met it was just below the target, for example blood transfusion awareness was the lowest at 89%

Medical staff received mandatory training but had not kept up to date with updates during the Covid-19 pandemic. We reviewed a snapshot of compliance data on 26 August 2021 and found medical staff were 100% compliant with duty of candour but had fallen well below their target of 95% for all other mandatory training courses. Whilst courses such as infection prevention and control, health and safety, and end of life care were around 80-86%, other courses such as basic and advanced life support were 40%, fire safety was 58%, moving and handling was 15%, consent was 73%. Managers were aware of these gaps as they monitored mandatory training and alerted staff when they needed to update their training. The provision of some face to face trainings, such as advanced life support had been impacted by the pandemic. However, plans were in place to address training gaps.

Compliance progress was reported to the senior team and discussed at meetings. In theatre, managers made use of regular audit time to enable staff to complete mandatory and other essential training and updates. Ward managers ensured staff had time scheduled to complete it.

All nursing and medical staff were compliant with mental health awareness training and mental capacity act training, which were between 93% and 99% compliant.

The mandatory training was comprehensive and met the needs of patients and staff. All staff completed life support training at either a basic, intermediate or advanced level on induction and were usually scheduled to complete updates periodically.

Clinical staff completed training on recognising and responding to patients with mental health needs such as dementia.

Surgery

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, medical and all theatre staff received training specific for their role on how to recognise and report abuse. We reviewed a snapshot of compliance data on 26 August 2021 and found nursing staff were between 99% and 100% compliant for all safeguarding training updates.

Staff knew where to access information about making a referral and who to contact on their ward if they had a concern. Staff knew there was a safeguarding lead who they could contact for advice or to escalate a concern.

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 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. This was usually the ward sister or nurse in charge. In the theatre department, the theatre coordinator would escalate any concerns to the safeguarding lead. Other staff usually alerted the nurse in charge if they had any concerns.

Staff followed safe procedures for children visiting the ward. However, during the pandemic, children visiting had been very limited.

Medical staff had achieved their target for adult safeguarding level 2, which was 100%, but had fallen well short of their target for all 3 other training modules including childrens safeguarding modules. Compliance was between 47% and 79% for the other modules.

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 very clean and had suitable furnishings which were clean and well-maintained. All theatres and work areas were very clean and uncluttered. Across the service, the use of 'I am clean' labels were used consistently.

The service performed well for cleanliness. We reviewed an audit conducted in July 2021 where a comprehensive hygiene inspection was made of all areas, rooms, toilet and shower facilities and other facilities within the surgery service. The assessment covered the following categories; Cleaning, estates and facilities, food and catering, and nurse related activities. The audit outcome showed overall compliance scores for each area was over 95%.

A 'PLACE Lite' desktop review was conducted for County hospital as a whole during 2019 and was published nationally in January 2020.The report showed that County hospital scored between 96% and 100% across all areas assessed, which was above national average.

Hand hygiene audits showed 100% compliance for most of the weeks that were displayed on the wallboards on wards.

Staff used records to identify how well the service prevented infections. This information was shared with staff and available on wall boards on the wards for patients and the public to see.

Surgery

Staff followed infection control principles including the use of personal protective equipment (PPE). Ward and theatre managers ensured that PPE was correctly fitted and always fully available. There was a good supply to the wards and all theatres and no supply issues during the pandemic. Staff and visitors complied with the trust's infection, prevention and control (IPC) processes, including additional COVID-19 precautions which were in effect across the service. Face masks and alcohol hand gel were freely available on each ward. Staff complied with social distancing precautions when required. Information for staff and visitors regarding IPC and COVID-19 precautions was displayed across the service, including at entrances to wards. Personal protective equipment (PPE) such as gloves and disposable aprons were used in accordance with the trust's infection control policy. Staff used alcohol hand gel when entering and exiting the wards and theatres. Handwashing facilities were appropriate and accessible. All staff adhered to being bare below the elbow

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff kept cleaning logs for all areas to show compliance with cleaning protocols and to assure staff and patients about the safety of the environment.

Staff worked effectively to prevent, identify and treat surgical site infections. Where infections occurred, this was discussed at meetings and performance data shared with staff.

Patients received screening for MRSA (Methicillin resistant Staphylococcus aureus), Clostridium difficile (commonly known as C. difficile) and Covid-19 at their pre-operative assessment before surgery.

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.

Patients could reach call bells and staff responded quickly when called. Patients who were unable or unlikely to use call bells, such as patients living with dementia, were kept under close observation of the nursing staff.

The design of the environment followed national guidance. The theatre department was compliant with national guidance on ventilation with laminar flow air changes in all theatres. This system controlled and changed the air in the room at regular intervals. Some theatres had separate preparation rooms with air change control to allow preparation for the next case under sterile conditions. Wards had a mix of six bedded units and single rooms with plenty of access to toilet and shower facilities. Due to the Covid-19 pandemic, the six bedded units had been reduced to two or three beds depending on the speciality being cared for. This allowed for social distancing between patients.

Staff carried out daily safety checks of specialist equipment. Managers had ensured that equipment had been tested and serviced regularly. In theatres, this included anaesthetic and resuscitation equipment.

The service had suitable facilities to meet the needs of patients' families. Wards had a dayroom where patients could meet to eat their meals at a large dining table or play games or watch TV with their families or other patients. There was a therapy room on the orthopaedic ward where a team of physiotherapists and visiting occupational therapist worked daily with patients to assist their recovery.

The service had enough suitable equipment to help them to safely care for patients in a safe way.

Staff disposed of clinical waste safely. In theatres, there was a separate corridor where used instruments and surgical waste was placed until the patient had left the theatre. This was labelled with the patient's ID and case number until it was deemed safe to remove.

Surgery

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. Staff used the National Early Warning Score (NEWS) tool electronically which triggered an alert to the ward manager or nurse in charge where a patient's condition deteriorated. Ward managers checked that the NEWS2 tool was being used according to their protocols and conducted daily checks on patients and regular reviews to check compliance.

The ward managers for surgery services at County hospital conducted daily checks and weekly audits and were assured that any triggers were acted on promptly on their wards. The NEWS2 records we reviewed on the day of our inspection showed that all observations were completed on time and acted on.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly. Nursing staff used nationally recognised tools to assess patient's risk of developing, for example, pressure ulcers, nutritional risks, falls, and risks associated with moving and handling. These were reviewed regularly, and if a patient's condition changed or following an incident, a new risk assessment was completed. Assessment booklets were comprehensively completed and had input from therapy staff.

Staff knew about and dealt with any specific risk issues. Staff were vigilant in checking for signs of sepsis through use of the NEWS2 tool and regular observation of the patients. There was an effective post surgery protocol in place whereby patients returning from theatre were closely observed. There was a sepsis care protocol in place for the management of patients with presumed or confirmed sepsis.

All patients were assessed for venous thromboembolism risk (VTE) on admission and prior to surgery and this was recorded in their assessment booklet and on their prescription chart.

Staff used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. Use of the WHO checklist was well embedded, respected by all staff grades, and was completed comprehensively. All patients had the site of their operation clearly marked for surgery. At each stage of the process, staff checked for swabs, needles and instrumentation to ensure patient safety was maintained and no items had been identified as missing. Regular audits were undertaken by the theatre manager and recorded electronically which showed 100% compliance with the WHO surgical safety checklist. This had increased from 99% over the previous four quarters.

Staff shared key information to keep patients safe when handing over their care to others. There were discharge coordinators who oversaw the discharge process for inpatients, including any ongoing community care support. Daycase patients received information telling them what to do if they developed a complication or were concerned after being discharged, and relevant information was shared with the patient's GP.

Shift changes and handovers included all necessary key information to keep patients safe. Handover information was shared with relevant nursing and therapy staff on wards. In theatre, all staff met for a briefing at the start of their shift to discuss their work assignments that day.

Surgery

Patients were reviewed by a consultant or registrar within a few hours after surgery and any patient staying overnight on ward 8 were reviewed again in the evening and by the Senior House Officer at 7am to complete their discharge arrangements. Patients on the orthopaedic ward were reviewed by their treating consultant and there was a daily ward round by the consultant on call and nursing and therapy staff.

County hospital had no critical care unit or high dependency beds to care for patients who needed a higher level of clinical support or those who had deteriorated following surgery. They had mitigated risks to patients by ensuring a strict criteria was followed during pre-assessment process so that only suitable patients were accepted for surgery at County hospital. Any patients who did not meet the criteria were scheduled to have their surgery at The Royal Stoke hospital. Pre-assessment nurses had received training in pre-assessment and were supported by protocols and worked alongside a senior anaesthetist for advice and support at the pre-anaesthetic management clinics. There was a dedicated anaesthetist clinic weekly to assess patients where necessary. Patients were given help and advice to optimise their health prior to surgery where possible.

There was a transfer policy which was put into action if a patient deteriorated. This included review by the consultant and anaesthetist on call within 30 minutes being contacted, and alerting the surgical assessment unit at the Royal Stoke hospital of the arrival by ambulance. Senior leaders told us that since implementing the transfer policy, there had been only two patients who had required transfer to the Royal Stoke due to deterioration. Success was attributed to robust selection criteria and the pre-anaesthetic management service in operation.

There was an Operating Department Practitioner (ODP) available at all times at County hospital who would attend any event where staff required support for a patient who was deteriorating. A matron was always on site at County hospital at all times.

Nurse staffing

Both wards 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; However, theatres did not always have enough staff. All staff had the right qualifications, skills and training and experience to keep patients safe.

The wards had enough nursing and support staff to keep patients safe. Staffing rotas from the previous six months showed the wards generally filled their daytime rotas and overfilled their night time rotas, apart from the months of March and April 2021 where rota fulfilment dipped to between 43% and 58% for registered nurses on the elective orthopaedic unit. Where staffing gaps existed due to sickness during the pandemic, ward managers rearranged the rotas between the wards and staff worked additional hours to fill the rotas. Regular Bank shifts were used which were often filled by staff who worked on the ward.

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. Matrons held daily meetings across sites to review staffing rotas and this had meant some staff moved to other areas to meet the needs of other wards during the pandemic.

In theatres, many staff were re-deployed to critical care or theatres at the Royal Stoke hospital to cope with the increased demand placed on critical care service due to high numbers of patients with Covid-19. Some staff remained at County hospital to continue with scheduled surgery for higher priority patients. For example patients who needed urgent surgery for cancer.

Surgery

Rota fulfilment for the last six months showed a daytime fill rate of between 56% and 84% for registered nurses, but 100% or more fill rate for non registered staff. Challenges in fulfilling the rota was attributed to staff sickness or staff having to isolate due to Covid-19 national guidelines. Staffing capacity issues were discussed at the daily senior clinical leadership meeting. Managers limited their use of bank and agency staff and requested staff familiar with the service. Gaps in rotas were filled by offering extra shifts to the ward staff and using bank staff who knew the wards well. Managers made sure all bank and agency staff had a full induction and understood the service.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff were sometimes redeployed to other wards and sometimes to the Royal Stoke hospital to meet the needs of patients

The service had low vacancy rates for nursing staff. The theatre department had actively recruited overseas nurses and newly qualified staff. They were due to complete their induction during September.

The service had low turnover rates. Staff told us they were happy to work at County hospital and many staff had worked there for many years.

The service had reducing sickness rates which had fluctuated during the Covid-19 pandemic and were around 6% at the time of our inspection . Managers attributed their current sickness to staff isolating as per government guidelines.

Managers usually limited their use of bank and agency staff, but this had risen during the Covid-19 pandemic and had been variable during the last 12 months. Managers told us staff on the wards who filled bank shifts had been very flexible and accommodating during this time.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers usually requested staff familiar with the service. Most bank shifts were filled by staff who worked on the wards.

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 and this staff matched the planned number. All medical staff worked across both sites and rotas were aligned to specialities. During the pandemic and at its height, doctors, including consultants, junior doctors and trainees were re-deployed to the Royal Stoke hospital to support the critical care unit and essential surgery. Elective routine surgery was initially paused to accommodate this, and shortly after, recommenced and increased the specialities conducted for higher priority patients. This meant that patients with cancer on a 2 week wait pathway were able to receive their surgery quickly at County hospital.

The service had low and/ or reducing vacancy rates for medical staff. The trust were recruiting consultants in critical care due to three consultants leaving or retiring soon.

Sickness rates for medical staff were reducing. During the Covid-19 pandemic, sickness rates were around 6%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly during the senior clinical team daily capacity meeting.

Surgery

The service always had a consultant on call during evenings and weekends. There was also an anaesthetist on call and an operating department practitioner (ODP) on site at all times at County hospital. This was primarily to support ED and the medical wards out of hours, but they were also available to support the surgery service, and in particular were immediately available to review any deteriorating patients.

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 a combination of electronic and paper. Care records and assessments were in booklet form and completed by a range of staff. All of the 11 records we reviewed were fully completed.

Records were easily accessed by relevant staff, legible and comprehensively completed, stored securely and locked in cabinets. This had improved since our last inspection.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The five prescription charts we reviewed were legible and fully completed. Staff administered medicines safely by checking patients identification and allergies, and recording administration on the trust's electronic prescribing and medicines administration system. The ward managers ensured all medicines were administered appropriately during their daily ward round.

Pharmacy staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines when needed. Nursing staff usually provided medicines information when a patient was discharged.

Staff stored and managed medicines and prescribing documents in line with the provider's policy and followed current national practice to check patients had the correct medicines at the right times. The trust conducted storage audits every six months. The most recent audit conducted showed that ward 8 was 100% compliant, the elective orthopaedic ward was 96% compliant, theatre recovery and theatres achieved between 90% and 100% compliance.

An antibiotic compliance audit had not been conducted trust-wide since December 2020 due to the Covid-19 pandemic. At this time, ward 8 and the elective orthopaedic ward were temporarily not operational and so were not audited. However, ward managers included an antibiotic audit in their weekly assurance audit, which showed 100% compliance for the weeks we reviewed. Weekly audits contributed to a matron and ward manager monthly assurance report. This was reported to the Associate Chief Nurse through the governance structure.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Ward managers informed staff of any safety alerts and discussed these at team meetings. Alerts were also discussed at governance meetings at senior level.

Staff ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Pharmacists regularly reviewed records including medicines reconciliation and 'when required' medicines.

Surgery

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 understood their responsibilities to raise concerns, and there was a positive culture of reporting incidents. Qualified staff reported incidents and near misses in line with trust policy. Junior staff had access to to the reporting system but generally reported concerns to the nurse in charge and were informed of the outcome of these.

The service had no never events on either of the wards or theatres at County hospital. However, they knew about a recent never event at the Royal Stoke hospital as learning about this had been shared with them.

Staff knew to report serious incidents and 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 governance meeting minutes and found that duty of candour had been deployed for each of the incidents discussed.

Staff received feedback from investigation of incidents and met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example; on ward 8, where a patient had sustained an acute kidney injury whilst waiting to go for surgery, the ward introduced a protocol to consider starting IV fluids for all patients whose surgery is delayed beyond a certain point.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers knew to debrief and support staff after any serious incident.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance and used the data to improve. Information such as infection rates and falls were shared with staff at meetings and submitted nationally

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. 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

Each directorate has a leadership team which manages activity across both sites. Surgical directorate leaders told us they worked well with each other and understood the challenges they all faced around quality and sustainability of services, including bed capacity and staffing issues.

Local leadership was provided by matrons, ward managers and theatre managers. Staff were extremely positive about their local leadership team and said they were visible and supportive. Matrons worked mainly at the Royal Stoke site but visited the wards at County hospital weekly to ensure they were visible and accessible to staff who required support. Ward managers said their matrons were in contact daily by phone and could contact the matron from a different division when their own matron was not at work. Senior leaders including chief nurse and chief executive were also visible and made regular visits to the service.

In theatres, two managers were absent. To ensure continued leadership, two members of staff were acting into the role for one day a week each and were supported by their matron who was in daily contact. The theatre manager and operational manager who visited weekly on a rotational basis, were available by phone daily. Staff attended daily planning meetings to discuss workload and capacity for the day ahead.

Junior doctors said they felt well supported by their registrars and consultants, who were approachable and accessible including out of hours. Junior doctors had been re-deployed in response to the COVID-19 pandemic initially but still managed to maintain some level of surgical experience when scheduled surgery recommenced at County hospital, although there had been some disruption to their surgical learning opportunities. Senior leaders told us they were working to ensure junior doctors had access to the learning and experience they needed. They were running at 87% pre-Covid-19 activity at the time we inspected.

Vision and Strategy

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

All staff were mostly aware of the vision and values of the trust and were able to give examples of how their work reflected the values. Staff articulated their values centred around putting the patient first and being the most important person in the hospital.

The vision for surgery centred around continuing to deliver routine elective services. To create a centre of excellence at County Hospital to ensure the best experience, improved productivity and short access times for patients. The service had implemented an additional theatre at County hospital during the pandemic in preparation to increase the number of surgical procedures and help reduce the long waiting lists. This was paused because of staff shortage due to sickness and staff following isolation guidelines. However, they had introduced a number of new services during the pandemic including bariatric surgery and 23 hour gynaecology surgery. Leaders told us they were reviewing the inclusion criteria to identify additional procedures that could safely be undertaken at County to relieve pressure on theatres at Royal Stoke. There were no immediate plans to reinstate the critical care unit to support more complex cases.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff said they felt respected, valued and supported. They told us about how they had risen to the challenges of the pandemic in order to do their very best for patients. Many staff had been re-deployed in areas they not previously

worked in but all said they were focussed on the needs of patients at the time. However, managers told us how some theatre staff who had worked on the critical care unit were very tired and worn out but were still required to take on the challenge of reducing the surgery waiting lists. Leaders were aware of the changes that had been required in responding to the COVID-19 pandemic had impacted on staff morale and wellbeing. Local managers promoted a number of wellbeing initiatives to help improve staff wellbeing. These included events such as cake baking competitions, world food day, bingo, and celebrating international nurses day. Managers invited ideas from staff which resulted in initiatives such as 'chocolate in a mug' and 'complimentary day' where each person ensured they had paid a compliment to at least one colleague that day in order to boost morale and lift spirits.

Counselling and formal support from colleagues and managers was also available to all staff.

There was an open, supportive culture across the service. Staff of all grades were encouraged to speak up about any concerns and ideas for improvement were encouraged. All staff told us they felt part of the team and included in meetings and decisions about the future. Patients and their families were also encouraged to talk to the staff about any concerns they had. When something went wrong, patients received an apology and were told about any actions to prevent something similar happening in the future.

Staff told us they were proud to work for the trust and had a common sense of purpose. There was a culture of collective responsibility between teams and services, and we saw positive and supportive interactions between all 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.

There was a governance system in place where the trust used established systems, processes and a suite of clinical policies in conjunction with NICE guidelines to provide a set of standards for wards and departments to comply with during each stage of the patient's journey.

Monthly governance meetings took place where leaders discussed progress across the service. Staff understood their roles and what they were accountable for. Each division reported key quality, safety and performance information to the trust board monthly. At directorate level, a number of governance, finance, performance, safety, quality and risk meetings took place which fed into the divisional meetings. These were attended by directorate medical and nursing leaders and included relevant staff at different levels. Staff at ward level told us that key information was shared with them at ward meetings. We reviewed a sample of minutes from governance meetings. The meetings were not always quorate due to staff absences during Covid-19 pandemic. However, the chair agreed each time for the meetings to go ahead. Meetings were mostly via digital platforms and attended by the relevant leads and there was evidence of information sharing and escalation of risks, with actions to mitigate them. Consultants presented cases they had analysed because something had gone wrong. Learning was shared with the senior team. Other regular agenda items included infection prevention and control, policy and protocol review, audit outcomes and safety alerts.

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.

Risks, issues and performance were discussed at trust board level, divisional level and directorate level and information shared with staff at ward level. Each directorate maintained its own risk register, which included local ward level risks.

Surgery

Across the surgical service, the top risks included waiting lists with an increasing backlog of surgical patients, staffing capacity, and staff welfare. The risks accurately reflected the concerns described by staff across the service and at ward level.

Mortality reviews, incidents and complaints were discussed at directorate level. Complaints were also discussed at daily safety huddles and regular team meetings. Staff told us that they received feedback from incidents and complaints in team meetings and safety briefings.

Ward managers and theatre managers conducted audits and checks and monitored performance which they reported to their matrons. Performance measures were also shared with staff at meetings and visually on wallboards.

The service monitored compliance against national guidance and policies and took steps to improve compliance where further actions were identified. For example, audits were regularly undertaken to ensure compliance with WHO checklist completion in line with National Patient Safety Agency (NPSA) guidelines and trust policy.

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 up-to-date, accurate, and comprehensive information on patients' care and treatment. Patient data was constantly updated electronically, such as the recording of physiological observations and medicines administration. Staff were aware of how to use and store confidential information. Managers used dashboards to manage and share performance metrics and audit outcomes. Notifications were made to external organisations when required.

Engagement

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

The trust board met each month and had made changes to enable the senior leadership team to have their voice heard more and have their concerns discussed and addressed.

The divisional leadership team engaged with staff and aimed to ensure that their voices were heard and acted on to shape services and culture. The surgery service gathered feedback from staff through a variety of forums and methods. All staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and managers and all said they were encouraged to share their ideas to make changes and drive improvement.

Staff at County hospital told us they didn't feel separated from the Royal Stoke hospital as most managers worked across both sites. County hospital staff were included in all activities and decisions. There were joint "walk abouts" by the leadership team which ensured both sites had the same quality and access reviews to encourage learning and improvement.

Many staff described how they felt proud to work at County hospital and gave many examples of how they had worked well together during the Covid-19 pandemic to support one another. They were also proud to be one of the trusts in the Midlands to continue to provide some scheduled surgery for high priority patients during the Covid-19 pandemic.

Surgery

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 improvement.

The divisional and local leaders took action to make improvements in the running of the surgical service. They had regular meetings where learning was discussed, including quality and governance meetings and daily safety huddles.

Many changes were made in response to the COVID-19 pandemic to patient pathways and ward locations to improve patient care and safety. Elective surgery at County hospital was greatly reduced in line with national guidelines and staff were re-deployed to other areas within the trust to enable greater staffing capacity in those areas where there was a critical need. The elective orthopaedic unit utilised a portion of the ward to care for trauma patients from The Royal Stoke hospital who were recovering from surgery. Ward 8 increased the number of surgical specialities being treated there which freed up beds at The Royal Stoke to care for patients with Covid-19. Junior doctors whose surgical training and experience became interrupted by Covid-19 changes, were instead given the opportunity to enhance other skills and gain other experience with critically ill patients.

The ENT Head & Neck Service introduced 'Telescopic Referrals' which enabled around 1600 patients with cancer diagnosis to be found and treated quickly. Specialist nurses conducted video examinations of the throat which freed up time for consultants to review higher risk referrals. All patients received an expert opinion with days of being referred by their GP.

There was a quality improvement manager available to support managers and staff in making improvements as a team effort.

The trust recognised achievement and encouraged staff to develop leadership skills and to make improvements in their ward or area.

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, there were some significant gaps in training compliance rates in some key safety training areas. Plans were in place to address these gaps.

The mandatory training provided was comprehensive and met the needs of patients and staff. Staff training compliance rates exceeded the trust's 95% target in the mandatory training subjects of; safe use of bed rails, blood transfusion, complaints, duty of candour, end of life care, health records, medicines administration, controlled drugs, medicines storage, security awareness, infection prevention and control level one and equality, diversity and human rights. Staff training compliance rates also exceeded the trust's 90% target in dementia awareness training.

However, the staff training compliance rates fell below the trust's 95% target for the following mandatory training subjects. The compliance rates for advanced life support was 38% and compliance rates for consent was 54%. Moving and handling levels one and two had compliance rates of 72% and 77%, fire, information governance, level two basic life support, adult immediate life support and infection prevention and control had training compliance rates varying from 82% and 85% and conflict resolution and safety and welfare training compliance rates fell just short of the 95% trust target with compliance rates of 92% and 93%.

Managers were aware of these gaps as they monitored mandatory training and alerted staff when they needed to update their training. The provision of some face to face trainings, such as advanced life support had been impacted by the pandemic. However, plans were in place to address training gaps.

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.

Staff received training specific for their role on how to recognise and report abuse. Average training for all staff mostly exceeded the trust's compliance training targets of 90% for safeguarding adults level two and 95% compliance for; safeguarding adults level one, safeguarding children level one, safeguarding children level two and level one prevent training (prevent is a form of training that aims to ensure the safeguarding of children, adults and communities from any threat of terrorism). However, only 70% of staff were compliant with the trust's training target of 85% for prevent awareness training (prevent training aims to ensure the safeguarding of children, adults and communities from any threat of terrorism). Plans were in place to address this training gap.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff also knew how to make a safeguarding referral and who to inform if they had concerns.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

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

Ward areas visited were clean and had suitable furnishings which were clean and well-maintained and cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment in accordance with local and national guidance 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) and a bare below elbows approach.

The service generally performed well for cleanliness. Regular audits showed that cleanliness, infection control and hygiene were assessed and monitored. This included Clostridium difficile audits (C.difficile is the familiar term. C.difficile is a germ that causes severe diarrhoea and colitis), hand hygiene audits, PPE audits and cleaning audits. Where any gaps in compliance were identified, plans were in place to address these.

Data showed that although on the wards we visited there had been incidents of infections, there had been no outbreaks of any hospital acquired infections such as; Methicillin-sensitive or Methicillin-resistant Staphylococcus aureus and C.difficile.

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. Clinical areas had adequate space to facilitate safe care and bed numbers had reduced to help manage the risks associated with Covid 19. In particular, the environment of ward 15 which provided care and treatment to older people was noted to have been designed to meet the specific needs of older people. Private spaces were available on the ward to enable staff to have sensitive conversation with patients and their families and a day room was available for patients to access if they needed time away from their beds in a quieter space. The décor of ward 15 also provided a more homely feel to the ward with the aim of reducing patients' anxiety and distress.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment in accordance with local policies. We saw that all equipment, such as; blood pressure monitoring equipment and ventilators were tested regularly to ensure their safety and effectiveness. Resuscitation equipment was readily available in all the areas we visited. We observed regular, recorded checks of this equipment were completed to ensure it was safe and ready to use.

Specialist equipment was used as required. For example, bariatric beds were used when indicated. Staff told us they had received training in how to use this equipment. However, no formal records of this training were maintained on the wards to evidence this.

Environmental risk assessments had been completed to assess and mitigate the risks associated with fire and regular environmental audits were completed to check the environmental and equipment within it was safe. Where safety or compliance concerns were identified, action was taken to address these concerns.

We saw that staff followed safe and effective systems to dispose of clinical waste.

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. However, there was no effective process in place to assess, record and mitigate risks associated with acute mental health needs on the medical wards.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used appropriately. NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis. We saw that raised scores were escalated appropriately for medical reviews and early intervention was given as required.

Staff completed physical health risk assessments for each patient on admission, using recognised tools, and reviewed these assessments regularly, including after any incident. This included assessing risks associated with falls, skin, blood clots (known as VTE assessments).

Staff knew about and dealt with these physical health risk issues. For example, we saw that pressure relieving equipment was used to mitigate the risk of skin damage and interventions such as hip protectors were used when appropriate to mitigate the risk of harm from falling.

Shift changes and handovers included key information about patients' physical health risks to ensure staff had the information needed to keep people safe. Staff also shared this information as required with relevant health and social care professionals on discharge through discharge planning and discharge correspondence.

However, we found that there was no formal assessment in use to assess, record and mitigate the risks associated with acute mental health concerns specifically to the medical wards. Staff told us that mental health risk assessments were completed in the emergency department, but these were not reviewed or revisited on admission to the wards. This meant that whilst patients were awaiting mental health assessments from specialist mental health trust staff any risks to themselves or others were not effectively assessed, recorded and mitigated. Since our inspection, the trust have recognised this gap in risk assessment and mitigation and have told us how they plan to address this.

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. The number of nurses and healthcare assistants matched the planned numbers most of the time.

Staff rotas showed that staffing gaps were filled with bank staff when required and vacancy rates on the wards we visited were generally low totalling 10.4 whole time equivalent (WTE) vacancies for registered nursing staff and 7.33 WTE vacancies for HCA's. An ongoing rolling recruitment programme was in place and there was evidence to show new staff were due to start and fill some of these vacancies.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Gaps in rotas were filled by offering extra shifts to the ward staff and using bank staff who knew the wards well. Managers made sure all bank and agency staff had a full induction and understood the service.

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. Ward managers attended daily directorate meetings with their matrons where staffing requirements for the day were discussed and prioritised. This ensured staffing numbers were flexed and staff were redeployed as required to provide safe care across the medical wards.

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. The numbers of medical staff matched the planned numbers most of the time.

There were one WTE consultant vacancies on wards one and 15. These were filled by long term locum staff (locums are temporary staff not directly employed by the trust) which provided patients and the staff with continuity and consistency. Managers made sure all bank and agency staff had a full induction and understood the service. Recruitment plans were in place to address these vacancies and the rotating of consultants across the county and royal stoke sites was also planned to help improve recruitment.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was always appropriate consultant cover on call during evenings and weekends.

Records

Staff kept 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 multidisciplinary and all staff could access them easily. On ward 15 staff had implemented a system to ensure all notes were trackable at all times. If a member of the multidisciplinary team removed the records from the room they were located in, they left a laminated sheet where the records were originally stored which showed which staff member had taken the notes. This meant if the records were required urgently staff knew where to locate them.

A combination of paper and electronic records were maintained that contained a contemporaneous account of each patient's care. All entries we viewed were clear, legible, dated and signed.

There was on occasion a lack of key information in patient care plans. For example, one patient who had a pressure ulcer did not have a clearly recorded care plan that recorded which dressings should be used and how frequently they needed to be changed. This meant there was a risk this patient may receive inconsistent or unsuitable care. Despite this staff described the wound care they were providing this patient with and it was appropriate. They explained this information was shared with staff during handover but agreed it should be clearly recorded to mitigate the risk of inconsistent or unsuitable care.

Records were stored securely and when patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines administration records (MARs) contained patients' weights, allergies and the frequency, dosage and administration route of the medicines were clearly recorded. MARs we reviewed confirmed medicines were administered in accordance with their associated prescriptions. We also saw that antibiotics were prescribed and administered in accordance with local and national guidelines.

Controlled Drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, administered and recorded following best practice procedures which included daily checks by two nurses.

Staff reviewed patients' medicines regularly and followed current national practice to check patients had the correct medicines. MARs evidenced that regular pharmacy reviews took place. These reviews created a safety net that ensured medicines were prescribed and administered in line with national guidance.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The temperatures in the clinical rooms and medicine refrigerators were recorded and monitored and we saw that medicines were stored within the recommended temperature range for safe medicine storage. Any discrepancies were acted upon immediately and staff were aware of what action to take if the temperatures were not safe for medicine storage.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Relevant safety alerts were shared with staff and displayed in prominent clinical areas.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. MARs showed that patients who were described 'as required' sedative medicines only received these as a last resort.

Resuscitation trolleys containing emergency medicines and equipment were securely stored, but available and accessible if needed in an emergency. Checks were in place to ensure emergency medicines were available and safe to be used.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report 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.

Although staff reported serious safety incidents resulting in harm in line with trust policy, we could not be assured that staff consistently reported less serious incidents. Staff on all the wards we visited told us of incidents relating to significant delays in accessing speech and language therapy assessment. Staff told us this impacted on patient safety as

some patients required feeding tubes to be inserted or were kept nil by mouth whilst they awaited a swallow assessment. However, when we asked the trust for incident forms relating to this concern, only two incidents had been reported in the six months prior to our inspection and those two incidents were reported from ward 15. This meant there was potential under reporting as staff on ward one and AMU also described similar incidents to us.

We reviewed seven incident investigation reports, five of which were falls investigations. These falls investigations were all completed in a timely manner; however, this was not always the case for other serious incidents. One of the seven incidents we reviewed took place in January 2020. This incident report was not fully completed until April 2021 which meant there had been a 15-month delay in identifying actions to prevent a similar event from occurring, placing patients at risk of ongoing harm during that time period.

The majority of the incident investigation reports reviewed showed evidence of appropriate investigation and learning. However, one of the reports lacked detail around the need for an effective and formal process to evidence that the risks associated with patient's acute mental health needs were assessed, recorded and mitigated. We spoke with senior leaders about this following our inspection who told us they had identified gaps in the original serious incident investigation. They told us they were updating the investigation document to reflect this.

Staff received feedback from the investigation of incidents through various communication channels. Two of the wards we visited also displayed learning from incidents in clinical areas.

Patients and their families were involved in incident investigations when appropriate. Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong.

The service had no recent never events on any wards we visited.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety performance data was displayed on wards for staff and patients to see.

The safety performance data showed the service achieved harm free care within the six months leading up to the inspection.

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

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. National Institute for Health and Care Excellence (NICE) guidance was incorporated into trust policies and standard operating procedures and the implementation of this guidance was monitored. For example, the trust monitored its compliance with the NICE guidance on, 'falls in older people' and 'pressure ulcers: prevention and management'.

The service's acute medicine patient pathway audit programme also effectively monitored staffs' compliance with other national and local guidance and standards, including; the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest and compliance with agreed trust policies such as; the trust's policy on multidisciplinary health records. Any concerns with compliance were escalated to the trust's CQC working group where actions were agreed which were then managed at a local level with oversight from the CQC working group.

The service regularly audited staff compliance for screening and management of sepsis to ensure it was in line with national guidance. Audits showed that in June 2021 there was an 88% compliance with sepsis screening on the wards we visited. This raised to 100% compliance in July 2021. None of the patients selected in the audit required antibiotic treatment.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. There were no adults admitted under the MHA to the wards we visited at the time of our inspection. However, staff told us how they worked closely with the mental health liaison team if a patient required assessment or treatment under the Act.

Nutrition and hydration

Nutritional risks were not always assessed and planned for and specialist support from dieticians and speech and language therapists was not always available. The service made adjustments for patients' religious, cultural and other needs.

Staff did not always use a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust's policy stated all adult patients should be screened for malnutrition on admission to hospital using the Malnutrition Universal Screening Tool (MUST). Four of the patients records we reviewed did not contain evidence to show the MUST had been completed despite the patients being admitted for over 24 hours. On ward one two patients had not had a completed MUST. Staff told us this was because specialist weighing scales were not available to weigh one of these patients and staff told us that the second patient did not require this screening assessment which went against trust policy. Staff told us that the other two patients (one on AMU and one on ward 15) had not had their MUST completed due to an oversight. This meant patients were not consistently screened for malnutrition which could lead to delays in mitigating any nutritional risks.

Staff told us that they completed a nutritional assessment if a patient scored as being at risk of malnutrition on the MUST. However, we found that nutritional assessments were not always completed fully. Two of the patient records we reviewed had nutritional assessment booklets in place due to their risk of malnutrition. However, both assessments had not been fully completed. This meant we could not be assured that these patients' nutritional needs were being effectively met.

Patients told us they had a choice of suitable foods and drinks throughout the day. We saw that special dietary and cultural needs were met. For example, halal food was provided to patient's who requested this.

Records that contained fluid and nutritional charts were completed accurately and fluid balances were totalled each day to ensure staff monitored patient's total fluid intake when this was required.

Medical care (including older people's care)

Specialist support from staff such as dietitians and speech and language therapists was not always available for patients when they needed it. There was limited speech and language therapy (SaLT) cover at the County site. SaLT staff visited the county site on Mondays and Fridays only. Staff told us this had an impact on patient care including the potentially unnecessary insertion of feeding tubes. Dietitians were available week days only.

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 recognised tools and gave pain relief in line with individual needs and best practice. For example, the Abbey Pain Score was used on an individual basis for patients who had difficulties with verbal and non-verbal communication, such as patient's living with dementia.

Patients told us they received pain relief soon after requesting it and medication administration records showed that pain relief was prescribed, administered and recorded 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 participated in relevant national clinical audits. Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Patient outcome data against 22 national standards was available to us for the whole medical directorate across both sites. One of these measures 'Emergency readmissions: Acute cerebrovascular disease' was better than the national comparison, 17 were the same as the national compassion and four were worse than the national comparison. The four areas that were worse than the national comparison included, 'In-hospital mortality: Acute bronchitis', 'In-hospital mortality: Fracture of neck of femur (hip)', 'In-hospital mortality: Pneumonia' and 'In-hospital mortality: Urinary tract infections'.

Managers used information from the audits to improve patient outcomes and their care and treatment. The service evidenced it had explored and responded to the outcome areas listed above that were worse than the national comparison.

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. In addition to mandatory training additional training opportunities were available to staff. For example, medical staff had access to a variety of additional training that included; journal clubs, in house training on a variety of conditions and interventions and specific clinical skills training. Doctors spoke positively about their training opportunities.

Managers made sure staff received any specialist training for their role. For example, on ward 15 training in clinical holding was made available to staff. Clinical holding is when staff hold patients in a secure comfortable position that helps the patient feel safe and secure during care and treatment interventions. This approach to care is particularly

beneficial in care of older people and reduced the reliance for security staff to be called to support patients when they become agitated and distressed. Nursing and healthcare support workers could volunteer for link/champion roles where they accessed training in specialist areas such as; infection prevention and control, dementia and continence. Link/champion staff then shared their knowledge and skills with others on their wards.

Managers gave all new staff a full induction tailored to their role before they started work. Clinical educators worked with new and established staff to provide on the job training which staff told us they found beneficial.

Most staff had received an appraisal to review work performance and to provide support and monitor the effectiveness of the service. Appraisal rates for medical staff were 100% and other staff groups on these wards averaged an 88.6% appraisal rate. Staff told us their appraisals were effective because they helped them to identify and plan their training and development needs. Staff also told us they could request supervision sessions with senior staff/managers, to provide them with any support and feedback needed to enable them to work effectively in their roles.

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. This included regular multidisciplinary board rounds that were well attended by the multidisciplinary team (MDT). These meetings ensured each member of the MDT new the priorities for each patient and the role they each played to facilitate effective care and timely discharge.

We observed effective MDT working on the wards and areas we visited. Therapy staff worked alongside nursing staff to support patients to complete activities of daily living, such as getting washed and dressed and accessing the toilet. We saw nurses and therapy staff work together to answer patient call bells ensuring patient needs were met in a timely manner by which ever appropriate staff member was available.

The MDT worked together to provide good patient care. Each ward and unit we visited had named occupational therapy and physiotherapy staff allocated to them which meant patient's received consistent therapy input. These named therapy staff provided daily therapy interventions in working hours on Monday to Friday and handed over to a rostered weekend therapy team who provided therapy intervention on a priority basis.

Staff worked across health care disciplines and with other agencies when required to care for patients. Links with the local authority were in place which meant safeguarding and discharge concerns were effectively managed. The service also had close links with local and national universities which meant students were offered placements within the service.

Staff referred patients for mental health assessments and other appropriate assessments when they showed signs of mental ill health, such as psychosis, depression and substance misuse.

Patients were reviewed by relevant consultants from specific specialities within the trust as appropriate. Some of these reviews were completed at the County Hospital site. However, some patients were transported to the Royal Stoke Hospital for these reviews. Escorts were provided to ensure patient safety during transportation.

Medical care (including older people's care)

Seven-day services

With the exception of speech and language therapy and dietetics, key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. There was medical cover on-site 24-hour hours a day, seven days a week. In addition to this, consultants were also available on an on-call basis out of hours. Staff told us they could call for support from consultants at any time and reported no delays in receiving this support.

Patients could access occupational therapy and physiotherapy during working hours seven days a week if required. In addition to this an out of hours on call respiratory physiotherapy service was also provided to patients as required.

Radiographers were available 24 hours a day, seven days a week as an on-call rota was in place to facilitate this. This meant diagnostic X-rays and computerised tomography (CT scans) could be completed promptly when required.

In-patient pharmacy services were available on the medical wards between 9am and 6pm Monday to Friday and a dispensary only service was available at weekends from 10am and 2pm. At all other times an on-call pharmacy service was provided.

Staff could call for support from mental health services provided by another NHS provider between the hours of 8am and 10pm seven days a week.

There was limited speech and language therapy (SaLT) cover at the county site. SaLT staff visited the county site on Mondays and Fridays only. Staff told us this had an impact on patient care including the potentially unnecessary insertion of feeding tubes and delayed discharges.

Dietetic cover was available Monday to Friday between 8:30 and 4:30pm. No weekend dietetic service was available. Staff however, did not share incidents where this had led to poor care outcome.

Health promotion

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

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, patients were asked if they smoked and smoking cessation services were offered to them if they wanted this intervention.

Falls prevention and pressure area care leaflets were available for patients and their relatives to access. These leaflets provided patients and their relatives with practical advice to promote their health and wellbeing.

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, the required mental capacity assessments and best interest decisions were not always made in a timely manner. They used measures that limit patients' liberty appropriately.

Medical care (including older people's care)

Where patients could consent to their own care, staff made sure patients consented to their treatment based on all the information available. Nursing staff told us and patients confirmed that verbal consent was gained prior to the provision of ward based care and treatment. However, this was frequently not recorded in the patient's care records. Therapy staff also gained verbal consent prior to interventions and did record this in the patient's records.

Some patients were unable to consent and make decisions about their care and treatment due to health conditions such as dementia. In these cases, staff have to follow the legal requirements of the Mental Capacity Act 2005. Staff understood how to assess whether a patient had the capacity to make decisions about their care. However, this assessment was not always completed in a timely and responsive manner.

We reviewed the records of four patients whose records evidenced they displayed significant signs of confusion that could impact their ability to make decisions about their care and treatment. Two of these records evidenced that appropriate mental capacity assessments and best interest decisions had been completed in line with the requirements of the Mental Capacity Act 2005.

However, mental capacity assessments were not always completed as required. Two of the four care records we reviewed did not contain the required mental capacity assessments or best interest decisions. On ward one, one patient's records showed the plan was for them to be moved to a community assessment bed for older people with mental health needs. This patient had an urgent Deprivation of Liberty Safeguards (DoLS) application in place that meant they were being deprived of their liberty on the ward in order to keep them safe. DoLS only apply to people who do not have capacity to make decisions about their care and treatment. Despite this application being in place their care records contained no evidence to show that a mental capacity assessment had taken place to enable the DoLS application to be made. There was also no evidence of a mental capacity assessment or best interest decision around the plan to discharge to a community in patient bed.

On ward 15 we saw that a patient was being nursed on a specialist bed that could be lowered to floor level to mitigate their risk of falling. This patient's care records showed they were confused and agitated at times. No mental capacity assessment had been completed to identify if this intervention was in their best interests. Staff on both wards confirmed that mental capacity assessments should be completed for both of these patients and they informed us they would complete these as a priority.

We reviewed two DoLS applications and found them to be appropriate. The reasons behind the restrictions placed on patients was clearly recorded and staff were aware of who had a DoLS in place and the content of the DoLS. Managers monitored the use of DoLS Safeguards and ensured extensions were applied for if required.

Nursing staff received and kept up to date with training in the Mental Capacity Act and DoLS. Compliance rates for nursing staff training working on the wards we visited was 100%

Medical staff received training on the Mental Capacity Act 2005 and DoLS through the completion of consent training. Compliance rates for medical staff working in the areas we visited was 53.8%.

Is the service well-led?

Good ↑

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

Medical care (including older people's care)

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.

Managers had the right skills to perform their roles effectively. Managers and senior staff told us that management level training was provided to ensure their leadership skills continued to be developed and improved. Staff who aspired to become future leaders could access leadership training to help develop their skills. This ensured there was a proactive approach to succession planning.

Managers and senior staff displayed the qualities required for effective leadership. This included being approachable and accessible. Staff told us and we saw that managers and senior staff were visible in all the areas we visited. All the staff we spoke with told us they felt supported and valued by their managers.

Staff told us that board members including the chief executive were visible at the county site.

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.

The service contributed to the trust's five-year plan that set out its 2025 vision, objectives and priorities. This plan detailed each speciality's individual clinical strategies, including the medical division's specialities. We saw that this plan was in line with local sustainability and transformation partnerships (STPs) plans which are now known as integrated care systems (ICSs) and the aims of commissioners. This evidenced that senior leaders and managers worked effectively with the wider health economy.

Service leaders told us there was no current standalone medical division strategy in place. However, the service worked towards the trust's strategic objectives which were clearly defined and visible.

Staff evidenced they had an understanding of the trust's vision and values. The trust's values were; together, compassion, safe and improving. Staff told us these values had been agreed with staff involvement.

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. The service had an open culture where staff could raise concerns without fear.

We saw there was a positive open culture as staff spoke with the inspection team openly and honestly. Staff told us there was a no blame culture and they felt able to raise concerns with their managers and freedom to speak up guardians were accessible if required.

Staff morale in the areas we visited was particularly positive. Staff told us how the pandemic had bought their teams closer and they felt proud of the way they delivered care and treatment.

Systems were in place to recognise staff for displaying the trusts values. Staff could nominate their colleagues under the values recognition scheme. We also saw that staff were nominated for external awards by their colleague. For example, the ward manager on ward 15 had successfully nominated a nurse for a Daisy Award. The Daisy Award is an award given by the daisy foundation to nurses who display exemplary compassionate nursing care to their patients and their families.

Staff we spoke with did not report any concerns regarding equality and diversity. An equality and diversity policy was in place. This set out the processes in place to ensure the trust met equality and diversity legislation.

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.

Cross site monthly medical divisional governance meetings were held. A cross site approach facilitated shared problem solving and learning. Minutes of these meetings showed effective governance and oversight. This included effective discussion and oversight of; incidents, policies, procedures and patient information. For example, minutes of these meetings showed how managers had learned of incidents of missed Covid 19 swabs and had put an effective system in place to support staff to obtain and easily record when swabs were taken and when they were due. This new process had gone through the divisions governance system and was being audited to ensure it's effectiveness continued.

The medical division's governance meetings linked into the quality assurance committee and audit committee that met regularly to discuss quality, safety and performance issues. These committees understood their role in monitoring quality, safety and performance within the service. These committees reported directly to the board to ensure they had a regular overview of quality, safety and performance relating to all services at the trust, including medical care. Board reports showed that these committees effectively updated the board on quality and safety issues. For example, the August 2021 board papers showed that the quality assurance committee had escalated and was managing some training compliance gaps for medical staff. Training gaps highlighted in these papers did not included the training gaps we identified. However, these papers preceded our inspection so different compliance rates would have shown at that time.

Management of risk, issues and performance

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

We found that most risks were appropriately identified and managed. For example, medicines storage on AMU had been placed onto the risk register and appropriate mitigation plans were in place whilst a long-term solution to address the risk was in progress. However, we found that the risks relating to the limited speech and language therapy provision at the county site was not on the medical divisions risk register. The trust's risk register showed this risk had been considered for the specialised services division and mitigation plans were in place. However, we could not be assured that the risk to the patients on the wards we visited was being appropriately assessed, monitored and mitigated as this risk was not recorded.

Identified organisational and patient safety risks were recorded on the service's risk register. Each risk was assigned a risk score and level based on its severity and review dates were set and met. Minutes of governance meetings evidenced that the risk register was discussed on a regular basis which showed there was senior management and board level oversight and management of risk.

Mortality and morbidity reviews were regularly completed to review and learn from deaths, incidents of sepsis and other adverse incidents. Minutes of these reviews clearly stated learning actions, including who was responsible for sharing this learning.

A monthly quality performance report was produced. Items covered included; complaints, friends and family test data, sepsis screening compliance and duty of candour. Senior leaders told us this provided key information to enable them to have effective oversight of quality and safety within the division.

Managers told us that staff performance issues were addressed in line with the trust's performance and disciplinary policies and procedures. This included where necessary suspending staff and making referral to professional bodies, such as the Nursing and Midwifery Council.

Information Management

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

The trust's website assisted patients and visitors to familiarise themselves with the services offered at County Hospital and what to expect during an admission.

Information technology systems were used to monitor and improve patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.

Service performance measures were reported and monitored. Manager's and senior staff had access to these reports and service performance information was displayed on boards within the service so that staff and visitors could see at a glance how well the service was performing.

The service shared data securely with us and other agencies in accordance with legislation. For example, serious reportable incidents were reported to us and the National Reporting and Learning System (NRLS) as required.

The service did not have a dedicated integrated electronic records system. Despite this, staff told us information was shared effectively between departments and services through verbal handovers and through the sharing of paper based medical records which could be promptly requested and accessed.

The trust had a business continuity plan which provided guidance on maintaining services and dealing with business interruptions which might disable services or require special arrangements to be put in place to allow them to continue, for example a cyber-attack.

Engagement

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

The chief executive engaged well with staff. Staff told us that they received regular updates from them and they spoke positively about these updates.

Patients and their families were given the opportunity to be involved in the planning, development, delivery and monitoring of the services provided. This included opportunities to; volunteer, share patient stories and join the patient information ratification group.

The service worked effectively with other local organisations within the integrated care system. This included; other hospital trusts, Clinical Commissioning Groups (CCGs), local authorities and Healthwatch. For example, local general practitioners (GPs) were invited to join the AMU teaching sessions to facilitate and support their learning.

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.

Medical staff in the division were actively involved in research and their work was published in professional journals. Examples of published research for 2021 included, 'Feedback on Video consultation for the management of Parkinson's disease during the COVID-19 pandemic' and, 'The Changing Façade of Medical Education' which were both published in the Geriatric Medicine Journal and.

Staff at all levels were encouraged to think creatively and take ownership for improving patient care using quality improvement methods. We saw multiple examples of this, including; medical staff designing and implementing an out of hours handover sheet and a discharge coordinator who devised a method to track patient records on their ward.

Systems were in place to ensure the quality of care was continually assessed and monitored so improvements could be made. The care excellence framework awards (CEFA) was a trust wide uniform approach to monitoring quality standards of patient care within the clinical environment. The framework was based on CQC's key lines of enquiries. The aim of the CEFA was for departments to sustain and continually improve their CEFA status with the ultimate goal of achieving and maintaining a platinum status. At the time of our inspection, ward one was awarded silver and ward 15 had been awarded gold. AMU's award was not on display at the time of the inspection.