The Rotherham NHS Foundation 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?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires Improvement**

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

The leadership of the trust had significantly improved since our last inspection in 2018 but this was not yet enough to make an impact on the rating. Staff including the trust chair, who we interviewed at the last inspection, were overall very positive about the changes in leadership. Members of the board articulated they felt much more enabled, supported, listened to and empowered to undertake their roles than previously.

The leadership team led by the new CEO and chair had identified that the trust needed to develop their own plans to improve the people of Rotherham's experience of services and this was a message we heard consistently throughout our inspection.

The trust had recognised that there was a need, because of the changes within the healthcare system, the impact of COVID-19 and the changes in the trust itself over recent years, to update and refresh the vision and strategy and hoped to take this to board in September 2021. The CEO articulated a clear vision of what the trust wanted to achieve. A new strategy was being developed with input from the wider system and local staff about how this was going to be achieved.

It was recognised by the board there had been challenges regarding the trust's organisational culture over the last few years. To address this, targeted and focused work had been undertaken with the board and executive team, including input from facilitators to identify issues to establish open and honest strong working relationships.

The trust had made good progress in strengthening its operational financial management and governance arrangements but there was further work needed to understand the scale of any underlying deficit supported by a credible analysis of the key drivers.

Whilst the improvements in leadership and culture were evident since our previous inspection, the trust recognised more work needed to be done to embed service improvements and for these changes to be reflected in positive patient outcomes.

Our findings

When inspecting the core services at the trust we saw that some of the changes that had happened at a senior level in the organisation had not yet become embedded at ward/department level. There continued to be a slow progress in some areas against our previous inspection findings particularly in urgent and emergency care and medicine. All divisions had a triumvirate management team in place, however, not all posts were fully recruited to support this. Additional posts had only very recently been recruited to, such as quality improvement matrons and the deputy director of quality assurance.

The trust promoted equality and diversity in daily work and mainly provided opportunities for career development. However, the trust currently had no formal staff networks.

The aim of the trust was to work within the system and create partnerships with the local community as well as accessing NHS support to establish the trust as a supportive, diverse and inclusive employer for all the Rotherham community.

A significant level work had been done within the trust to improve the governance. Several initiatives had been put in place to improve governance at the trust. Including 'Safe and Sound', 'Perfect Ward' and the employment of quality improvement matrons.

The arrangements for some areas of governance were very new and at the time of the inspection it was not possible to fully evidence their effectiveness and the impact these changes would have. In some core services not all staff were clear about their roles and accountabilities and processes were not always completed in a timely manner. However, plans had been put in place to create the conditions and structures for effective governance in the trust.

Medicines optimisation within the trust required further development. The trust medicines optimisation strategy was out of date and had not been reviewed or renewed from April 2020. The trust did not have a pharmacy business plan, workforce plan or strategy specific to the pharmacy team. Medicines reconciliation rates within 24 hours consistently fell below the national average. There was no seven-day clinical pharmacy service. Multidisciplinary attendance at key medicines committees was not always in place with two out of the last four meetings not meeting quoracy.

Work was underway to embed the medicines safety officer role into trust governance processes. The controlled drug accountable officer role required further embedding and oversight to ensure that governance arrangements highlighted and took action on areas of concern found during the core service inspection. This was still an issue when we revisited during our well-led inspection.

We raised our concerns during our inspection and following the inspection, the trust provided an action plan which aimed to review medicines management, oversight, audit and governance processes within the trust.

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, systems to manage performance effectively were not always implemented.

In interviews with members of the Executive and Senior Leaders team people were all clear about the trust's risks and articulated a coherent consistent narrative. These included mortality, medical and nursing staffing and Child Adolescent Mental Health (CAMH) services.

Our findings

However, the performance dashboard used in core services were at a high level and did not focus on the detail of quality or highlight specific concerns about patient care. Also, we were not assured in all core services that senior leaders had enough oversight of performance targets which could have a negative impact on patients' care and experience of services.

Information and data overall were well managed across the trust. New systems had been developed to improve patient outcomes such as 'Perfect Ward', these were introduced in a phased way and learning taken at each stage to improve the system. However, we did see instances on wards and departments where patient information was not stored securely.

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

The trust provided evidence of continued engagement with patient groups despite the pandemic and acted on their feedback.

The trust were committed to continually learning and improving services. Quality improvement methods had been introduced and staff understood the skills needed to use them, but these improvements were not fully embedded in all areas at the time of the inspection.

Outstanding practice

We found the following outstanding practice,

Trust-wide:

- The trust had also custom designed an integrated discharge team where health and social care colleagues came together in co-located teams in the clinical operations hub. There was real vision and ambition being driven by staff involved. The team won an HSJ award for "Innovations around integrated working in health and social care".

In Medical Care:

- The service had a custom designed integrated discharge team where health and social care colleagues came together in co-located teams in the clinical operations hub. There was real vision and ambition being driven by staff involved. The team won an HSJ award for "Innovations around integrated working in health and social care".

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Trust-wide:

Action the trust MUST take to improve:

Our findings

- The trust must strengthen oversight and governance arrangements to support effective medicines optimisation.
- The trust must strengthen the oversight of divisional and ward to board governance.

Action the trust SHOULD take to improve:

- The trust should continue with the development of formal staff networks.
- The trust should continue to work with the system and create partnerships with the local community as well as accessing NHS support to establish the trust as a supportive, diverse and inclusive employer for all the Rotherham community.

Urgent and Emergency Care :

Action the trust MUST take to improve:

- The service must ensure that systems and processes must be established and operated effectively to safeguard patients'. (Regulations 13 (2)).
- The service must ensure systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. (Regulation 13 (3)).
- The service must ensure that care or treatment for service users must not be provided in a way that includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. (Regulation 13 (4) (b)).
- The service must ensure that a service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. (Regulation 13 (5)).
- The service must ensure that governance arrangements are in place so that persons authorised to practice under a PGD are recorded. (Regulation 17(2)(d)).
- The service must ensure that controlled drug registers are completed in line with legal requirements (Regulation 17(2)(d)).
- The service must ensure that there is a clear prescribing audit trail for the supply of over labelled take home medicines (Regulation 12(2)(g)).
- The service must develop systems to allow for the assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. (Regulation 12 (2) (h)).
- The service must ensure that all premises and equipment are clean, secure, suitable for the purpose for which they are being used, properly used and properly maintained. (Regulation 15 (1) (a) (b) (c) (d) (e)).
- The service must ensure that it is effectively assessing the risks to the health and safety of service users of receiving the care or treatment. (Regulation 12 (2) (a)).
- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2) (c)).
- The service must ensure that the nutritional and hydration needs of service users are met. (Regulation 14 (1)).
- The service must ensure that care and treatment of service users must only be provided with the consent of the relevant person. (Regulation 11 (1)).

Our findings

- The service must ensure that the care and treatment of service users must be appropriate, meet their needs and reflect their preferences. (Regulation 9 (1) (a) (b) (c)).
- The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in line with national guidance. (Regulation 18 (1)).
- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Regulation 18 (1), (2) (a) (b)).
- The service must ensure that systems or processes are established and operated effectively. (Regulation (17) (1)).
- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (Regulation (17) (2) (a)).
- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (Regulation (17) (2) (b)).
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulation (17) (2) (c)).

Action the trust SHOULD take to improve:

- The service should consider increasing mandatory training to include awareness of learning disabilities and autism.
- The service should consider increasing their participation in a full programme of external and internal audits.
- The service should consider increasing the profile of learning from incidents within team meetings.
- The service should consider increasing the health promotion given to patients' by staff.
- The service should seek to improve the application of referral pathways to ensure consistency in patients' receiving same day care.
- The service should consider how to utilise adaptations for patients' with dementia within the department.
- The service should continue with work on improving access and flow.
- The service should consider displaying complaint information in all patient areas of the department.
- The service should fully embed its patient engagement plan as soon as is practical.
- The service should continue with its programme of innovation.

Medical Care:

Action the trust MUST take to improve:

- The trust must ensure that nursing staff receive a regular appraisal in line with trust policy. Regulation 18(2)(a)
- The trust must ensure governance systems for responding to incidents are effective. Regulation 17(2)(f)
- The trust must ensure that all staff working in medical care services are compliant with the safeguarding training relevant to their role. Regulation 18(2)(a)

Our findings

- The trust must ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced medical staff in line with best practice and national guidance taking into account patient's dependency levels. Regulation 18(1)
- The trust must ensure that audit systems and processes are robust and feed into the overall governance and assurance systems in place. Regulation 17(2)(a)
- The trust must ensure that when staff complete mental capacity and best interest decisions, they clearly document the assessment and decision making-making process. Regulation 12(2)(a)
- The trust must ensure that incident learning is appropriately acted upon and embedded to prevent similar incidents occurring in the future. Regulation 12(2)(b)
- The trust must ensure that patient records are contemporaneous, accurate and complete. Regulation 17(2)(c)
- The trust must ensure that risk assessments are reviewed and updated in line with the trust process. Regulation 12(2)(a)
- The trust must ensure that there is an appropriate system to easily identify patients' who have a DNACPR in place. Regulation 12(2)(b)
- The trust must ensure that patient files and curtains in bays comply with infection prevention and control guidelines. Regulation 15(1)(a)
- The trust must ensure that controlled drugs are managed and recorded in line with legislation. Regulation 12(2)(g)
- The trust must continue to make improvements and embed actions on the AMU and across medical wards in line with their action plan to safely care for and treat patients'.

Action the trust SHOULD take to improve:

- The trust should take the necessary action when medicine fridge temperature readings are outside the recommended range of 2 – 8 degrees Celsius.
- The trust should share learning from incidents throughout the trust to improve medicines safety.
- The trust should continue to improve the proportion of serious incidents with harm.
- The trust should continue to embed the ward-based audit system to identify improvements. These should link to specific actions which are monitored.
- The trust should work to improve opportunities for patients' to provide feedback about the service, such as friends and family test response rates or other appropriate mechanisms.

Maternity:

Action the trust MUST take to improve:

- The trust must ensure effective systems are in place to reduce outpatient waiting times and robust process are in place for continually measuring them. Regulation 17 (2)(a)
- The trust must ensure the environment of the antenatal day unit promotes the privacy and dignity of women. Regulation 10(2)(a).
- The trust must make sure systems are in place to manage medications, including those that are high risk and those for women to take home. Regulation 12 (2)(g).

Our findings

- The trust must ensure that all staff working under a PGD are authorised to do so. Regulation 17 (2)(a)

Action the trust SHOULD take to improve:

- The trust should consider reviewing their processes around the midwifery led unit to ensure choice of delivery is maintained for women.
- The trust should ensure appraisals are completed annually.

Children and Young People:

Action the trust MUST take to improve:

- The trust must ensure that routine safeguarding supervision is in place for consultant staff. Regulation 13(2)
- The trust must ensure that all medical equipment is appliance tested and serviced as per equipment specification. Regulation 15 (1)(e)
- The trust must ensure that daily checks of medicines fridges take place. When medicines fridge temperatures are outside of identified acceptable ranges this is escalated, and appropriate actions taken to ensure the fridge is working effectively. Regulation 12 (1)(2)(g)
- The trust must ensure that daily resuscitation trolley checks take place as identified within the trust resuscitation policy. Regulation 12 (1)(2)(g)
- The trust must ensure that the check lists on the neonatal unit are specific to the resuscitation equipment in use on the neonatal unit. Regulation 17 (2)(a)
- The trust must ensure that paediatric early warning scores are audited. Regulation 17 (2)(a)
- The trust must ensure that the service meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011) for qualified in speciality (QIS) nursing staff. Regulation 18 (1)
- The trust must ensure that the nurse in charge of the neonatal unit, is supernumerary in line with British Association of Perinatal Medicine (BAPM) Guidelines (2011). Regulation 18 (1)
- The trust must ensure the service meets the British Association of Perinatal Medicine (BAPM) Guidelines (2011) for medical staff. Regulation 18 (1)
- The trust must ensure they meet the medical staffing standards identified by the Royal College of Paediatrics and Child Health (RCPCH) Facing the Future standards. Regulation 18 (1)
- The trust must ensure that young people with mental health needs who may be admitted to the paediatric ward receive and are involved in agreeing their evidence-based care and treatment in line with their specific needs. Regulation 12(1)(2)(a)(b)
- The trust must ensure children and young persons' with mental health needs guidance includes individual responsibilities amongst the paediatric and CAMHS teams. Regulation 12(1)(2)(a)(b)
- The trust must ensure that transitional care for all young people is in place. Regulation 12 (1)(2)(i)
- The trust must ensure that training and psychological support is identified to support staff should the service continue to admit children and young people with mental health needs where there is a shortage of tier four beds. Regulation 12 (1)(2) (c)

Our findings

- The trust must ensure that all eligible staff complete neonatal and paediatric life support training so that staff maintain the necessary skills in these areas. (Regulation 12 (1) (2) (c)

Action the trust SHOULD take to improve:

- The trust should ensure that all clinical guidelines are in date and where there are out of date paper clinical guidelines that these are removed from clinical areas.
- The trust should ensure that the general safeguarding section in records is strengthened.
- The trust should ensure that staff can access a deteriorating baby, children's and young person's policy and procedure.
- The trust should ensure that pain audits specific to children and young people take place.
- The trust should ensure that all staff have their yearly appraisal.
- The trust should ensure that readmission rates within two days of discharge following emergency admission improves.
- The trust should ensure that safeguarding supervision episodes are recorded in the child or young person's records.
- The trust should ensure all staff know what action to take if they felt a parent did not have capacity to consent.
- The trust should remove the out of date guidelines from the folders on the neonatal unit.

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

Leadership

Senior leaders demonstrated the necessary experience, knowledge and capacity to lead effectively. They had identified their priorities and developed plans to manage these in an effective and timely way. However, there were some new appointments to the board and the plans they had developed had not yet had time to evidence their impact or sustainability. Executives were visible and approachable. They worked well as both an executive team and with leadership teams/team across the trust.

The chief executive (CEO) joined the trust in February 2020 on an interim, part time basis. The role included leading the trust as well as working in partnership with the integrated care system (ICS) in the region. The deputy chief executive also joined the trust in February 2020 and following an interim period was appointed substantively in November 2020. The medical director joined the trust in September 2018 as interim medical director, before being appointed to the substantive medical director role. The chief nurse joined the trust in October 2018 as interim chief nurse, before being appointed to the substantive chief nurse role. The chief operating officer (COO) joined the trust in April 2018. The finance director was an interim post, but a permanent appointment had been made recently. The trust had a joint director of workforce with another local NHS trust who joined the trust in April 2019.

Our findings

At our previous inspection in the Autumn of 2018 we reported 'that leaders did not lead effectively and there was a disconnect between department leaders, directorate leaders and executive leaders within the trust. Senior and executive leaders did not appear to be sufficiently aware of what was happening on the front line in the departments. Safety did not appear to be the top priority for leadership and senior leaders were not fully sighted on the lack of safety in some areas of the department".

At this inspection during interviews with staff and managers we explored what changes in senior leadership people had experienced since the last inspection. Staff were overall very positive about the changes in leadership; they articulated they felt much more enabled, supported, listened to and empowered to undertake their roles than previously. However, whilst positive changes had been made at board level there was more work for the trust to undertake to ensure directorates, divisions and core services demonstrated these values and this impacted on the care patients' received within the trust.

The chairman was appointed in 2017 and had worked with both the leadership team in 2018 and the current one. The chairman described a much-improved leadership team, with higher expectations of leaders across the trust to drive improvements. There had been a period of frustration for the trust that the overall goal to ensure the patients' of Rotherham received a more than average hospital service was not being achieved, with a seeming inability to drive improvement and sustain changes.

The new leadership team led by the current CEO and chair had identified that trust should not be driven by actions or concerns identified by the regulators but the trust needed to develop their own plans to improve so that the people of Rotherham experienced high quality services.

The level of professional challenge between the non-executive and executive team had been developed and improved over the past 16 months. There had been a focus on board development to ensure the board could work effectively together and support staff to feel valued and empowered. An example of this was where external facilitators spoke to the board individually. Any issues raised were discussed using a peer-to-peer approach, giving people the opportunity for confidential, open discussion and develop different ways of working. During our interviews we had positive feedback on how this had improved the working of the board. Staff we spoke with were complimentary about the visibility and accessibility of the leadership team.

The board were aware of the trust's priorities and challenges and had developed plans and strategies to address these with the aim to improve the quality of services. While improvements had been made, some were not yet embedded and there was limited assurance in areas of service delivery as to the impact of the changes made had had on service quality.

The staff survey completed in March 2021 showed several improvements, these included effective communication between managers and staff, senior managers involving staff in decision making and managers acting on staff feedback.

Communication and engagement with the board on medicines related topics required further embedding and oversight of services delivered and an opportunity for scrutiny. The Hospital Pharmacy Transformation Plan was out of date in April 2020 and had not yet been reviewed. The Pharmacy department had no clear work force plan. Previous workforce development had not resulted in the planned clinical pharmacy improvements and required further review. We raised this with the medical director during our inspection and following the inspection were provided with an action plan to address the concerns.

Our findings

Medicines management and safety issues in both medicine and urgent and emergency care core services were still an issue and had been identified at our previous inspection. Although work had been undertaken to address them, further work was needed to ensure improvements to practices and that these were sustainable and embedded.

The governors were aligned to the board and involved in various activities. The use of virtual technology during the pandemic had meant more opportunities to attend meetings. However, visiting restrictions had meant they were unable to visit patients' on wards as they had done prior to the pandemic. However, plans were being put in place to restart the visits when pandemic restrictions were completely lifted.

Operationally the trust was run through Divisions; Medicine, Surgery, Urgent and Emergency Care, Clinical Support Services, Family Health and Community. Each Division was led by a team made up of a divisional director, chief nurse and divisional general manager who were supported by matrons and service managers.

During our inspections we found that local leadership of the core services varied. There was a lack of progress in relation to the leadership of the emergency department and the medicine care group. Not all concerns identified within the Urgent and Emergency Care and Medicine Divisions had been addressed since our last inspection and there was a lack of timely actions to address these concerns going forwards.

Fit and Proper Persons Requirement (FPPR)

We found that the Fit and Proper Person Procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation.

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed 5 executive and non-executive director files in total. Our review included checks for the newest executive and non-executive appointments. All files included references and signatures saying copies of original documents such as degree certificates had been seen.

We also looked at the trust's Fit and Proper Person Procedure and spoke to the company secretary who was responsible for oversight and compliance with the FPPR procedure.

We reviewed the six-monthly self-declarations, made by the directors, to confirm that they remained fit and proper. We found these were completed consistently and in line with the trust's procedure.

The trust had recently improved the declaration of interests process to an electronic system (from 2020). This had made it easier to complete and had improved overall compliance.

Vision and Strategy

The trust had a current vision and a strategy, developed with relevant stakeholders for how they wanted to achieve this. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, in the core services we inspected staff were not always able to articulate their role, also there was a lack of a trust wide medicines strategy in place.

Our findings

The current trust vision and strategy Together We Can was a five-year strategy 2017 to 2022. However, the trust had recognised that there was a need, because of the changes within the healthcare system, the impact of Covid-19 and the changes in the trust itself over recent years to update and refresh the vision and strategy. A new strategy was being developed about how this was going to be achieved and the trust hoped to take this to board in September 2021.

The CEO articulated a clear vision of what the trust wanted to achieve: 'to be an outstanding trust delivering excellent care at home, in our community and in hospital. The mission was to improve the health and well-being of the population. The new strategy was supported by an operational plan which started to be developed in April 2021 and was based on six areas. This included: safely exiting the COVID-19 pandemic, empowering and enabling staff to deliver and a focus on the fundamentals of care with the primary focus being patients' and providing exceptional care.

There was a plan to ensure the proposed strategy would be consulted on. The six areas had been discussed at board and senior leadership team meetings. Staff engagement meetings had been held and feedback boxes located around the trust to gain a range of views about the proposed strategy.

The trust was taking steps to revise its vision and strategy by the end of September 2021. Within this there was a need to reflect the strategic financial situation and relevant actions needed to address the underlying deficit. The trust had yet to develop a financial strategy, supported by a long-term financial plan. The trust told us this was due to the suspension of national contracting arrangements, which was a key issue affecting all NHS organisations.

The trust had no systematic understanding of the factors which drive the costs of its clinical services. There was a need to develop and implement service line reporting and patient level costing to better understand the relationship between costs and income; and develop financial benchmarking capabilities to identify opportunities for improvement. The trust Finance and Performance Committee received regular reports on all areas that drive costs across the organisation, with the majority of costs being pay. The trust had established mechanisms for control and monitoring of pay.

It was envisaged that once agreed, the overall vision and strategy would be reflected in the core service and divisional service plans.

The core services we inspected had a clear vision statement based on the current strategy and the trust had developed objectives and divisional workforce plans which linked to the vision which senior leaders on the whole could articulate. However, measures used to monitor progress did not always link to patient outcomes or improvements. Also, not all staff could describe what the vision and strategy was for the service nor could they articulate how their role contributed to the strategy.

From our interviews with executives, non-executives and senior managers they could clearly articulate, what the priorities for the organisation were.

The trust had a number of strategies that were aligned to the overall existing strategy which would be carried forward including an estates strategy and a financial strategy. There was an emphasis on the importance of integrated services throughout the region and the involvement of the ICS.

The trust had strategies in place for meeting the needs of patients' with a mental health, learning disability, and a dementia diagnosis. We recognised that there had been improvements in supporting patients' with a mental health diagnosis within the trust, however further improvements needed to continue particularly in the emergency department.

Our findings

The trust had plans to increase elective activity as part of their COVID-19 recovery program. The estate strategy was well aligned with this to ensure the trust environment would meet the needs of an increased surgical service with minimal impact to other services.

There was a lack of a trust wide medicines optimisation strategy. In addition, the current Hospital Pharmacy Transformation Plan expired in April 2020, there was also no pharmacy business plan, work force plan or strategy.

Although key medicines roles were assigned, for example lead clinical pharmacy roles for divisions, medicines safety officer and controlled drug accountable officer, there was a lack of direction, role responsibilities and supervision to ensure staff worked within their role and provided the suitable oversight and leadership.

Culture

In the core services we inspected, we found that the culture was positive in all areas apart from the emergency department. Overall staff felt respected, supported and valued. Staff spoke about the improvements in morale. Staff were focused on the needs of patients' receiving care despite the challenges in services. The trust was working towards an open culture where patients', their families and staff could raise concerns without fear.

The current CEO had recognised that there were challenges regarding the trust's organisational culture when they joined the trust. To address this, targeted and focused work had been undertaken with the board, including input from facilitators to identify issues to establish open, honest and strong working relationships.

During interviews with the board and executive team we were told about improved relationships between members of the senior team who were now working together with the shared aim of improving patient care and experience.

The most recent staff survey feedback (from 2021) had improved significantly since the last survey. The results showed staff thought the trust was good, or better than similar trust's for:

Morale

Team working

Equality Diversity and Inclusion

Immediate managers

Safe environment - bullying and harassment

Safe environment - violence

We found staff morale to be generally good in the core services we inspected except for urgent and emergency care core service. Staff supported each other well and there was good teamwork. We observed good rapport between staff of different professions, and teams we spoke with were proud of the services they provided and the work they had done during the COVID-19 pandemic to care for patients'.

Our findings

However, the internal staff survey results for urgent and emergency care showed that team working was beneath the trust average. Also, staff survey results from the previous two years in emergency department reported that morale within the service was beneath the trust average. There was acknowledgement from senior managers in the department regarding the negative responses in the staff survey. Despite this being a longstanding issue, we found there were no action plans in place to address the issues highlighted.

The trust showed a clear commitment to the health and well-being of staff during the COVID-19 pandemic with a range of resources available to staff. They introduced areas where staff could take 'time out' and psychology services were made available to staff if needed.

When asked about well-being, the 2020 staff survey results showed positive responses about how the organisation acted on health and well-being. A garden, external gym and woodland walk were being created for staff, patients' and their families to enjoy and were very close to being completed at the time of the inspection.

Most staff told us that there was an open culture and they felt able to raise concerns with managers and or the Freedom to Speak Up Guardian (FTSUG). The FTSUG and champions, both clinical and non-clinical were available to staff across the trust and could be accessed either by email, phone or the application available through the trust's website. The FTSUG was part of the trust's campaign to support safety for patients and staff well-being. They would follow up concerns that had been raised by making time to revisit staff after a period to assure themselves they were satisfied with the outcome and changes made had been sustained and embedded. For example, they described an issue from a couple of years before regarding non-invasive ventilation where changes to practice had been needed. As a result of the pandemic and the increase in non-invasive ventilation the FTSUG followed this up to ensure the changes that had been made were still happening. They described that staff felt very supported by this.

The trust had reviewed its FTSUG strategy in March 2021 with the focus of the strategy was for the FTSUG and champions to work with department heads to address concerns. The Lead FTSUG attended regional network meetings to share learning with other NHS trust's in addition reports and any recommendations were presented to board.

The guardian for safe working (GFSW) team supported junior doctors in their role and facilitated meetings to discuss support and concerns with good representation from all relevant areas in the hospital. The pandemic had meant that more meetings were able to be attended via a virtual platform rather than needing to take time out of busy work schedules to travel to face to face meetings. The divisional BMA Representative, foundation training programme director, director of medical education and medical director would attend meetings.. The main topics for discussions included problems with rotas, staffing and day-to-day work, with the majority being raised by the division of Medicine and Care of the Elderly.

The GFSW reported to board on a quarterly basis. They had identified themes, with most exception reports referred to excessive hours and lack of rest periods. For example, the July 2020 report stated all doctors were working hours in excess of the 2016 contract for the foreseeable future and new work schedules were in force. The GFSW requested the board to help ensure adequate support with facilities, accommodation and appropriate recompense once the current emergency had passed.

Action to address junior doctor fatigue during the pandemic had been recognised and included, rotas adapted, and non COVID-19 work decreased to ease pressures. Finances had been made available with the bulk of this money spent on renovating a room for staff to use for time out, a new TV and improving quality of life in general for the teams, for example sleep pods.

Our findings

Inclusion and Diversity

The trust promoted equality and diversity in daily work and mainly provided opportunities for career development. However, the trust currently had limited formal staff networks and they had recognised the need to address this.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trust's in April 2015. Trust's were required to show progress against nine measures of equality in the workforce.

The WRES report of September 2020 showed the percentage of Black Minority Ethnic (BME) staff in the trust's overall workforce had increased from 7.7% to 8.4%. There had been improvements in board diversity, and in the capture of data around board diversity. The proportion of BME staff varied significantly across different areas of the trust's workforce.

Within the non-medical, non-clinical workforce (which was primarily made up of corporate staff, administrative staff and estates and facilities staff) there had been a small increase in the proportion of BME staff, from 3.2% to 3.7%, however there was a decrease in BME VSM (Very Senior Managers) within this workforce group from 4 to 2.

The non-medical clinical workforce had seen a small decrease in white staff, and a small increase in BME staff, and the proportion of BME staff within that workforce group had increased from 5.1% to 5.4%. Within the non-medical clinical workforce, 5% of staff at Bands 8a-9 were BME.

The trust's medical workforce was significantly more diverse than the rest of the workforce. The proportion of the trust's medical workforce who were BME had increased from 44.5% to 46.5%, and 54.8% of consultants were BME.

Whilst this data was not a WRES indicator, it has been noted that the proportion of job applicants for non-medical roles who are BME had increased slightly, from 16.8% to 17.4%, however the proportion of shortlisted applicants who are BME had fallen slightly, from 13% to 11.9%. In relation to indicator 2, BME applicants continued to be slightly more likely to be appointed once shortlisted than white applicants.

Workforce data suggested that retention was higher amongst BME colleagues than amongst white colleagues, and this supported a continued growth in the proportion of trust colleagues who were BME, despite a slight decline in the proportion of new starters who were BME from 16% to 15.7%.

BME staff continued to be equally as likely to access non-mandatory Continual Professional Development (CPD) as white staff. BME staff remained less likely than white staff to enter the formal disciplinary process, although the gap had narrowed slightly. However, staff survey data continued to show BME staff had a worse experience of working at the trust than white staff, and indicators all showed a widening of this gap. BME staff were more than three times as likely as white staff to report (via Staff Survey) they had experienced discrimination at work from managers, team leaders or other colleagues in the last 12 months. The data showed improvements in experience for white staff, but a worsening of experience for BME colleagues.

The WRES report and action plan was due to be submitted to NHS England/Improvement by the end of August 2021 with the data and narrative report informing action planning. The 2021 WRES data showed improvements in the staff survey-based metrics. The responsibility for producing, approving and monitoring the action plan sat with the trust board, but

the action plan was to be co-produced with members of the BME staff network and other colleagues and shared with the People Committee. The aim was for the trust to work with the system and create partnerships with the local community as well as accessing NHS support to establish TRFT as a supportive, diverse and inclusive employer for all the Rotherham community. .

However, the trust currently had limited formal staff networks. The trust recognised the need to address this to meet its overall aim. Senior members of the trust's HR team had begun shaping this work and were engaging with the regional equality & diversity steering group to inform the development of this work within the trust.

As well as identifying good practice opportunities to define and promote the wider diversity and inclusion agenda, there was a reference to networks. The trust's diversity and inclusion work plan concentrated priorities in the areas of:

BAME (including Eastern European)

LGBT+

Disability

The trust launched a campaign in July 2020 aimed at encouraging staff, patients' and visitors to challenge and report instances of discriminatory behaviour and language on sites called 'Call it out, work it out'. Reports could be made anonymously using the trust website.

This was originally thought up by the BME (Black, Minority, Ethnic) staff network. It worked alongside the existing initiatives Safe and Sound and Freedom to Speak Up and was not just related to BME issues but to anyone experiencing discrimination.

Interpreter services were available face to face and through a telephone system. There were hearing loops available for those identified with hearing impairments. Interpreters trained in basic sign language could be sourced in the trust.

The trust had commissioned an external company to review accessibility of all clinical areas in the main hospital and produce accessibility guides. However, production of the accessibility guides had been delayed due to the COVID-19 pandemic.

The trust had a Disability Staff Network who started to work in partnership with the estates and facilities team in 2021. They were working to identify parts of the trust estate where there were accessibility issues and to resolve them. This took place as part of a career development programme for staff living with a disability.

Patient information leaflets could be sourced according to individual need in alternate formats. Details of how to source them was included on the back of patient leaflets accessed at the hospitals or via the trust's website or social media sites.

Governance

The arrangements for some areas of governance were very new and at the time of the inspection it was not possible to fully evidence their effectiveness. In some core services not all staff were clear about their roles and accountabilities and processes were not always completed in a timely manner. However, plans had been put in place to create the conditions and structures for effective governance in the trust.

Our findings

A significant level of work had been done within the trust to improve the governance. Several initiatives had been put in place to improve governance including ‘Safe and Sound’, 'Perfect Ward' audits and the employment of quality improvement matrons.

The Safe and Sound quality initiative was launched in the trust's operational plan of 2019/2020 and stated:

‘Our focus is to put quality at the heart of all that we do, improve colleague engagement and provide more timely access to emergency care. Your feedback about our effectiveness is important to us and I encourage you to share your views and ideas with us about how we can improve our services.’

Governance improvements were also part of the 2019/20 operational plan:

Have an effective performance framework to help deliver outstanding results

Be outstanding on the CQC ‘well-led’ framework across the trust

Have high quality data to provide robust information and support decision making

Ensure all teams have regular reviews and updates around key issues and opportunities to learn

Quality Improvement Matrons had been in post for less than three months at the time of the inspection and had five governance workstreams priorities:

Falls

Pressure ulcers

The deteriorating patient

Medication safety

Admissions and discharges.

Therefore, it was too early to see how these roles would impact on improvements for patient care and experience and the effectiveness of governance within the core services.

Perfect Ward audits were newly implemented across most medical wards including the acute medical unit (AMU). The tool was interactive and allowed for monitoring of issues across wards from audit to audit. This was new to the trust and had not yet to be rolled out across the trust and not embedded in all areas where it had.

Some of the of the quality and governance target dates set by the trust had not been achieved as a result of the pandemic.

Our findings

There had been step change improvements due to the trust implementing the 60-point financial governance improvement action plan, although for the completed actions it was not always evidenced that the actions had translated into the desired improvement outcomes, nor that they were yet fully embedded. The trust needed to undertake further work to ensure the action plan was completed and that the intended improvement outcomes had been achieved, sustained and embedded throughout the trust.

We reviewed a sample of serious incident reports, during the inspection, that included both initial reports (72-hour reviews) and completed investigations. The trust reported incidents on an electronic system and followed a root cause analysis (RCA) approach. In the sample we reviewed, we found the quality of reports was good and followed trust policy. They included detailed information and actions were identified however, serious incidents action plans were not always robust and did not always address the recommendations in enough detail. Actions were not given clear measures when the action plan was developed but were recorded after the report. This meant that actions taken to make improvements may not address the recommendation or learning identified in the report. The trust had done work to improve the quality and timeliness of reports.

Of the serious incidents reviewed, we found that duty of candour had been applied appropriately. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person). Timescales in most cases were met, and where there was a delay this was explained to patients and families. Staff told us managers supported staff after any serious incident and provided counselling where necessary.

Effective governance processes were not always in place in the core services we inspected to support service performance and recognise patient safety, patient experience and clinical effectiveness concerns/issues. There were gaps in governance framework, governance meetings were not always quorate, and actions were not always measurable. We found through our core service inspection it was unclear how ward to board governance was in operation for all services and divisions. We saw examples within medicine management and urgent and emergency care services of this.

Through some of the core service inspection we saw that there were different methods to share information from meetings with all staff. For example, the trust's Organisational Learning and Action Forum (OLAF) gave opportunity for divisional leaders to meet and discuss themes and trends across the divisions, share patient stories and innovations or changes made. Staff on the wards and in departments were not always aware of these methods and told us that they had no additional time to consider, implement and evaluate governance processes and sometimes felt disconnected.

In the emergency department there was no evidence found to support that senior leaders had an oversight and understanding of the specific challenges within the department. We saw evidence that issues had been repeatedly identified and escalated but action was not always taken to address them by senior leaders.

Although governance processes could be described clear lines of accountability were not in place to promote safe medicines optimisation. As part of the trust's action plan following the inspection a governance review was planned to ensure that robust processes were in place to enable identification, management and escalation of risks associated with medicines management.

Relevant guidelines and proposals relating to medicines optimisation were presented to the appropriate multidisciplinary group for review. However, both Rotherham Medicines Optimisation Group and the trust's medicines safety group's terms of reference were under review to encourage quoracy at the meetings.

Our findings

Key performance indicators (KPIs) showed medicines reconciliation figures were consistently under the national average with figures provided showing for April 2021 64.7% and May 2021 58.3% which is below the KPI of greater than 70%. There was no clear plan on how this could be addressed.

Compliance with turnaround times for prescriptions dispensed were less than 100 minutes on average. However, the trust's KPI was set at less than 120 minutes which was set higher than the national average turnaround time of 100 minutes.

Controlled drugs (CD) recording had been identified as a risk and a trust wide alert was issued in February 2021. We were told that the impact of this was being monitored through auditing however we found continued recording errors and significant amounts of CD errors during our inspection.

Patient Group Directions (PGDs) (a system for enabling medicines to be given without the patients having to be seen by a prescriber under pre-defined circumstances) had been reviewed and updated but had not been implemented effectively in some wards/departments. Compliance for medicines management training was 84.4% overall in divisions.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact in most areas and they had plans to cope with unexpected events. However, this did not happen in all areas and systems to manage performance effectively were not always implemented.

In interviews with members of the Executive and Senior Leaders' teams they were clear about the trust's risks and articulated a coherent consistent narrative. These included mortality, medical and nursing staffing and Child Adolescent Mental Health (CAMH) services.

In January 2021 the trust's internal auditors looked at how the Trust was managing risk according to the trust's policy and was scoring risk appropriately. The report produced was overall positive giving the executive team significant assurance. The auditors concluded that risk was being managed effectively and made minor recommendations.

Risks scorings 15 and above were discussed and approved at Risk Management Committee with the input of the Risk Analysis Group (RAG).

Risk Management Committee (RMC) was chaired by the chief nurse (CN) with two executive directors attending to achieve quoracy. The minutes of the meeting showed that the medical director (MD) and director of finance (DOF) would often attend to facilitate strategic and escalate any national issues, e.g. CAMHS issues.

The RMC and RAG agreed when risks were to be closed or the risk score was reduced. Some risks, e.g. mortality, had their own action plan to more closely monitor if actions identified were having a positive impact and if not re-evaluating mitigation.

Risk management training undertaken by the trust was currently e-learning, with 83.65% of all 8as or equivalent and above trained in risk management. The trust was looking to return to face to face training as soon a pandemic restriction allowed.

In the core services we inspected there was a good understanding of the trust's risk management processes and risk registers were regularly updated.

Our findings

The CEO and Executive team had focused on areas of performance that the trust had historically struggled with such as mortality. A new system to monitor performance regarding mortality had been introduced and the medical examiner role had been fully recruited to however at the time of the inspection was not yet fully operational.

Performance was managed through divisional performance meetings attended by members of the executive team. The divisions would present their key issues and performance data. The trust had worked hard to improve assurance on divisional performance. A standing agenda had been introduced to divisional performance meetings to mirror clinical governance committee meetings.

To improve sharing of any learning across the divisions, staff attending the performance meetings would then use the trust OLAF system.

Harm free care performance reporting had been suspended due to the pandemic. However, the MD and CN continued to hold weekly Harm Free Care meetings where any quality of care issues were discussed, and actions taken where required.

Each division had a performance meeting where quality, safety, performance was discussed. These meetings fed into the divisional board who looked at areas of concern and escalated them as appropriate.

Performance dashboards were used to measure performance improvement, rank against benchmarks, identify improvements in metrics and trendlines for the previous four and 12 months to monitor performance. They gave opportunity for narrative comments as well as data trends, graph imaging and RAG ratings based on targets.

However, the performance dashboard in the medical division was at too high a level and did not focus on the detail of quality, state progress against the warning notice issued in November 2020 or highlight specific concerns about patient care.

Also, we were not assured in the emergency department that senior leaders had enough oversight of performance targets; whilst the department were above average in some areas, there were significant issues especially around total time in department, time to initial assessment and time to see a clinician. We saw no action plans to address performance issues. We were also concerned about the lack of oversight of the waiting room and systems in place to monitor patients' who were sometimes sat in there for significant periods of time.

The trust was reviewing the reporting process for the medicine's safety officer with a potential move to a more corporate role, this was to enable greater oversight and actions to learn from medicines incidents. Although learning from incidents was shared and communicated further work was needed to ensure this was embedded and actions sustained to prevent further incidents of the same nature.

Prior to the inspection medicines audits had not been undertaken robustly. As part of the trust's action plan following the inspection medicines administration and management audits had been actioned with the trust showing 100% compliance in 18 areas and 87.5% compliance in 3 areas. With further development of the medicines audit process into the Perfect Ward app to ensure visibility of results at all levels. Further work was in development for clinical medicines audits and oversight.

The pharmacy risk register was reviewed as part of the medicine's safety group.

Information Management

Our findings

The trust collected reliable data. The data they needed was in easily accessible formats, to understand performance, and make decisions and improvements. However, this was not fully utilised in all core services.

Information systems were integrated and secure, however staff did not always follow the appropriate information governance requirements. Data and or notifications were consistently submitted to external organisations as required

Information management systems were used effectively to support patient care and for audit purposes to monitor quality. Managers used information to manage the performance in most divisions and against local and national indicators.

There was a new ward audit programme put in place by the trust in April 2021 across all divisions called 'Perfect Ward'. This gave managers real time audit, quality assurance and staffing information. The information was sent to the CN daily to be discussed with members of the senior team with responsibilities for risk and quality. Ward managers and matrons in most divisions/wards told us they felt they got the information they needed to make decisions, escalate issues and make improvements to improve patient experience.

However, in the emergency department staff we spoke with were not able to articulate how they analysed data to make service improvements.

Centrally there was a command centre, where real-time dynamic data could be viewed. Staff could monitor patient numbers in the emergency departments and capacity in other areas of the hospitals. The system had software that predicted the likely numbers of patients; this assisted with planning including staffing requirements. The command centre was opening in April 2021, replacing the previous site management room.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the medical wards. In the emergency department we saw from departmental audits that there were ongoing issues with computer security and staff not securing patient data. We did not see any ongoing processes to improve overall data security.

Since the last inspection in 2018 the trust had implemented trust wide electronic prescribing, this had been successfully rolled out and was embedded within all areas of the trust.

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 system working across the South Yorkshire ICS was emphasised through many executive interviews. The trust's future engagement strategy was in development for 2021-2023 and had not yet been ratified by the board. The plan had suggested timescales to meet the aims and objectives of the strategy.

Our findings

During 2020/2021 the trust had focused on improving engagement across the trust. These initiatives included improving trust policies about linking them with Equality Impact Assessments (EIA). The head of equality and diversity and the engagement and inclusion lead had led on reviewing documents and supporting authors to engage with relevant, patient, public and third sectors to ensure they were relevant to all.

The trust had redesigned its friends and family test (FFT) questionnaire in late 2020 to enhance its ability to collect and analyse patient satisfaction data by protected characteristics. The data would then be used to support service improvement.

The trust had recommenced friends and family test (FFT) in divisions, which had been suspended during the pandemic, in February 2021 to gain feedback about services. However, response rates were low, and we did not see any specific plans to improve this across all divisions.

In July 2020, the trust launched a scheme called 'call it out, work it out' which supported patients, visitors and staff to challenge and report instances of any discriminatory behaviour either anonymously, or give their details so they could receive feedback. An example we were given of how this had worked was where a group of staff whose office was in the town centre had been racially abused when leaving their office at specific times. This had been reported and measures were put in place to address this successfully.

The NHS Rainbow Badge scheme which coincided with trust LGBT + awareness training was launched. The badge was designed to show LGBT+ patients', visitors and staff that the wearer is a safe person to discuss any LGBT+ issues with. Training had been delivered to over 100 staff at the time of the inspection. The scheme had been promoted to the local community on the trust website and local press as well as at Rotherham (virtual) Pride.

The trust provided evidence of continued patient engagement with patient groups despite the pandemic, for example engagement with the local deaf community, children and young people's diabetic transition services, young parent and carer forum and acting on their feedback.

However, staff told us that engagement with some external groups was limited because of the COVID-19 pandemic. We were told plans to improve engagement had been developed but were not yet implemented.

Patient feedback was displayed on quality boards on the medical wards. Thank you cards and letters from patients and relatives were also displayed.

Staff on the AMU had been involved in service improvement planning as part of the response to the warning notice issued in November 2020. The trust was rolling out the improvements across the wards and had plans in place to engage staff across the medical wards in the events, on a ward by ward basis.

Staff we spoke with from the children and young people's division said they had contributed to the children's staff survey. The survey had identified themes and areas for improvement. Recommendations related to communication, staff involvement in change processes and staff being given shared objectives. Actions had been put in place to address these with time scales identified and completion by July 2021. Progress was shared at the children and young people's governance meeting.

A number of actions were put in place to support staff during the covid-19 pandemic. From the start of the pandemic there was a strong emphasis on staff well-being. Staff were encouraged to access support that was available including counselling and therapies as well as specific risk assessments.

Our findings

Staff we spoke with during the core service inspections were positive about the visibility and approachability of the chief executive and senior leaders. During the pandemic the board executives took on the 'gold command' role where they were onsite at weekends. This provided an opportunity for staff to speak to senior staff.

The staff survey completed in March 2021 showed several areas where staff engagement had improved at the trust since the previous survey, these included, senior managers involving staff in decision making and managers acting on staff feedback.

There was a pilot in clinical pharmacy service in the emergency department which demonstrated clear benefits. However, pharmacy was not embedded into MDT working across the trust.

The medicines safety officer was part of local and national medicines safety groups.

The chief pharmacist worked collaboratively with local trust's and chaired the local chief pharmacist group.

Learning, continuous improvement and innovation

Whilst the trust had systems in place to identify learning from incidents and the mortality and complaints review process, these systems were not always effective or delivered in a timely way which meant any required improvements to patient care was delayed. Staff were committed to continually learning and improving services. Quality improvement methods had been introduced and staff understood the skills needed to use them, but these improvements were not fully embedded. Leaders encouraged innovation and participation in research.

Mortality performance continued to be an area of focus during 2019/2020 and 2020/2021, and the trust continued to see a deterioration in both its HSMR and SHMI figures rates throughout the first part of 2020. As a result, increased focus, attention and oversight had been put in place by the trust led by the CEO and medical director (MD).

A new Mortality Improvement Group had been established chaired by the CEO with the MD being the senior responsible officer. The group had its own analytical support and used the outputs from the trust's safe and sound mortality group. The newly established groups had a grasp of where the trust was at and what needed to be done to ensure this was effective. The group had identified key actions required around themes and trends of the 3 Cs (quality of care, coding and case mix) to drive improvement.

The MD had facilitated 'deep dive' reviews of deaths involving key mortality alerts to focus learning and improvement, these included pneumonia, intestinal obstruction without hernia and Chronic obstructive pulmonary disease (COPD).

Mortality reviews were completed weekly with a monthly mortality report submission to the board. Structured judgement reviews (SJR) were completed by mortality reviewers. In the records we inspected we saw these were reviewed in line with trust policy and there was with an emphasis on prioritising deaths that were identified as requiring further review. There was a positive working relationship between the mortality reviewers and medical examiners.

These actions had contributed to an improvement in the first four months of the year in HSMR and SHMI results.

To support the trust with its improvement journey both a new chief nurse and two deputy medical director manager appointments had been created to enhance the senior leadership oversight of patient safety, quality and monitoring of professional standards.

Our findings

The MD and CN continued to lead weekly Harm Free Care meetings where any quality of care issues arising that week would be discussed, actions agreed, and learning disseminated.

Following a pilot in 2019 the trust had rolled out electronic prescribing across all inpatient and outpatient areas in 2020. This was successful, and the trust had now started to introduce the system into community services.

The medical division had several projects to improve patient experience which included the introduction of a multi professional approach to clinically led length of stay reviews for patients. There were regular MDT meetings to address long length of stay and right to reside.

The trust had also custom designed an integrated discharge team where health and social care colleagues came together in co-located teams in the clinical operations hub. There was real vision and ambition being driven by staff involved. The team won an HSJ award for "Innovations around integrated working in health and social care". A new discharge lounge had been created with the input of the estates and facilities team to support this and improve discharge safety and quality.

Following the last inspection in 2020 changes in ways of working, included changes in safeguarding practices for children, had been put in place. For example, a daily safeguarding huddle had been introduced including a psychological support huddle aimed at challenging patients throughout the service, a twice daily safeguarding huddle led by the medical team was also taking place.

We saw examples of innovation within the emergency department such as changes in the assessment process and the introduction of advanced care practitioners (ACP). However, these were still being developed and not all were fully embedded.

The trust had introduced a weekly patient safety bulletin that summarised serious incident reports and any organisational learning and then communicated it via the trust website.

In the bulletin there was a weekly '5 in 5'section produced by the patient safety team where five key learning points were shared across the trust. These are short 5-minute learning sessions that focus on action points and learning from datix reports, complaints and any areas of new practice.

The service had systems to ensure staff knew about safety alerts, so patients received their medicines safely. However, we asked nursing staff about learning from incidents on each medical ward we visited but none could give us an example. Pharmacy staff told us they no longer logged interventions by the pharmacy team due to time pressures.

During the inspection, CQC reviewed a sample of complaints. We found the overall quality of the complaint responses were good and the tone of the letters were appropriate. An apology was included where necessary and needed. The letters included advice on next steps and signposting both internally and externally, if not satisfied with the outcome or response provided. The timeframes for a response were improving and only one of those sampled did not meet the trust's target for a response.

Following the inspection an action plan had been developed which detailed the development of medicines management training and competency assessments for clinical staff.

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 →← Sep 2021	Requires Improvement →← Sep 2021	Good →← Sep 2021	Good →← Sep 2021	Requires Improvement →← Sep 2021	Requires Improvement →← Sep 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.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Mental health	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021	Good ➔➔ Sep 2021	Good ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Rotherham General Hospital	Requires Improvement ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021	Good ➔➔ Sep 2021	Good ↑ Sep 2021	Requires Improvement ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021
Overall trust	Requires Improvement ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021	Good ➔➔ Sep 2021	Good ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 2021	Requires Improvement ➔➔ Sep 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 Rotherham General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Sep 2021	Requires Improvement ↓ Sep 2021	Good → ← Sep 2021	Requires Improvement ↓ Sep 2021	Requires Improvement → ← Sep 2021	Requires Improvement → ← Sep 2021
Services for children and young people	Requires Improvement ↓ Sep 2021	Good → ← Sep 2021	Good → ← Sep 2021	Good → ← Sep 2021	Good → ← Sep 2021	Good → ← Sep 2021
Critical care	Good Mar 2017	Good Mar 2017	Good Jul 2015	Good Jul 2015	Requires improvement Mar 2017	Good Mar 2017
End of life care	Good Jul 2015	Requires improvement Mar 2017	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Surgery	Good Mar 2017	Good Jul 2015	Good Jul 2015	Good Mar 2017	Good Jul 2015	Good Mar 2017
Urgent and emergency services	Requires Improvement → ← Sep 2021	Requires Improvement → ← Sep 2021	Requires Improvement ↓ Sep 2021	Requires Improvement → ← Sep 2021	Inadequate ↓ Sep 2021	Requires Improvement → ← Sep 2021
Maternity	Good → ← Sep 2021	Good → ← Sep 2021	Good → ← Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021	Good ↑ Sep 2021
Overall	Requires Improvement → ← Sep 2021	Requires Improvement → ← Sep 2021	Good → ← Sep 2021	Good ↑ Sep 2021	Requires Improvement → ← Sep 2021	Requires Improvement → ← Sep 2021

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Community health services for adults	Good Mar 2017	Requires improvement Mar 2017	Good Jul 2015	Good Jul 2015	Requires improvement Mar 2017	Requires improvement Jul 2015
Community health inpatient services	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community health services for children and young people	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Community end of life care	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Requires improvement Mar 2017	Requires improvement Mar 2017
Overall	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

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

Rotherham General Hospital

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Description of this hospital

The Rotherham NHS Foundation Trust was awarded foundation status in 2005 and provides a wide range of acute and community health services to the people of Rotherham (population approximately 242,160). The trust provides the full range of services expected of a district general hospital including urgent and emergency care, maternity, paediatrics, surgery, medicine, critical care and community services for both children and adults.

The Trust employs approximately 4000 staff who predominantly work in either the main hospital site or in one of the community locations. The trust has close connections with a number of educational providers including Rotherham College, Sheffield Hallam University and is an Associate Teaching Hospital of the University of Sheffield. Services are predominantly commissioned for the people of Rotherham by NHS Rotherham Clinical Commissioning Group, who also act as lead commissioner for other Clinical Commissioning Groups. There are a small number of services commissioned by NHS England. The trust works in close partnership with Rotherham Metropolitan Borough Council, NHS Rotherham Clinical Commissioning Group and Rotherham, Doncaster and South Humber NHS Foundation Trust on developing and implementing the health element of the Rotherham Place Plan and with other health organisations across South Yorkshire and Bassetlaw as part of the Integrated Care System.

From March 2020 to February 2021, there were 74,618 attendances in the emergency department. From April 2020 to March 2021, there were 51,760 inpatient admissions, 283,051 patients attended the outpatient department, and 2,273 deliveries in the maternity department.

Maternity

Good ↑

Is the service safe?

Good →←

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Records showed overall compliance rates met the trust target of 85% with 87% of midwifery staff, 88% of medical staff and 88% of support staff having completed training. Staff said they received alerts when they needed to update their training.

Safeguarding

Staff understood how to protect women 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. Midwives and medical staff completed level three children's safeguarding and level two adults safeguarding training. Compliance rates were 87% for midwifery staff, 88% for medical staff and 88% for support staff.

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. Safeguarding huddles were completed daily for women and babies. We observed a woman who had given birth within three days of arriving in the UK being discussed to determine if there were any safeguarding concerns regarding her or her baby within a huddle.

Staff were supported to keep women and babies safe by specialist midwives. The service had a young persons, vulnerabilities and substance misuse midwives. Separate midwife leads for children's and adults safeguarding worked with other leads to provide a 24- hour on call rota.

Women were asked routinely, and risk assessed if concerns were raised about female genital mutilation. The service had a consultant lead and individualised care plans were made in liaison with gynaecology if required. A family approach to find siblings and protect babies was undertaken.

Safeguarding leads were part of the local network for midwives to help share learning and promote good practice.

Staff undertook baby abduction drills. The ward areas were secure, and doors were monitored.

Cleanliness, infection control and hygiene

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

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

The service generally performed well for cleanliness. Staff followed infection control principles including the use of personal protective equipment. Handwashing and sanitising areas were available however sinks were outside of bay areas on Wharncliffe ward and hand sanitisers weren't available at each bed. We saw one curtain had not been changed as per the policy of every six months.

Audits of staff adhering to bare below elbows for the last six months showed compliance rates of 100% for both midwifery and medical staff. Microbial decontamination audits, which included hand hygiene, the use of personal protective equipment, disposal of sharps and the use of aseptic techniques showed 100% compliance for midwifery staff over the last six months and 100% compliance for medical staff in five out of the last six months.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. We saw evidence of actions plans and timely rechecking where environmental audits had identified less than the 95% target for cleanliness.

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.

Women could reach call bells and staff responded in a timely way when called.

Staff carried out daily safety checks of specialist equipment. Adult resuscitation trolleys were surface checked daily, and the contents checked monthly by the theatres team.

The service had enough suitable equipment to help them to safely care for women and babies. Portable resuscitators were available for babies in both delivery suite and on the post-natal ward, these were checked daily.

Resuscitaires where available on the Labour ward and Wharncliffe ward. Staff said they had no concerns accessing these when required.

Staff disposed of clinical waste safely.

The antenatal day unit (ANDU) included three beds and a waiting area for women and their partners. We identified the size and lay out of the unit would make moving one bed out of the area difficult due to its location and that of the waiting area. In an emergency this could potentially result in a delay in a woman receiving treatment. This concern was escalated to senior leaders whilst we were on site and they took immediate action changing the bed to a trolley which was narrower.

The ANDU had a portable defibrillator, however no access to oxygen, when asked, staff reported they would access bottled oxygen if required from a locked treatment room. When reviewed, the oxygen had no masks or tubing located with it. Both would have resulted in a delay in administering oxygen in an emergency. We raised this concern with senior leaders whilst on site and we were advised this would be rectified the same day with the use of a 'grab bag'.

We observed that both the ANDU and triage areas did not always promote the privacy and dignity of patients' due to their size and use of curtains in between beds. The trust informed us that plans to make alterations to the triage area had been delayed due to COVID-19. The lack of privacy on ANDU was on the service risk register.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff completed risk assessments for women. One electronic records system used by the service had risk assessment completion as a mandated field, this however wasn't across all systems and we saw some gaps in paper records where risk assessments hadn't been completed at each contact.

Staff knew about and dealt with any specific risk issues. We saw evidence that risks were escalated where required.

The service had a lead for fetal monitoring and we saw evidence that the recognised 'fresh eyes' approach to checking fetal heart rates was applied. However, practice had only been updated the previous month to identify this should be undertaken hourly, an updated policy was not in circulation and the changes were not yet embedded with staff.

We saw evidence that incidents within maternity were reviewed against the use of the fresh eyes approach and compliance across the previous six months was good. Our review showed one case were the approach had been started but not completed.

The ANDU and triage unit had systems in place which allowed electronic interpretation of fetal monitoring to be undertaken which could potentially improve outcomes.

The service monitored incidents that occurred within the department to ensure compliance with the modified World Health Organisation (WHO) surgical checklist and swab counts. Information we reviewed saw compliance to these over the previous six months was 95% for swab counts and 94% for the modified WHO checklist. Records we reviewed showed check lists and swab counts had been completed where appropriate. Trust spot check audits however highlighted compliance with their own process for swab counts was often not followed. We did not see any action plans in place to address this.

Staff used a nationally recognised tool to identify women and babies at risk of deterioration. A policy was in place for the detection and management of neonatal sepsis which detailed 'red flags' for escalation and babies were monitored using the Newborn Early Warning Track and Trigger framework (NEWTT), in line with the regional operational delivery network for neonatal units.

Women were monitored using the modified obstetric early warning system (MOEWS) and staff told us there was a set criteria for escalation. Sepsis scenario training had recently been completed using a simulator and the trusts sepsis educators.

Staff shared key information to keep women safe when handing over their care to others. The service used electronic handover documents for routine discharges however where concerns had been identified midwifes provided a verbal handover to community teams.

Shift changes and handovers included all necessary key information to keep women and babies safe. Handovers were in the recognised Situation, Background, Assessment, Recommendation (SBAR) format.

Midwifes told us medical staff were responsive when contacted with anything urgent and reviewed women in a timely way.

Maternity

Nurse staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and midwifery staff to keep women and babies safe. Staff told us staffing had recently improved with the addition of an extra midwife overnight on Wharncliffe ward.

Managers calculated and reviewed the number and grade of midwives and assistants needed in accordance with national guidance. At the time of the inspection the trust was meeting their birth rate plus recommendations for staffing (staff in post) for their case mix requirements. They were working towards the recommendation of 90% registered midwives to 10% maternity support worker, with 88% midwifes and 12% support workers.

At the time of the inspection, the service had no midwife vacancies. Plans had been approved to recruit additional midwives to meet the national targets for the continuity of carer approach to care.

At the last inspection we said the trust must ensure ongoing audit of delivery suite acuity and resulting staffing needs are carried out and documented to enable optimum staffing. At this inspection we found within inpatient areas, acuity was monitored using a recognised tool four times a day and included the collection of red flag data.

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing and is recommended by the National Institute of Health and Care Excellence (NICE).

Acuity levels and staff were shared between the labour and Wharncliffe ward to help keep women safe.

For midwifery staff there was a rolling sickness absence rate of 4.40% against a trust target of 3.95%. Higher levels of sickness were seen with outpatient services.

The service used bank staff to fill gaps in midwife rotas. Data over the last three months showed there had been an average of two unfilled shifts each month within the acute environment. In May 2021 labour ward had 1.3 shifts (14%) unfilled and Wharncliffe ward 1 shift (23%) unfilled.

Labour ward was supported by continuity of carer midwives, we were told these were additional to planned staff.

Information from the service dashboard showed over the last six months the percentage of women receiving one to one care in labour ranged between 94% and 97%.

Managers 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 women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe.

The service had 12 consultant obstetricians and 10 registrars . At the time of inspection there were no consultant vacancies and two registrar vacancies were being recruited to with a number of applications for the positions.

Maternity

The service had 2413 births over the period June 2020 to May 2021 with 62.5 hours of consultant cover each week on the labour ward which exceeded recommendations for the number of births.

Rolling sickness rates over the last 12 months for medical staff was below the trust target of 3.95% at 1.99%.

Managers could access locums when they needed additional medical staff. Over the last 3 months there had been no unfilled cover.

Consultant staff were on site seven days a week and held ward rounds twice a day. Cover was provided by an on-call rota during evenings.

Anaesthetist cover was available 24hours a day, seven days a week.

Records

Staff kept detailed records of women's care and treatment.

Women's notes were comprehensive, and staff could access them easily.

The service had three different types of records, one paper based and two electronic systems. We found that information was repeated across the records and this created extra work for staff. We were told the outpatient clinic had increased the time of booking appointments to account for duplication of work.

The record systems were on the service risk register and senior leaders where aware of their need to streamline them.

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

Records were mainly stored securely however, we saw that some fetal heart rate traces were not always securely stored.

Medicines

The service did not always have processes in place to safely prescribe and administer inpatient medications. Storage of medication was not always secure.

We saw appropriate action had been taken to address high temperatures within a medicine fridge.

Emergency boxes which contained medication were available for a range of conditions. We did not see any evidence of checks of medication in these boxes.

Midwifery staff worked to patient group directions, staff on the ward told us these were managed by pharmacy, however the trust told us these were managed by an education lead. We did not see any signed copies on the ward, and they were not readably available for staff to refer too. We asked for signed copies of these following the inspection, we received one for flu vaccinations.

We saw guidance around midwifery exemptions was included in the trust's Administration of Medicines Policy.

We found there did not appear to be any clear process for issuing and recording medications from ward stock for women to take home.

There were no systems in place to prevent misuse or theft of high-risk medications or for tracing outpatient prescriptions from prescription pads.

Staff told us the service had a weekly review from a pharmacist.

Incidents

The service managed 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff met to discuss the feedback and look at improvements to patient care. We observed learning from incidents being shared at team 10 at 10 meetings. The outcomes of internal and external investigations were detailed on walls for staff to see.

There were zero never events within obstetrics in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Managers investigated incidents thoroughly and reported to external organisations for investigation where appropriate. Between June 2020 and June 2021, five incidents had been referred for external investigation to the Health and Safety Investigation Branch (HSIB) and 12 incidents met the threshold for NHS serious incident reporting (including those also referred externally).

HSIB conducts independent investigations of patient safety concerns in NHS-funded care across England. Investigations had been completed by HSIB, action plans to address issues had been created and actions completed.

The service had three antenatal deaths within the month of March. Deaths within the service were investigated as part of the service's serious incident process. Those involving babies were put through an MDT review using the Perinatal Mortality Review Tool (PMRT). The PRMT is a national programme aiming to standardise perinatal mortality reviews across NHS maternity services. Perinatal mortality review meetings were also undertaken, and the service had an annual MDT Perinatal Mortality Review Day. The most recent review day included attendance by the non-executive director safety champion.

Staff received feedback from investigation of incidents, both internal and external to the service and managers debriefed and supported staff around incidents.

There was evidence that changes had been made as a result of incidents. Staff were able to describe how falls risk assessments and guidance for mums had been put in place following a serious incident.

We saw evidence that duty of candour had been applied to incidents that had occurred within the last year and we observed staff discussing the requirements for duty of candour for a woman who had recently given birth.

Safety Thermometer

The service monitored areas of practice to improve safety. Data was shared with staff, women and visitors.

Maternity

The service collected data on a set of performance and outcome measures via a maternity dashboard but no longer collected generic safety thermometer information. We saw that pressure ulcers were included in dashboards but there was no record of falls.

Local and regional maternity dashboards were used to monitor the service and target areas for improvement. The service used regional dashboards to maintain oversight of their care against other services.

Data on display for May showed breast feeding, skin to skin and normal birth rates had improved from the previous month.

The service published monthly updates on the number of babies born.

Is the service effective?

Good  

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

We found practice had been updated to reflect changes to the fresh eyes approach to fetal monitoring however old policies were still in circulation. We were told policies had been updated but were not yet available for staff to use. We saw no evidence a risk assessment had been undertaken to mitigate the change of practice before the updated policy was available to staff.

We saw information that detailed the service was compliant with the Saving Babies Lives Care Bundle Version 2.

The service had achieved targets for meeting the continuity of carer approach to midwifery care and were in the process of expanding the team to meet further targets, including for black and minority ethnic women and those from socially deprived areas.

The service undertook screening for gestational diabetes in line with national recommendations.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers.

Nutrition and hydration

Staff gave women 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 women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition needs such as diabetes and food was available to accommodate different cultural choices.

Maternity

The service was going through the United Nations Children's Fund (UNICEF) Unicef Baby Friendly re-accreditation process, a programme that accredits units for supporting breast feeding.

The service had specialist breast feeding midwifes and support staff. The support team covered seven days a week and covered different shifts to provide guidance throughout the day. The team supported on both the labour ward to support women with first and early feeds and on postnatal wards. We saw breastfeeding encouraged prior to a woman giving birth to help the labour process. Systems were in place for following up mothers on discharge.

Women had access to their own expressed milk whenever they needed. A milk fridge and bottles were provided. To ensure safety the women had their own lockable box in which to store their milk which was then put in the fridge. Breast feeding rates over the previous three months had increased to 70%

Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs.

Staff prescribed, administered and recorded pain relief accurately. We observed a midwife checking if a woman was in pain and prescribed medicines were explained before being given.

The service had access to an anaesthetist 24 hours a day, they told us delays in receiving an epidural would be reported via the trust electronic incident reporting system. We reviewed the national reporting system and found no incidents of delays reported in the last year.

Women we spoke to did not highlight any concerns with their pain management.

The service did not undertake routine audits around pain.

Patient outcomes

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

The service participated in relevant national clinical audits and had an audit programme in place.

The service had introduced a matron's daily assurance audit using the perfect ward tool, the outcomes of this were fed back immediately to area managers to implement any actions.

The maternity dashboard was maintained monthly and reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators and public health information. Trust dashboards also included staffing and incident overviews. Local dashboards were aligned to regional maternity systems dashboards. Senior leaders we spoke to were aware of their position against their own performance and that of services within the local area.

In the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) perinatal mortality surveillance report published in December 2020 (based on births in 2018), the case-mix adjusted perinatal mortality rate at the trust was up to 5% higher than the comparator group average including congenital anomalies, and up to 5% higher excluding congenital anomalies.

Maternity

From the weekly data received from MBRRACE, the trust reported 13 perinatal deaths in 2020 compared to 16 expected deaths (based on 2018/19 data). Four cases have been reported for 2021 (as of 18/5/21). Perinatal deaths were investigated and reviewed by the trust to identify themes and implement learning. We saw evidence the service had reviewed its processes against the 2020 enquiry into neonatal deaths in twin pregnancies.

The service had a higher rate of neonatal readmissions than the England average for the first quarter of 2020/21. Staff told us actions to address readmission had been put in place including the use of optimal cord clamping and community bilirubin monitoring. We saw optimal cord clamping being carried out following a delivery.

Over the last 12 months the service had a total caesarean section rate above the national target of 26.3% for eight out of the 12 months, staff told us that they had seen an increase in caesarean sections as a result of the pandemic and women's concerns around the uncertainties of spontaneous births.

Emergency caesarean rates had reduced over the last three months to below the national target of 15.5% with 8% in March, 9.2% in April and 9.3% in May.

Rates for 3rd and 4th degree tears in normal births were below RCOG targets for 10 out of the previous 12 months and 8 out of 12 months for assisted births.

The service had a target of less than four women each month having a post partum haemorrhage of less than 1500ml, over the previous 12 months this had been achieved in 8 out of 12 months

Transitional care was undertaken on the postnatal ward and a policy was in place to support this. A daily neonatal huddle had recently been introduced to improve safety and increase compliance with a daily neonatal review. Work had also recently been undertaken to review the process for administering intravenous antibiotics for babies.

Managers shared and made sure staff understood information from the audits. We saw evidence actions from medicines audits being fed back from managers to staff.

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 women.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor. Staff we spoke to were positive of the programme and the support it provided.

Band 5 midwifes were part of a rotational post to enable them to develop their skills across all areas of midwifery.

The trust had adopted the A-EQUIP model of supervision and there were six Professional Midwifery Advocates (PMA) within the service. Staff told us the PMA's had protected time for their role and were given additional ad hoc time if needed.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff reported they were supported to develop and access further training. Appraisal rates at the time of the inspection were 70% for midwifery staff and 63% for medical staff.

The clinical educators supported the learning and development needs of staff. Compliance rates for training in areas specific to maternity was on average 87% for midwifery staff, 93% for consultant staff, 95% for registrars and 77% for support workers. The service told us new staff within the service had reduced compliance figures. Training covered a range of areas including mental health, screening, safeguarding, feeding, smoking cessation, pain management and risk.

The service undertook multidisciplinary (MDT) training and utilised external resources including those produced by the Practical Obstetric Multi – Professional Training (PROMPT) charity. Staff we spoke to confirmed they participated in MDT training and that the service had adapted during the COVID19 pandemic to include training virtually.

Staff told us they received training and assessment on fetal heart rate monitoring through a maternity specific training programme (K2), however information on competency rates provided by the trust was for in house training. Internal competency rates met the trust target of 85% with 88% of midwifery staff and 92% for medical staff trained.

Managers were not clear when asked around competency assessments and had identified a need to review the processes they had in place.

We saw evidence that live skills and drills training had been completed for acute areas and outcomes of the session reviewed. Staff we spoke to confirmed these happened across different scenarios. Staff told us no live drills had been undertaken within the outpatient clinic despite this being a new building.

Managers made sure staff attended team meetings or had access to notes when they could not attend. Managers would come in early to see staff that only worked night shifts.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received specialist training for their role. We saw evidence that midwives were supernumerary on shift to develop skills and competence within an area.

Continuity staff were supported to maintain clinical skills by specialist midwives and hospital-based training, however some staff we spoke to felt that the role may result in a loss of skills.

Staff told us the service had midwives trained to undertake newborn and infant physical examinations (NIPE). NIPE failsafe systems were in place to monitor if this was undertaken within 72 hours. An incident would be reported if outside of this for eligible babies.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients' and improve their care. Handover on the labour work was multidisciplinary and we observed good MDT working and prioritisation of patients' depending on risk. Handover included women receiving midwifery led care allowing continuity for with medical staff if input was needed.

Maternity

We saw handovers on both the labour ward and Wharncliffe ward followed the recognised SBAR format.

Staff we spoke with said they had a good working relationship with the MDT. Midwives told us they were happy to raise concerns and challenge practice with medical staff where they felt this would help to keep women and babies safe.

Staff reviewed women's mental health and the service was supported by two specialist mental health midwives. Where required the service would work closely with colleagues from the local mental health trust.

We observed good MDT team working within theatre.

The service worked with neighbouring trust's to support women needing specialist care at a fetal medicine unit. Screening midwives worked alongside consultant leads, community midwives and specialists at regional centres to provide MDT care and care planning for women.

The service completed routine handovers to the community team via electronic referrals, where any additional concerns had been raised, verbal handovers were also provided.

Seven-day services

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

Consultant led ward rounds were carried out twice a day on labour ward, including weekends. Women were reviewed by the Consultant 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.

The ANDU was accessible for women during the day and triage was open 24 hours a day.

Health Promotion

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

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff received training in smoking cessation and the service had resumed carbon monoxide testing for women following a pause due to Covid-19. However, we did not see any evidence in the notes we reviewed this was being undertaken.

The service provided guidance and encouragement to women on vaccinations including flu, pertussis and coronavirus and we saw evidence that Vitamin D was appropriately offered to some women.

The service had information on its website to support women make healthier choices including smoking and diet.

The service had good support for women around breastfeeding.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Maternity

Staff gained consent from patients' for their care and treatment in line with legislation and guidance. During the inspection staff we observed informed consent being taken and written consent being checked for women undergoing elective caesarean sections. Consent for screening was undertaken and sonographers would request this if not completed.

At our last inspection we said the trust must ensure that all midwives understand and use Gillick competence checks or Fraser guidelines before discussing consent for care and treatment with young women. At this inspection we found that not all midwives were aware of the checks or guidelines however the service was supported by a young person's midwife and explained how they would provide care for young women.

The service had policies in place to support staff caring for women with learning disabilities. The service was supported by leads for learning disabilities within the trust. We observed staff working as an MDT to support the care of a women who had been assessed as not having capacity to make her own choices.

Staff clearly recorded consent in the woman's records.

Is the service caring?

Good 

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

Compassionate care

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

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

Women said staff treated them well and with kindness. We saw staff place monitors at one side of a women's bed during a caesarean section to enable her to hold the baby following the procedure and we saw staff checking to see if a partner had their phone ready to enable them to take pictures of their baby.

Staff followed policy to keep women's care and treatment confidential. We saw staff maintain a women's privacy and dignity whilst being transferred between beds.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

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

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. The service had a bereavement suite for women and support from a bereavement specialist midwife. Staff undertook bereavement training

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.

The service had a maternal mental health and perinatal mental health midwife who worked and supported women who had undergone a stressful or traumatic birth as well as those women who were supported by the perinatal mental health team. A psychotherapist was also available to offer support for pregnancy and previous birth trauma. Women could self-refer to this service.

Understanding and involvement of women and those close to them

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

Staff made sure women and those close to them understood their care and treatment. We saw good practice around informed consent.

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

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Friends and family questionnaires had restarted following a break due to Covid-19. We saw friends and family information points across all areas.

The trust performed similarly to other trust's for all 19 questions in the 2019 CQC maternity survey

Is the service responsive?

Good  

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

Service delivery to meet the needs of local people

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

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

The service had three continuity of carer teams and were working towards the introduction of a fourth. The continuity of carer approach to midwifery provides women with a named midwife who follows them throughout pregnancy, birth and the postnatal period. The model was aimed at supporting the natural ability of women to experience birth with

minimum intervention; the monitoring needed to ensure a safe pregnancy and birth, and the physical, psychological, spiritual and social well-being of the woman and family throughout the childbearing cycle. The continuity teams had been reconfigured to work within areas where women may be at greatest risk including those from areas more socially deprived.

During our inspection we saw evidence that care was being provided for women by their continuity team on the labour ward, we did not see any continuity midwives on the postnatal ward.

The service worked with their local maternity voices partnership (MVP) and the Rotherham Ethnic Minority Alliance Group (REMA) to help them provide a service that reflected their local population and provide targeted work for areas where women may be at higher risk during pregnancy.

The outpatient's service had been relocated to a new outpatients department to meet the needs of the population.

The service had identified where their facilities and premises did not meet the needs of the service, this included the location of the bereavement suite. We were told plans were in place to refit the labour ward which included three curtained areas for triage however the pandemic had led to delays.

Systems were in place to communicate with a woman's GP if they did not attend an appointment.

Partners were still able to visit on Wharncliffe ward despite trust wide and national restrictions in place due to the pandemic. A system of advanced booking and time slot allocations enabled fair access to visiting for all women on the ward. Women were able to have support whilst on the labour ward.

SBAR handover was used on both the Labour ward and Wharncliffe ward which met the needs of the women. Alerts were added to a patient's electronic records and on handwritten patient boards in staff only areas.

Meeting people's individual needs

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

The introduction of a neonatal safety huddle had improved communication and timely reviews of babies by neonatal and paediatric staff. We saw further changes to improve these huddles had recently taken place and staff shared positive feedback about its effectiveness.

National guidance outlines that women should be provided with three choices of places to birth. The service offered women the opportunity to birth at home, in hospital with MDT input, and the midwifery led unit, during our inspection we were unable to distinguish how care in the midwifery led unit differed to that of the labour ward. We saw place of birth was documented in some but not all records we reviewed.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. We were told information leaflets were available in languages other than English, we saw safety notices produced in other languages commonly spoken and some links on the service website provided several languages to choose from.

We did not see a hearing loop available, we were told interpreters could be requested if required. Information on the trust website could be accessed using 'browse aloud' software.

Staff could access emergency mental health support for women. Care was provided by an on-call crisis team from a neighbouring mental health trust.

A specialist perinatal mental health midwife worked with the local mental health trust and community midwives to support women with mental health concerns, a weekly consultant led mental health clinic was available for women receiving pharmacological treatment. Staff told us however that for women with significant mental health problems the service and those across the region were already at capacity.

Women who experienced mental health difficulties directly arising from, or related to the maternity experience were supported by a specialist maternal mental health midwife. This was a new role.

A birth afterthoughts service was available for women who wished to talk about their previous birth or maternity experience ran by a specialist afterthoughts midwife.

We saw evidence that women were asked about domestic abuse, audit results from February 2021 showed domestic abuse questioning in 95% of records reviewed, we did not see this audit had been completed again. The service had created innovative ways for women to discreetly alert staff if they needed to raise concerns in private.

A bereavement suite was available on the labour ward and support provided to women and their families by a bereavement specialist midwife. The early pregnancy assessment unit had an alternative exit away from the waiting area and butterfly rooms were available on EPAU and in outpatients for people who had received bad news. Guidance was in place for staff to support them in working with bereaved parents and covered taking their baby home, post mortem, placental samples and histology.

Women were given a choice of food and drink to meet their cultural and religious preferences. We observed catering staff obtaining a Halal meal for a woman.

Access and flow

People could access the service when they needed it however there were often delays for women awaiting outpatient appointments.

For the period June 2020 to May 2021 the service had achieved over their 90% target for initial antenatal bookings undertaken before 13 weeks, with a range of 91-95%.

The service had an escalation policy and procedures in place for the closure of the unit however there had been no unit closures in the last 12 months. Staff we spoke to were unable to recall the last time the unit was closed.

During our last inspection we said the service must ensure antenatal clinics run to time. At this inspection, managers we spoke to highlighted waiting times were not routinely monitored and we were not assured effective systems were in place to do so.

Data received from one recent spot check audit showed less than 30% of women were seen by a consultant within 10 minutes of their appointment time, however 64% were seen for a scan within 10 minutes of their appointment time.

Feedback from women highlighted outpatient delays to be an issue with many saying they were waiting for over an hour after their appointment time. Communication around waiting times was also an issue.

Maternity

Managers monitored transfers, from April 2020 to March 2021, 32 women were booked to birth at home and 9 (28%) did so, of the remaining 23, 20 (63%) gave birth at hospital, 2 were not recorded and 1 recorded as other.

The ANDU offered booked appointments for women with referrals coming from self referrals, GPs, and community midwives. There were no systems in place to triage or monitor waiting times within however staff reported that they could see patients' within 30 minutes of arrival and could escalate if there was an increase in women attending.

Women attending labour ward were seen in triage however during our inspection we saw that the area became busy and women were escalated to the labour ward. Staff reported all women were seen within 30 minutes of arrival, with the escalation process assisting in this. Red flag data showed over the last 12 months there had been one reported delay in the triage process.

The service had a digital midwife 'Ask Olive'. Olive supported women in the community with guidance and advice through the use of social media. Links to Olive's page were available on the trust website and social media pages. Questions could be raised confidentially through messenger services and key information about contacting the service in an emergency were visible.

At the time of the inspection, one woman was being cared for outside of the maternity unit, this was to support medical treatment needed alongside midwifery care. Staff told us they did not need to use areas not designated for birth outside of medical need. They told us they would occasionally have women on Wharncliffe from other areas such as gynaecology.

There was no direct access to the labour ward, we were told A&E was on the same level and through a set of doors allowing a quick transfer for women into the unit who had been brought in by ambulance.

Staff we spoke with in outpatient areas said there were processes in place to follow up women who did not attend appointments.

At the last inspection we said the service must ensure women experience timely postnatal discharge from the ward, at this inspection we did not see any evidence of delays to discharge.

Red flag data showed there had been six reported episodes of delays to inductions due to staffing once women had arrived on the unit over the last year

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 women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. The trust displayed information about how to raise a concern in patient areas.

Staff said concerns were dealt with locally where possible and, escalated if required.

Maternity

Complaints and concerns were raised on the trust's incident reporting system. In the period June 2020 to May 2021 the service received a total of 77 complaints and concerns, 20 of these were formal complaints. All formal complaints up to April 2021 had been actioned and closed. Only two received in May 2021 remained open. The main theme relating to complaints and concerns was around communication.

Managers investigated complaints and identified themes.

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

Is the service well-led?

Good  

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

Leadership

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

Maternity was part of the Family Health division along with the Children and Young People's service (CYPS). The division was led by a director, general manager and heads of midwifery and CYPS. The division had leads for clinical effectiveness and audit, medical leads and audit specialists. The Maternity leadership was complemented by a head of quality and governance.

The service had appointed a new head of midwifery (HOM) since our last inspection. The HOM had implemented changes within the service's management. There had been the recruitment of a deputy head of midwifery and additional leaders had been created on Delivery suite and antenatally, deputy ward managers had also been created on Wharncliffe ward. A Senior Midwife, with the remit for Maternity Transformation and Quality Governance had been recruited. Additional lead and specialist midwives roles had also been created. Three matrons supported the work of the senior leadership team covering, acute, community and outpatients' services.

Although the service had no direct board level member the HOM was able to present to board where maternity was a key part of the agenda. The service said they felt supported by the board and the non-executive lead for maternity had recently been round the service.

Safety champion leads for midwifery, obstetrics and neonates where in place. The service displayed how clinical staff could contact the leads. Information we saw suggested monthly feedback sessions were held along with weekly safety ward rounds. Board level champions were also in place including a non-executive director and measures were in place to feedback including bimonthly meetings.

Board reports highlighted the key metrics of the maternity dashboard were reviewed each month since January 2021 and actions discussed to address underperformance. We asked the trust for their plans for compliance with the Perinatal Clinical Quality Surveillance Model, however these were not received.

Staff we spoke with said they felt supported by their manager and were accessible. We saw that senior staff where known within the department.

Vision and Strategy

The service did not have a current vision for what it wanted to achieve or a strategy to turn it into action. Leaders told us a new strategy was being developed in consultation with staff and the local community.

The service did not have a current vision and strategy in place. Leaders told us this was being re developed as part of the trust's wider strategy and through engaging with all teams within the service. We saw the trust were engaging with the local community on its strategy.

We reviewed the expired strategy and found this to be based on national drivers and improving safety for women and babies.

Culture

Staff were focused on the needs of patients' receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff we spoke to talked of a positive culture within the service, staff were supported to access additional training and junior midwives were positive about their preceptorship and progression.

Staff survey results for 2020 highlighted an improvement from 2019, however the service still had a number of areas below the trust average, these included for health and well-being, moral and safe environment. We saw that a comprehensive action plan had been put in place following the survey and many of the actions had been completed.

Senior leaders we spoke to talked of the positive reputation the service had gained and how this resulted in an oversubscription of newly qualified midwives and positive response to recruiting to medical staff vacancies.

We found that staff were task focused and not always encouraged to take their breaks.

Staff were encouraged to report incidents and those we spoke to felt there was a no blame culture. We saw staff ‘you asked we did’ boards and details of representatives for the Royal College of Midwives were displayed.

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 service had clear governance processes in place which supported performance, recognised safety, patient experience and clinical effectiveness.

There were a number of service level reporting meetings which fed into a monthly obstetrics meeting, this fed into a monthly Family Health divisional meeting. The divisional meeting fed into the clinical governance committee which was led by the trust’s medical director.

Maternity

The governance structure had a 'golden thread' around safety. We saw evidence that meetings were quorate and attended by the MDT. Leads for maternity were represented at all levels of the governance structure and areas for escalation and dissemination were included. Divisional meetings incorporated those from service level.

At ward level we saw daily meetings covered safety, performance and key service updates.

Incidents were investigated and reports were produced with recommendations and lessons learned that linked to the findings. Deaths within the service were investigated, where appropriate, using the perinatal mortality review tool, discussed at perinatal mortality review meetings and reported externally in line with national recommendations.

The service engaged with external organisations and reported any notifiable incidents to relevant bodies including the Health and Safety Investigation Brach (HSIB) and learnt from completed investigations.

The service had completed the maternity services assessment and assurance tool and submitted this to NHS England. The tool required services to complete a self-assessment against immediate and essential actions arising from the Ockenden report. We reviewed the self-assessment against the urgent and immediate actions and found both had been completed with actions to ensure compliance.

Information provided by the trust showed they were compliant with the Saving Babies Lives Care Bundle, Version 2

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.

Performance dashboards were used to measure relative performance, rank against benchmarks and national targets, help to identify improvements and show trends for the previous 12 months. Targets were based on those sent by the local maternity and neonates system (LMNS) and the service reviewed there performance against others within the LMNS.

At the last inspection we said the trust must ensure all identified risks affecting the service in line with trust policy are escalated to the risk register. At this inspection we found senior leaders were sighted on their risks and we found these reflected risks documented on the register. Staff at all levels had awareness of the current service risks and we found these detailed in staff areas for information. However, we reviewed the risk register and found this contained limited information, no date added was included or dates of review and there were no mitigations to the risks. We did see that risk register was discussed within governance meetings.

The service had an established Maternity and Neonatal Safety programme which included designated obstetrician, midwife, board and non executive director (NED) champions, monthly meetings and the opportunity for staff to feedback via safety walk-arounds. A 'board to ward' visit had recently taken place by the NED.

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.

Maternity

Managers used information to manage the performance of the department against local and national indicators. Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training.

The service had three different record systems for patient information, two electronic and one paper, this caused significant delays in areas. Information was duplicated in some instances on all three systems and there was significant risk of important information being missed, for example community safeguarding information was on a separate system to the internal electronic notes. The service was aware of the limitations of this and it was identified on the risk register, we were told they were looking at ways to improve processes.

The service collated and reported information in line with national requirements and best practice within maternity.

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 had recommenced friends and family test (FFT) in February 2021 following the pandemic, to gain feedback about the service. We saw boxes for comments in various places around the units.

The service had a strong relationship with their local MVP and had worked with REMA to engage with women from different and harder to reach backgrounds. We were told the MVP had been involved with issues including scan photos and had engaged with the community on the outpatient service.

The service engaged with their LMNS, regional and safety improvement groups to share learning and improve outcomes for women and children.

Learning, continuous improvement and innovation

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

The service had adopted initiatives around safeguarding following the CQC’s focused inspection in 2020. This included the introduction of safeguarding huddles and a multi- agency safeguarding hub (MASH) baby clinics.

Learning from staff feedback and reviews of practice had led to the development of a daily neonatal huddle to improve timely reviews and the safety of babies.

The service was one of the first in the region to successfully recruit to a specialist perinatal mental health midwife to work with women who experienced mental health difficulties directly arising from, or related to, the maternity experience.

Services for children and young people

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement because:

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Training statistics provided by the trust for 2020-21 confirmed that staff had received training in safety systems, processes and practices.

In 2020 – 21 mandatory training compliance for all staff groups ranged from 85.71 % to 100%.

Information provided confirmed that the head of nursing reviewed training data and highlighted any shortfalls to staff. The electronic staff record system also automatically informed staff of any out of date training.

Going forward the trust identified they were about to commence detailed reports for each service. An overview of training compliance was also discussed at divisional governance, reviewed by the triumvirate and monitored at the Clinical Governance Committee.

Staff said monthly mandatory training sessions had re - commenced in January 2021. Neonatal staff had re-commenced mandatory training sessions; some through TEAMS calls; however, staff told us that there was no neonatal sepsis training.

Staff could access the trust guidelines for paediatric sepsis and for the management of early onset neonatal sepsis which were in written flow chart form. The service confirmed that the trust had worked alongside Sepsis UK and purchased e-learning packages. These modules were to be introduced as a job specific requirement for medical and support staff during 2021/22. A senior manager for Family health confirmed medical staff compliance was 100% for sepsis training.

The children's department had provided an e-learning package from another NHS Trust to nursing staff as an interim measure until the job specific training was implemented. Nursing staff compliance was currently 96% (47 of 48 staff).

Safeguarding training was monitored within the safeguarding groups. Safeguarding training compliance was monitored by leaders; the named professionals and head of safeguarding had oversight and reported within the safeguarding strategic group. Leaders reported safeguarding training compliance had increased across the trust. The trust identified the safeguarding training trust target as 85%.

Services for children and young people

Clinical staff confirmed they had completed safeguarding of vulnerable children level 3 training. Training statistics for the acute children's and neonatal services confirmed children's level three safeguarding training compliance ranged from 72.22% to 100% for nursing staff. We saw some gaps in level one and level two safeguarding children's training compliance identified for some band five and six nursing staff. Additional clinical staff compliance at level three children's safeguarding training completion ranged from 66.67%(one person) to 100%.

For medical staff training compliance ranged from 90.91% to 100% for completion of level one, two and three child safeguarding training. Adult safeguarding training compliance at level one and two for medical staff was 100%.

Safeguarding adult training statistics at level one and level two confirmed 100% compliance across children's services for medical staff and from 94.44 to 100% compliance for nursing staff.

We did not see evidence that agency and locum staff had completed safeguarding training in accordance to the intercollegiate guidance.

Outside of the immediate children's service in areas which treated children and young people. In day surgery and theatres staff undertook training on safeguarding children level 2 every three years, with senior nurses undertaking level 3. Operating department practitioners and emergency team staff were trained in safeguarding level 3. Medical staff in the Division of Surgery, treating children in theatre and outpatient areas, had children's safeguarding level 3 training.

Children were also treated in adult outpatient areas and registered staff in these areas completed level 3 children's safeguarding training, whilst health care assistants completed level two children's safeguarding training.

There was a comprehensive staff nurse four-week supernumerary induction programmes were in place within the children's service. This induction included mandatory training and clinical competency training and assessments. To ensure nurse competency development the newly qualified nurse document had also been adapted for non-newly qualified starters.

Safeguarding

Staff understood how to protect children, young people and their families 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.

Prior to this inspection the trust was served with a letter of intent under our urgent enforcement powers. This related to the findings from a focused inspection of safeguarding children at the trust from the 07 to 10 July 2020. We issued this letter as we found that children will or may be exposed to the risk of harm because your safeguarding children processes, practices and procedures are not robust or embedded across the whole organisation. In response to our letter the trust provided a detailed action plan which indicated what actions they were taking to mitigate these risks.

As this inspection we looked to see what progress had been made by the trust against the concerns raised. We found at this inspection:

The trust had made improvements in the safeguarding arrangements for children and young people since the letter of intent, following the July 2020 safeguarding inspection.

Services for children and young people

The trust set out a clear and ambitious 'safeguarding quality improvement plan' to address the significant concerns. The chief nurse identified completion of the action plan and next steps were to continue moving forward and build on these foundations. Some of these initiatives were very new and not fully embedded across the trust. These new initiatives included the 'Think Family' template which was incorporated into the Meditech records as part of all adults' assessments in the urgent and emergency care centre (UECC) and the new safeguarding children's risk assessment which was shared with external partners and was due to be adopted. Leaders stated they had an action plan which incorporated a 'Think family' proforma in UECC all adults' assessments to strengthen the 'Think family' approach within the trust.

The twelve children's records reviewed showed evidence of good professional curiosity and the 'Think Family' approach. Evidence within these 12 records confirmed improvements to safeguarding procedures to support with early identification of safeguarding, for example, the child protection information system (CPIS), SystemOne checks, general safeguarding screening template completed and recording of family demographics. The 12 records confirmed CP-IS and system one records were reviewed to check for known safeguarding concerns.

Records also confirmed that discharge planning meetings and strategy meetings were held. Family demographics were consistently captured, and the general safeguarding section was also completed in all records as part of the triage**.** However, this section was minimal and could be strengthened by using additional prompts.

Partnership working had improved, and the trust met with the local council to discuss cases of concern and best practice. The chief nurse and named professional were the trust representative at various external panels, for example, the group for children sexual exploitation. Quarterly executive stakeholder meetings were held with police, the local clinical commissioning group and other parties so safeguarding concerns and updates on improvement plans were discussed and shared.

Clear and cohesive governance structures ensured safeguarding was embedded at all levels and was an integral part of multiple strategic and operational committee and panels meetings with monthly reports provided to the board. These processes provided a mechanism to monitor, measure performance and effectiveness across the trust.

Processes were in place to monitor and report serious incidents, serious case reviews and incidents. These once completed provided an oversight about the working practices within the trust.

The trust launched 'appreciative enquiries' to look at change focus and doing more of what is working well. Seven-minute briefings included different safeguarding themes dependant on the trends emerging from the data collection based on electronic multi-agency assessment form (e-MAF) referrals, audits, peer reviews, supervision and huddles. Stop the clock was implemented to share lessons learnt and promote changes to practice. Although, one practitioner was not sure about how information was distributed across the trust.

Auditing processes were effectively in place enabling the trust to monitor the quality and effectiveness of the safeguarding arrangements for children and young people. Named professionals and the safeguarding team conducted safeguarding audits as part the monitoring safeguarding performance and quality; which included child protection medical and body mapping completed as part of a holistic assessment. Quarterly auditing of the quality of child protection medicals and the completion of body mapping within children's records took place; in February 2021 67% were completed and the action was to improve practice to achieve 100%.

There were newly appointed roles within the safeguarding team. Safeguarding children's champions were well established who offered further training, attended monthly meetings and cascaded key messages across all

departments. Discussions with staff across the service showed they had an awareness of the safeguarding team and how to contact them. However, when asked, staff could not always name the safeguarding team member. The trust informed CQC that there had been new staff members into the team. The safeguarding office was based on the children's ward and easily accessible to staff.

Safeguarding professionals including named professionals were more visible to practitioners. The safeguarding professionals had regular walk-about sessions; supported staff with embedding safeguarding processes and encouraged respectful professional challenge, prompt practice resolution in the management plans for safeguarding concerns.

The safeguarding vulnerable people policy (2019-2022), set out the overall agenda for safeguarding and the action required when a concern was identified. Discussions with paediatric staff and leaders confirmed the person who identified concerns completed the referral. Training delivery and updates were shared across the workforce on how to complete safeguarding referrals and how to use the check list. The e-MAF standard operating procedure was in place.

Daily safeguarding huddles were fully established across acute paediatric services and UECC with plans to extend into community services. Leaders shared examples of learning and themes emerging from the huddles in supporting to drive services improvements.

At inspection we were told that work was required to develop routine safeguarding supervision for consultant staff. Following inspection, the trust said routine safeguarding supervision for consultants had been in place for some time. The recording of this on the electronic staff record was being developed, however, manual records were kept by the safeguarding team. We did not see evidence of these records whilst on inspection or following inspection.

In the event of a young person presenting to the service pregnant, that person's details were recorded on the hospitals meditech system. Staff received a situation, background, assessment and recommendation (SBAR) handover from the labour ward. Discharge planning included meeting with all relevant services. The neonatal outreach team would visit the young mother for six weeks in coordination with health visitor and social worker visits. The maternity unit's teenage pregnancy midwife is also involved.

We did not see information regarding staff Disclosure and Barring checks (DBC's), however at inspection no concerns were raised about DBC's.

Staff acted as chaperones when needed.

Where a child or young person were assessed to be at risk of self-harm or suicide staff contacted the children's and adolescent mental health team (CAMHS) for support and guidance. Staff said that they would refer the child to the CAMHS team who would then assess the child on the ward. However, some staff expressed concerns that this did not take place until the child was medically fit. During our inspection of the service children and young people with mental health concerns were resident on the children's ward and would be there until a tier 4 mental health bed was found. The situation had been appropriately escalated to NHS England and all appropriate agencies were involved in the care planning to ensure the young person received the care and treatment required. CQC also escalated this as we had concerns that these young people's care and emotional needs may not be fully met on a general paediatric ward.

The trust had completed a training needs analysis and an action plan to deliver training around safeguarding/CAMHS/ Mental Capacity Act and Deprivation of Liberty throughout 2021.

Cleanliness, infection control and hygiene

Services for children and young people

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

In response to the pandemic we saw local environmental changes had been made to allow for social distancing. The paediatric ward was designated the COVID-19 ward whilst the paediatric assessment unit was a designated non COVID-19 area. We observed that all clinical areas were visibly clean. Staff said they had received training in donning and doffing personal protective equipment and were seen to be bare below their elbows.

Throughout the service signs were located reminding people to wash / gel hands on entry and exit to clinical areas and above sink areas. We saw enough hand gel and hand sanitiser available and staff used hand sanitiser between patient contact and on entry and exit to clinical areas.

To monitor practice saving lives' audits took place which included handwashing, bare below the elbow, cannulation, ventilation and cares audits. We reviewed these monthly audits which took place from April 2020 to March 2021 and saw compliance was rated as 100% against 21 of the 22 audits we reviewed. One audits non-compliance related to two staff wearing stoned rings.

During 2020/21, the formal collection of cleanliness audits in some months were ceased to facilitate the high touch point cleaning and allocation of staff to backfill any staff gaps caused by illness, shielding or isolation. This resulted in fewer audits recorded formally. The facilities team continued to undertake visual audits during the months when formal audits were not recorded. The transition from C4C audit software to MiCAD4 cleanliness audit system resulted in no formal audits recorded in January 2021. Environmental cleanliness audits which took place across the service identified average compliance from 99.10% (neonatal unit) to 98.83% (children's ward).

Children's toys were cleaned by the nursery nurses or nursing staff.

Environment and equipment

The premises design and environment were child friendly. We found gaps in equipment checks throughout the service. Staff were trained to use the equipment. Staff managed clinical waste well.

Access to all children and young people's services had secure doors with camera assisted entry system. Windows that could be opened were secured with restrictors. Overnight facilities were available to parents and carers. There were private areas that parents could use when breast feeding to maintain privacy and dignity.

Six bed spaces on the children's ward had piped oxygen; in addition, central monitoring was installed on the children's ward. Fire extinguishers were accessible, stored appropriately, in date and there were clear fire exit signs.

Staff received training in the use of new equipment either as part of their mandatory training or training specific to new equipment.

Trust maintenance records for the children's ward confirmed when equipment maintenance checks had taken place. We observed that 19 pieces of equipment were identified as not found, one piece of equipment was lost, and eight pieces of equipment were not within the department. Where maintenance dates were due, we saw they had either been sent for testing or testing was complete.

Trust maintenance records for the neonatal unit identified 27 pieces of equipment as not found / in use for when their maintenance was due. It was not clear from the records whether this equipment was in use and if so, the maintenance dates had passed.

The 2019 CQC report had identified that 'the trust must ensure that all medicines refrigerator checks are recorded in line with trust policy, and action is taken if they are out of range.' A review of data loggers showed that temperatures remained in range, except for the medicine's fridge in the children's outpatient department (COPD). The COPD fridge readings were: 10 May 11.1, 11 May 10.9 and 12 May 10.1 The medicines stored inside the fridge labels said they should be kept below four degrees. Staff were not all clear as to the process for reporting temperature discrepancies, one staff member said they thought they did not have to report that the medicines fridge temperature was out of its acceptable range unless this had happened on three occasions. Staff reported that discrepancies had been reported through the incident reporting system several times as it was a persistent problem, especially when the weather was warm. The COPD medicines fridge guidance was identified on a note on the fridge.

We escalated this to the senior management team and went back to the COPD the following day where we saw that the temperature was now within range

The milk fridge and freezer on the neonatal unit were not locked. Expressed milk was stored as per trust guidance. Senior managers said new milk fridges had been ordered for the neonatal unit so that babies breast milk could be stored separately in their own drawer in the freezer. The milk fridge on neonates had lockable units for each baby's milk to be stored securely and the mother set the code for the lock.

Equipment checks on the children's assessment unit and children's ward were not always completed daily as per trust policy. Records showed 53 gaps in daily equipment checks from the 26 April to the 9 May. Across the service the portable appliance checks against seven pieces of equipment had expired.

Across the service not all daily resuscitation trolley checks were completed. Resuscitation trolley record check documents on the neonatal unit (NNU) were not specific to the NNU although they were stored with the resuscitation trolley. The resuscitation trolley check lists identified labour ward and intensive care unit. Nurses had signed resuscitation trolley checklists in the NNU however, this checklist did not identify it was specific to the NNU resuscitation trolley. We went back to the NNU and rechecked the resuscitation trolley checklists during the well led inspection and found the checklist related to the neonatal unit only.

Products subject to the control of substances harmful to health (COSHH) regulations were kept in locked cupboards on the NNU and children's assessment Unit. However, these products were stored in an unlocked metal cabinet on the paediatric ward. Later, we went back to check the COSHH cupboard which we found to be locked.

Staff managed clinical waste well. Sharps bins were used by staff to dispose of sharp instruments or equipment and were secure, dated, signed and stored off the floor.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Services for children and young people

The service had systems, guidance and protocols in place to manage the deteriorating baby and child. Staff when asked were not aware of a deteriorating baby or child policy and procedure. Retrieval services for children and neonates were provided by a children's transfer service whose role was to transfer sick babies and children to the paediatric and neonatal intensive care units based in Leeds and other centres.

Situational awareness for everyone (SAFE) 3/1/2016 informed staff of the safety huddle process. Completed safety huddle documentation was seen in the neonatal unit. Discussions with staff throughout children's services confirmed these safety huddles took place.

Risks to babies on the neonatal unit were identified during initial assessment and documented within care plans. Ongoing reviews of babies' risks took place. At shift handovers, safeguarding issues and specific risks were discussed with incoming staff.

Deteriorating babies were transferred out to more specialist hospitals, staff said they did not use a specific system for babies who exhibited signs of sepsis. However, sick babies' clinical observations were monitored hourly and discussed at the daily safety huddle meeting. Staff said they completed full septic screens on sick babies and antibiotic therapy was commenced within the hour of arrival or recognition of the septic episode commencing, Staff we spoke with felt confident that all staff knew what to do in a baby's sepsis situation.

The trust said that in line with the region they had not implemented the national early warning score on the neonatal unit.

A neonatal sepsis guideline was in place and benchmarking against NICE guidance had been undertaken. The trust had incorporated the early neonatal sepsis NICE guidance into local guidance and as part of this the new-born early warning trigger and track (NEWTT) was used as a trigger tool in identifying at risk neonates and managing them.

The children's service had invested in an electronic track and trigger system. The paediatric early warning score (PEWS) was used to monitor children at risk of deterioration by grading the severity of their condition and prompted nursing staff to get a medical review at specific trigger points. Of the nine children's records we reviewed we observed that four children's PEWS assessments had been escalated appropriately; the other five PEWS assessments had not required escalation. Conversations had taken place in relation to how this digital form of PEWs could be audited.

In 2020-2021 the service cared for 14 level one patients' in the children's HDU. Two high dependency unit (HDU) beds were located on the paediatric ward in separate areas due to COVID-19 isolation requirements. Two HDU cots were located on the special care baby unit.

The CQC March 2019 report identified a MUST action that the trust must ensure 'there was a nurse trained in European life support (EPLS) or advanced paediatric life support and their competencies maintained present on each shift'. We reviewed three different nurse rotas and saw that there was a minimum of one but often more EPLS trained nursing staff per shift working on the children's wards.

Children who underwent surgical procedures were admitted under a designated surgeon at the trust. During our inspection, we tracked one child through theatre and observed the surgical safety checks were completed appropriately.

Staff said they could access the children's and adolescent mental health (CAMHS) team 24/7. Staff could access a flow chart in the CAMHS folder which advised staff what to do in a CAMHS crisis. Staff said CAMHS admissions were also identified on the local risk register.

Services for children and young people

When a CAMHS admission was admitted to the children's ward to mitigate the risk to individual children and young people in addition to the ward assessment staff completed a daily environment ligature risk form assessment for each person.

Children's Nurse staffing

The service did have enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 children's service confirmed that all registered nurses within the children's unit were trained in accordance with The Nursing and Midwifery Council (NMC) requirements to care for sick children and Royal College of Nursing (2013).

The paediatric ward was established for five registered nurses on shift. This will only reduce due to absence/sickness and will be proactively covered using bank/agency staff or redeployment from across the trust.

Staff said monthly reviews of staffing establishment were completed. The Safe care tool was used to confirm acuity/ staff skill mix needs. Safe care was completed three times daily by the nurse in charge. The new electronic roster commenced as a trial six weeks ago. Staffing within the children's service was considered safe by staff who worked throughout the service. Where shortfalls existed, bank and / or agency staff were sourced.

During the last 12 months the service had deployed bank staff who were predominately made up from their own staff working additional shifts and mental health agency staff.

The figures for funded and actual staffing establishments in paediatrics confirmed that the nursing establishments were fully recruited into.

We reviewed four staff duty rotas which confirmed band 6 and European Paediatric Life Support (EPLS) trained staff cover the department 24/7. The staff list we saw confirmed that 11 staff had completed and passed the EPLS course. Staff said that EPLS training was now being offered to band 5 nurses.

Three advanced paediatric nurse practitioners (ANPN) worked within the service and were based on the ward. Specialist paediatric nurses trained in asthma, epilepsy, diabetes and enuresis, were available to support the acute and community paediatric service. Link nurses were identified to provide additional support and expertise for the service, for example, tissue viability, surgical, moving and handling, CAMHS.

Neonatal nurse staffing

The service did not meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011) for qualified in speciality (QIS) nursing staff. The unit was expected to be compliant in 2022. The existing action plan was updated regularly. To mitigate staffing risks in the interim pre-QIS training and competencies for neonatal nursing staff were introduced and staff said the neonatal unit had escalation guidance in place. This was the 'Escalation policy for safe staffing and cot pressures within the neonatal unit' (Ref129).

We reviewed staffing skill mix with staff against five weeks of nurse rotas. The duty rotas confirmed that every shift had a minimum of two qualified in speciality (QIS) staff present. In total the unit now had four band 6 QIS trained sisters and 14 band six staff nurses. Staff confirmed that the unit had 14 band five staff nurses who were being put forward for QIS training.

Staff said the neonatal unit aimed to have five nurses per shift. If necessary, bank shifts would increase cover to five staff per shift. This system commenced at the end of April 2021. Night shifts sometimes had four staff dependent on acuity levels.

We reviewed nurse staffing levels information on the electronic Badger system with a staff member which showed where BAPM guidelines were met and any shortfalls against national staffing average levels. The information provided showed an improvement in the percentage of shifts staffed to BAPM recommendations. From January 2020 to May 2021the percentage of qualified staff in speciality (QIS) was from 79.51% in 2020 to 85.99% in 2021. The national average was 79.98% shifts QIS to toolkit for the period January to May 2021.

Staff said that on occasion the ward manager had worked clinically to ensure appropriate skill mix per shift and there had been occasion when the nurse in charge had also taken a small caseload.

Staff described staffing levels over the last 12 months as safe. Some staffing incidents over the last 12 months were reported and had been when the unit had gone over capacity or acuity. The last incident was reported a couple of weeks ago, was investigated by the incident team and the sister was sent the outcome.

A what's app group for staffing was in place where shifts were advertised at the last minute due to increasing dependency levels on the unit.

The unit employed three nursery nurses. Two nursery nurses worked 24 hours per week, and one was contracted for 30 hours. The nursery nurses worked long days on the unit and their work included preparing parents for discharge and parent craft work.

Bank and agency staff usage

Staff said to mitigate staff shortfalls additional funding for bank staff was available. From April 2020 to April 2021, the trust reported a bank shift total of 862 in children's services for qualified nursing staff. The monthly average was 71.8; shifts not filled was 14.6. In total, 176 shifts were not filled by bank staff.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 did not meet British Association of Perinatal Medicine (BAPM) Guidelines (2011) for medical staff, as there was no dedicated medical provision for the special care baby unit (SCBU) out of hours. A business case was submitted in 2020 to address this but was not supported. This was part of the clinical negligence scheme for the trusts action plan for this business case to be revised and resubmitted.

To mitigate the risk the twilight shift was instigated to meet the requirements of the RCPCH standards to ensure Consultant cover. Close working existed with maternity and In February 2021 a business case was submitted to create a substantive post. In the interim a locum covered the middle grade gap. These staffing shortfalls were also identified on the risk register.

The service was not compliant against two of the ten 'Royal College of Paediatrics and Child Health (RCPCH) Facing the Future standards. The current establishment for acute paediatric consultants was eight whole time equivalent (wte) consultants.

The trust submitted a 'Business Case to address RCPCH 'Facing the Future Standards' dated 28/10/2020. Within the business case they confirmed non-compliance against the RCPCH standards as:

A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.

Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned.

To mitigate the risk the paediatricians had bridged the gap using substantive consultants until the additional consultant post was recruited into. Routine twilight shifts between 16:30 – 20:30 were introduced within existing consultant job plans which ensured that the trust was compliant against the 'Facing the Future' standards. These were implemented at the start of the COVID-19 pandemic (March 2020). A business case was approved in February 2021 for recruitment of an additional consultant paediatrician to support this on a permanent basis. This post is currently out to advert.

Consultants were not always on site out of hours and there was a backup consultant on call. The resident on call consultant remained until 9pm. Staff said they could access consultants help in-hours by either ringing the consultant's office or contacting the consultant on call by phone. During out of hours staff contacted the switchboard for the neonatal consultant. Consultants were described as very responsive and generally they would arrive within 20 minutes or straight away during working hours.

The hot consultant of the week has no other fixed commitments and is freed up to provide daily in-reach to the wards as well as overnight on-call. The hot consultant of the week covered both areas and they completed the paediatric ward round whilst the specialist registrar completed the neonatal unit ward round. Post ward round debriefs with the consultant and specialist registrar took place.

Children's out of hours admissions were seen the following morning by consultant staff. This meant the target of being seen by a consultant within 14 hours of admission may not be achieved. Staff said that most children were seen by a consultant within 24 hours, but this was not always documented. Shortfalls in completion of documentation was recognised and work was in progress to correct this. Nine children's records confirmed they were seen by a paediatrician or surgeon within four hours of admission, whilst eight records confirmed children and young people were seen by a paediatric consultant within 14 hours of admission.

Staff described a good medical presence and support throughout the service and consultant staff were described as supportive. Junior medical and nursing staff told us they had been able to access consultant or registrar level doctors when needed.

The service had ongoing issues with recruitment at middle grade doctor levels. The service had 6.5 equivalent middle grade staff to run a 1 in 9 middle grade rota. Staff said there were three specialist registrar vacancies. Middle grade recruitment was a nationwide issue, however, was worse in this region. The middle grade (tier 2) service ran with the use of locums.

The senior house officer rota was supported by foundation year two doctors in training; the advanced paediatric nurse practitioners will support if required.

A designated paediatric anaesthetist was responsible for children's anaesthesia services throughout the trust.

Consultant ward rounds take place daily. Consultants see all new children and young people between 08.30 and 09.00. The Clinical lead for neonatology carries out an additional weekly ward round each Wednesday. The paediatric Grand Round takes place each Friday where weekend plans are agreed.

The neonatal grand round took place via Teams every Monday and was attended by members of the multi-disciplinary team. The daily huddle which was led by medical staff was introduced recently at midday.

We attended a multi-disciplinary handover session. Handover was concise; identified bed status, staffing levels and flagged up concerns about sick patients'. We noted that necessary people were present, staff were more than one metre apart, everyone wore masks and windows were open.

Bank and locum staff usage

From January to May 2021, the trust reported a bank and agency shift total of 5833 in children's services (2915 bank and 2918 agency). There were approximately 50% unfilled shifts by bank or agency staff for medical staff.

Records

Staff kept records of children and young people's care and treatment. Records were clear, not always complete, stored securely and easily available to all staff providing care.

The trust had implemented its electronic patient record (EPR) within the service during 2021, which supported ongoing overview and history of a child and young person across all areas within the organisation. Staff knew how to flag and alert safeguarding concerns electronically.

Records were stored securely.

We reviewed 20 children's and young people's clinical notes on the paediatric ward and three neonates' clinical records. We observed that staff had completed risk assessments where appropriate and they were reviewed as directed. Children's records included documentation of weights and allergies on seven clinical notes and medication charts reviewed. Body maps were not used as standard; however, staff knew when they did need to be used to monitor skin integrity. One child/young person on the children's assessment unit who should have had fluid intake monitored did not have fluid balance charts.

During the review of neonatal notes, we observed shortfalls in information in two neonates' notes. One set of notes had no Badger admission summary present, whilst, the other Badger summary was not fully completed, and this additional information was not available from the handwritten notes.

Information for children aged five and under was also recorded in the parent held book. We saw this on the neonatal unit where red books were presented together with children's notes and completed.

Medicines

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

Staff followed systems and processes when safely prescribing, administering and recording medicines. Medicines were prescribed on Meditech and allergy status and weight were recorded. We reviewed 11 medicines charts which were completed appropriately. Staff followed current national practice to check children's and young people had the correct medicines.

Staff reviewed patients' medicines and provided specific advice about children and young people's medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines were stored securely. The Trust's pharmacy team provided a 'top up' supply service and clinical pharmacy visits.

Staff completed medicines training as part of their mandatory training. Medicines calculation and infusions are mandatory and are completed annually.

Patient group directions (PGD) were in place on the children's ward and assessment unit to allow staff to administer paracetamol and Ibuprofen without prescription. The PGD was up to date and was stored in the practice education office and nurses could also view it electronically on the hub. We saw that 24 out of 32 nursing staff were authorised to work under the PGDs within paediatrics.

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 children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Systems were in place to ensure incidents were reported, investigated and lessons learnt. The trust had an incident and serious incident policy.

Serious incidents and red flags were on the agenda across all trust boards and committee meetings. Incidents which related to children and young people were viewed within the 'Children and young people governance group'; all incidents discussed, grading was agreed by the group and action taken. Clinical risk assessments were also reviewed, and risk red, amber, green rated, monitored and action taken as deemed necessary. The safeguarding operational and strategic groups reviewed serious incidents, serious case reviews and the children's and young people's risk register.

Medical and nursing staff confirmed they knew how to report incidents and had received feedback from the incidents they reported. Staff said that incident feedback was cascaded through staff meetings and by email.

Staff we spoke with knew of the duty of candour requirements. They understood this involved being open and honest with patients' when things go wrong. Staff described an honest culture and blame free learning following serious incidents.

Services for children and young people

Quarterly paediatric multi-disciplinary team critical care meetings included discussions on morbidity and mortality. The children's transfer service, Sheffield, ear, nose and throat representatives and Sheffield paediatric intensive care representatives attended these meetings.

Monthly mortality data and learning took place at peri-natal mortality and morbidity meetings, clinical governance committee and trust board. An annual perinatal event also took place attended by paediatricians and other agencies.

Minutes of the Rotherham child death overview panel and critical care group demonstrated learning and identified actions from the cases discussed.

The children's service incident register captured all incidents within the service. Top themes were identified for 2020 which included: Term admissions to SCBU, Environmental factors, Medication incidents, Readmissions, Communications and CAMHS. In response to these themes' actions have included training, conversations with the estates department and counsellor and security support.

Is the service effective?

Good

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

Evidence-based care and treatment

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

We reviewed 15 electronic clinical guidelines which were all in date. Staff said some guidelines were pending review. We asked for a report of how many were in date and not in date which we were told would be submitted. We also saw folders with printed guidelines which were mostly out of date kept behind the desk on the neonatal unit.

Following the inspection, the trust confirmed that there were 185 internal standard operating procedures, policies and guidelines within the children's and young people's service and identified that none were past their review date.

Clinical guidelines were discussed at all divisional governance meetings and at the clinical governance committee, quality committee and document ratification group. Compliance with completion of out-of-date guidelines was addressed within other forums such as the monthly divisional performance meetings.

Evidence provided confirmed that the service was working towards initiatives such as the 'Baby Friendly Initiative' and implementation of the 'Bliss Baby Charter. The neonatal unit had registered for Bliss to submit the audit data.

The Royal College of Surgeons children's standards were applied to the children's service. The children's service had reviewed the standards and actions were put in place to ensure compliance.

Feedback from anaesthetic staff identified regular participation in child anaesthesia audit. We saw a recent audit about the use of anaesthetic cream prior to cannula insertion. The audits outcome had improved success rates of cannulation at the first attempt.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service planned for children, young people and their families' religious, cultural and other needs.

A variety of food choices was available to children and young people. Basic foods were kept on the children's wards, which could be provided outside of the main mealtimes. Meal plans were tailored to individual needs, to ensure cultural and dietary needs were met.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff made alternative meal arrangements for children that were sleeping during mealtimes.

Specialist support from staff such as dietitians was available for children and young people who needed it. Staff fully and accurately completed children and young people's nutrition charts where required. The four nutrition assessments we saw were completed and had been reviewed.

Pain relief

Staff assessed and monitored children and young people 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.

The adult pain management team provided help and advice on pain management issues and were contactable by bleep. Services were provided to the over five-year olds, whilst, ear; nose and throat inpatients went to Doncaster. Children and young people had patient-controlled analgesia (PCA) for use in pain relief. The pain team reviewed children and young people with a PCA or called them. The pain team currently do not routinely go to the wards.

The children's service has identified a paediatrician link consultant to liaise with surgical doctors and an anaesthetic paediatric lead for surgery. The service had 24/7 access to an on-call anaesthetist for patient-controlled analgesia (PCA) support.

Babies, children and young people had access to a range of pain distraction techniques and pain medication. Nine children's charts were reviewed which confirmed the use of pain assessment tools.

There were no pain audits specific to children and young people; this area required development.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes.

Services for children and young people

We saw evidence that children's outcomes were being monitored through the national clinical audit programme the trust subscribed to. There was multi-disciplinary team involvement when these audits were undertaken from which action plans were identified and ongoing monitoring put in place.

Neonatal network review activity had taken place in 2019 and the Royal College of Surgeon's surgical standards assessed, and measures put in place to ensure compliance.

Children's educational outcomes were not met as onsite teaching support was not available.

A neonatal outreach team supported families to care for their babies at home and reduce length of stay on the neonatal unit. Twilight shifts for consultants for the acute hospital site provided senior support at the busiest times of day.

The trust had consistent afternoon clinics dedicated to providing child protection medicals. Rapid access clinics run by consultant paediatricians took place Monday-Friday to support GPs for quick access to review and treatment by the acute paediatric team.

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.

A learning needs analysis was conducted in 2020. The analysis was comprehensive and identified a training programme which covered a wide range of clinical and professional skills. The preceptorship programme ensured new staff were allocated buddies or preceptors. The neonatal band 7 clinical educator worked two days as an educator.

The trust integrated performance dashboard for April 2021 confirmed 87.84% appraisal completion compliance.

We saw evidence staff had received or had attended appropriate role specific training sessions. Ongoing training was being provided to ensure that staff had the competencies and skills relevant to their areas, for example, band 5 neonatal nursing staff had been put forward for qualified in speciality (QIS) training and European paediatric advanced life support (EPALS) training had been completed by nursing staff. Three CAMHS training sessions took place from March to May 2021.

Due to the pandemic face to face resuscitation training sessions were not delivered from March 2020 to November 2020. This had resulted in shortfalls in training compliance in this area, please see below figures. The trust resuscitation training completion target was 100%.

Resuscitation training compliance statistics for neonates confirmed 22 of 33 staff (completion rate 69%) had completed newborn basic life support whilst 19 of 31 staff (completion rate 61%) had completed advanced neonatal life support training. In addition, 22 of 33 (completion rate 69%) neonatal staff had completed level one resuscitation training.

On the children's ward 22 of 37 eligible nursing staff had completed paediatric basic life support which identified a compliance rate of 60% year to date. Eleven of 12 nursing staff had completed the European paediatric advanced life support (EPALS) training.

Services for children and young people

We saw training compliance shortfalls for neonates and the children's ward identified for medical staff; completion rates year to date ranged from 30 to 43%. Eligible staff to attend this training were identified from 10 to 21 staff. Ten medical staff were identified as eligible for completion of the four yearly European paediatric advanced life support (EPALS) training.

Outside of the immediate children's service in areas which treated children and young people. In day surgery and theatres staff undertook training on paediatric and adult basic life support annually. Operating department practitioners (ODP) and emergency team staff were trained in advanced paediatric life support. Adult outpatient staff had completed adult and paediatric basic life support training annually.

Operating lists with paediatric patients' were allocated to anaesthetists who had been trained to work with paediatric patients' and had completed advanced paediatric life support. Adult staff in the urgent and emergency care centre (UECC) attended breakfast clubs where topics included sudden unexpected death in childhood, paediatric observations, rashes, priority scoring systems.

All consultants appointed were trained to be educational and clinical supervisors. Medical training was supported by the consultant body and each junior doctor was appropriately allocated a clinical and educational supervisor. Teaching and training opportunities was by regular attendance of the grand round, mortality and morbidity meetings, departmental teaching and safeguarding.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

We saw evidence of close working between the multi-disciplinary team. Clinical assessment, discharge planning and treatments used a child friendly approach, which utilised play and distraction therapies. Play therapy staff provided a seven-day service.

Allied health professionals and community teams completed required assessments and liaised closely with hospital nursing staff.

The ward manager said relationships had improved between the urgent and emergency care centre (UECC) and children's service. Weekly multi-disciplinary meetings now took place between both specialities. A new nurse rotation was planned between UECC and the children's service. Two staff from both specialities were due to rotate into the specialities from June 2021 for a three-month rotation.

Seven-day services

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

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

Consultants and / or senior registrars led daily ward rounds, including weekends.

Health promotion

Services for children and young people

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards/neonatal unit.

Staff assessed each baby, child and young person's health on admission and throughout their hospital episode. Where required staff advised on healthier options, for example, diet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

In the 2019 CQC report we asked the trust to improve in one area. This was 'The trust must ensure all staff know what action to take if they felt a parent didn't have capacity to consent'. Three of the staff we spoke with knew how to support parents who lacked capacity to make their own decisions and showed understanding of Gillick competency.

Staff we spoke with demonstrated an understanding of Frazer guidelines and Gillick competence. Trust training statistics confirmed staff attendance at Fraser and Gillick competence training sessions included within children's safeguarding level two, three and four training sessions.

Staff demonstrated through discussion that they were informed of and understood the consent process. Staff understood when consent needed to be verbal and when it needed to be written.

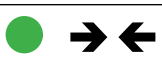
Royal College of Surgeons guidance was used for informed consent. Children and young people and their families were given the options of treatment and joint decision making took place. Consent forms were signed in clinic and reconfirmed on the day of surgery. Some specialties such as orthopaedics had consent clinics. The ear, nose and throat department letters for children booked for surgery were also sent to families so that they had a typed letter with the rationale for treatment, benefits and risks of the procedure.

Children were given the option of co-signing their consent form with a parent or guardian under the age of 16 and allowed to sign the form when 16 years and above.

Staff said surgeons obtained written consent for children requiring surgery. We reviewed one surgical child's notes and saw completed consent forms for specific investigations.

Parents confirmed staff had discussed the reason for treatments.

Is the service caring?

Good 

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

Compassionate care

Services for children and young people

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of individual needs. We spoke with seven parents and two young people about their experiences. They said they were happy with the care and treatment received and their privacy had been maintained.

Staff understood and respected the individual needs of the child and young person and showed understanding and a non-judgemental attitude when caring for and discussing those with mental health needs.

Staff understood personal, cultural, social and religious needs of children, young people and their families. We were told that parents, children's and young people's spiritual needs could be supported through the multi-faith service provided by the chaplaincy within the hospital.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's well-being. Parents described the nurses as 'amazing' and felt well supported from a psychological viewpoint.

Emotional support and advice were provided by staff. One example provided was identified by a parent who said they were offered an 'afterthoughts' service. The service was provided by a midwife who discussed problems they experienced during pregnancy.

Families were supported following a loss of a child by the maternity bereavement midwife and other staff in the service. Grieving parents could access a designated room on the neonatal unit. Memory boxes and a cold cot could be obtained from maternity.

Where children had additional needs such as learning difficulties and attention deficit hyperactivity disorders staff worked closely with the parents and the child and/or young person to support them through their hospital appointment and / episode.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure that children, young people and their families understood their care and treatment. Seven parents said they had been involved in decisions about their children's care and decision-making processes.

Parents, children and young people were encouraged to feedback their experiences through friends and family and directly to staff. Positive feedback about parents, children's and young people's experiences was displayed throughout the service.

Services for children and young people

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

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

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

The trust wide steering group met bimonthly and had oversight of the services offered to all children in non-paediatric services. All directorates were invited to the steering group to discuss any issues.

Staff could access emergency mental health support 24 hours a day seven days a week. The service had seen increased admissions of children and adolescent mental health (CAMHS) patients'. In response, completion of a ligature risk assessment of the paediatric environment took place in February 2021 and the risk was identified on the services risk register. Nursing staff on the ward also completed daily risk assessments for CAMHS patients'. Staff recognised that increased admissions of CAMHS patients' constituted a risk and escalated this to senior management, NHS England and the local Clinical Commissioning Group. From what we observed the trust had taken appropriate actions through escalation processes.

Facilities and premises were appropriate for the services being delivered. Bed capacity on the assessment unit allows for 10 bed spaces. However, staff said that bed capacity on the paediatric assessment unit had increased to 13 from 10 beds. In addition, a high dependency bed had been identified on the children's assessment unit.

The neonatal service was part of the Yorkshire and Humber neonatal network.

Transitional care for all young people was not in place, however, the trust was working with commissioners on young people's transition. Staff said a business plan was in development for a transitional care nurse to coordinate this process and a decision was to be made as to who would lead young people's transition across the trust. The diabetes service had included service user involvement when they looked at transition services. Staff said monthly meetings about young people's transition services had taken place where it was recognised that for children with complex needs the transition process was more difficult.

Managers took action to minimise missed appointments. Staff accessed local guidance in the policy for was not brought (WNB), Non engagement or withdrawal of children and young people 0-18 years from health service provision. In the adult fracture clinic, specialist surgery staff had SystmOne 'read only' access to view records of children if they had concerns, to enable them to link into other services involved with the child. These records were viewed if the 'child is 'not brought' to their appointment, if any concerns are raised by the medical/nursing staff or there is any suspicious injury.

Meeting people's individual needs

Services for children and young people

The service was inclusive and took account of children, young people and their families' individual needs and preferences. However, the current increase in children and young people with mental health needs meant that these patients' needs were not always being met. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet their needs.

Interpreters supported people with no or limited English in the spoken language to enable parents, carers and young people to ask questions relating to care and treatment options. Information leaflets were available in different languages.

Signing people supported parents, children and young people with hearing difficulties.

A learning disability nurse supported children's and young people's needs across the Trust.

Transitional care babies were cared for in the post-natal ward, staff awareness of these babies was ensured at staff handovers.

'Tell us what you think' posters told people about the forthcoming children's and young people's survey and confirmed 'Your views are important to us'. These posters were displayed in five different languages.

At the well led inspection the CQC mental health inspector met with senior staff who said that a decision was made on the 4 June 2021 to segregate these young people on the assessment unit. This resulted in a closure of the remaining beds on this clinical area. The clinical guidance was provided by RDASH and care procured from 'Secure Care'; however, advice on restraint and physical intervention was led by the trust security team.

Discussions with senior staff identified a lack of clarity over who was responsible for ensuring compliance with the segregation policy. The segregation plan indicated a daily review by the psychiatrist. The secure care team also completed a care checklist, which was shared with trust staff.

The CQC mental health inspector reviewed the care and associated documentation for two children with mental health needs who were resident on the assessment unit. Both young people had care plans which related to their care needs; however, it was unclear as to how much involvement these young people had when planning their care, during the risk assessment process and during clinical decision-making processes.

It was noted that one of the behavioural care plans for the long-term patient was not evidence based. A second care plan identified a stepped approach to encouraging dietary intake which included specific interventions. This young person was risk assessed as requiring one to one staffing support which we saw was provided by the trust.

Access and flow

People could access the service when they needed it and received the right care promptly. Arrangements to admit, treat and discharge children and young people were in line with national standards. Waiting times from referral to treatment performance had initially decreased but were now seen to have improved.

Services for children and young people

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Staff said no access or flow problems existed within the service and flow within the service was excellent due to the children's community team involvement. However, staff said that children and adolescent mental health patients' had stayed longer in the acute setting as mental health beds were not available.

From April 2020 until April 2021 the service admitted 2,271 emergency (non-elective), eight elective and 50 other patients'.

The trust confirmed referral to treatment (RTT) pathways incomplete performance at month end for paediatrics, paediatric cardiology, paediatric ophthalmology, paediatric urology, dermatology children and ENT children.

We saw percentage performance against the RTT pathways for each of these specialities was higher in April and May 2020. Since then each specialities performance after initially decreasing generally improved from June 2020 until April 2021.

A further dip in performance was noted for paediatric urology in August and September 2020 however, performance had improved and in April 2021 was at 60%. For paediatric urology, from May 2021 additional clinic capacity was being scoped for June and July and subsequent theatre demand would be accommodated within the theatre timetable.

Paediatric ophthalmology and paediatric dermatology RTT performance was 85.5% and 100% respectively in May 2021. We observed that paediatric dermatology performance ranged from 81.1% (one occasion) to 100% over this 12-month period.

For children who had waited more than 18 weeks the trust confirmed the actions taken to progress these waits. For example, in the paediatric ear, nose and throat speciality as of May 2021 32 patients' had waited more than 18 weeks. The actions identified were: Three patients' had confirmed outpatient appointments in May, four patients' had 'to come in' dates at the NHS Trust, 24 were waiting for to come in dates and one patient was in the process of being reappointed following investigations.

Measures to improve performance within surgical specialities included weekend clinics for ophthalmology and ENT patients, ad-hoc paediatric ophthalmology theatre lists and funded ENT theatre sessions at another NHS Trust were planned.

In 2019, the England average for readmission rates within two days of discharge following emergency admission was 3.7%. Children's services readmission rates within two days of discharge following emergency admission from April 2020 to March 2021 was 5.1% which was 116 readmissions. Discharges for this period were 2,272.

Clinic attendance was through a combination of telephone and face to face consultations. The rapid access clinic operated every working day to ensure urgent patients were seen immediately. Outpatient provision included consultants from other NHS Trusts undertaking clinics locally. Staff said some ear, nose and throat, dental and fracture clinics took place in adult clinics.

Dedicated paediatric lists were not in place, children were operated first on mixed lists. Day surgery children went to the children's ward post-surgery. Staff said this was on the risk register as children cannot be separated from adults in day surgery.

Discharges are completed through the electronic patient record. Community teams and GPs received a copy of the discharge summary. The children's community team attended daily team meetings. Nine parents said they had been involved in discharge planning arrangements.

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 children, young people and their families in the investigation of their complaint.

Throughout the service complaints and duty of candour guidance was displayed. Parents confirmed they knew how to complain and where to access this information.

Robust complaints management and monitoring systems were in place. Managers investigated complaints and identified themes. In 2020/21 some complaints received related to care, communication and information.

Staff said concerns were dealt with locally, escalated if required and complaints feedback was shared.

Is the service well-led?

Good ➔➔

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

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.

The children's service had seen changes in its management team. These changes included a new ward sister who commenced in June 2020, a new matron and a new head of nursing.

All the staff we spoke with described senior managers as visible and approachable and the service was well led.

Two designated children's leads sat at trust board level. The deputy chief nurse (who held a paediatric nurse registration), led the children's trust-wide steering group on behalf of the chief nurse. The service was supported by a lead paediatrician, lead neonatologist and lead anaesthetist. Network leads for each surgical speciality were provided to the children's service by another NHS Trust.

Vision and Strategy

The service did not have an overall vision for what it wanted to achieve. The strategy was due to be refreshed.

Some senior staff when asked were not aware of a strategy for the service. Information received from the trust following inspection confirmed there was a combined acute service strategy which was due for refresh and was being worked on currently. The current strategy dated April 2018 to April 2020 was submitted. This strategy covered acute, complex care and looked after children.

We saw some service visions displayed in both the special care baby unit and the children's outpatient department (COPD). Staff in the COPD said they had involved staff within the department in the development of this vision.

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.

We spoke with 20 staff throughout the service. Junior staff of all backgrounds said they enjoyed working in the service and had felt well supported within their roles. They described an open, learning culture which supported them to provide good patient care and learn from mistakes.

Staff we spoke with were not always aware of who the Freedom to speak up Guardian was within the unit or trust.

The service had an open culture where children and young people, their families and staff could raise concerns without fear.

Governance

Clear governance processes were identified for the service. However, in some areas communication and involvement within initiatives was not always clear. This included the children's strategy and the design of the local safety standards. Some clinical guidelines were also out of date. Staff at all levels had defined roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance processes were in place which supported service performance and recognised patient safety, patient experience, clinical effectiveness and committee governance requirements. The 'Children's Services Governance Structure' showed the associated groups which fed into the clinical governance committee led by the trust's medical director. To ensure a trust wide profile the children's trust wide steering group was led by the chief nurse.

Although, we saw robust governance systems in place we noted that in some areas communication and involvement within initiatives was not always clear. This included the children's strategy and the design of the local safety standards. Some printed clinical guidelines were also found to be out of date on the neonatal unit.

The trust said that clinicians were involved in the design of the local safety standards (Surgical Division, covering adult and paediatric services) and all clinicians involved in the procedures were responsible for ensuring that the relevant checklists were completed. However, on discussion with some senior staff they said they had not been involved in the development of these standards.

Services for children and young people

Robust safeguarding governance processes were in place. The 'Safeguarding and Vulnerabilities Team Annual Report 2019-2020' informed the quality assurance committee of the responsibilities and value delivered by the trust safeguarding and vulnerabilities team and provided progress on work streams agreed within the work plan for 2019/2020. The report was comprehensive and identified key priorities for 2020-2021 to strengthen safeguarding arrangements for the trust.

Management of risk, issues and performance

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

The trust integrated performance dashboard for April 2021 identified performance and compliance against key performance indicators (KPI).

The clinical audit plan for children's and neonates was a shared programme. National audits were identified with details of whether they were to commence, completed, awaiting national results or in the action planning stage.

The service trust risk management policy (v3) identified risk reporting, escalation and assurance arrangements.

Risk registers were in place. Staff said that the risk register was reviewed regularly, and staff knew what the overall risks were. Some of the risks identified included: inpatient children and adolescent mental health services, transition and guard rails on infusion pumps. Staff said that the guard rails on infusion pumps would go live in June 2021 once all staff had received training in their use. The risk register identified risks to the service; Currently, the maximum risk rating for the neonatal and inpatient children's service was identified as a 20. Staff were aware of the risks in their areas and identified some of these risks through conversation.

At the well led inspection the CQC mental health inspector met with senior staff who told them that a decision to close beds and segregate children and young people with mental health needs on the assessment unit was made on the 4 June 2021.The clinical guidance was provided by a local mental health trust and care procured from a specialist provider; however, advice on restraint and physical intervention was led by the trust security team.

Discussions with senior staff identified a lack of clarity over who was responsible for ensuring compliance with the segregation policy. The segregation plan suggested the need for a daily review by the psychiatrist, however, it appeared that the secure care team conducted these reviews.

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 had implemented its electronic patient record (EPR) within the service during 2021. This records system appeared to work well for children's services. However, this new records system has not been implemented in the neonatal unit. The Badgernet electronic information system was used in the neonatal unit to capture information. Staff said the digital transfer of information was identified on the risk register as it is a new process.

The Child protection and Information System (CPIS) allowed access of information from the community and Meditech.

The children's and young people's survey 2019/20 action plan identified an action of conflicting information and knowledge of medical history. In response to this action the digital handover programme was to be implemented week commencing 17 May 2021.

Telephone conversations between the multidisciplinary team also ensured information sharing took place. These conversations were documented in the child or young person's record.

In neonates' parents were consulted at 24 hours. However, this was not always documented on the electronic system. Staff said this had been recognised and improvements had resulted.

Caldicott meetings were bi-monthly and were attended by governance departments and chaired by the medical director.

Engagement

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

We saw that themes and areas for improvement were identified and were in progress against the 2020 children's staff survey. Seven recommendations resulted whose main themes related to communication, staff involvement in change processes and staff being given shared objectives. The recommendations time scales were identified as completion by July 2021. We saw this progress had been shared at the children's and young people's governance meeting on the 10 May 2021. Some staff we spoke with said they had contributed to this staff survey.

The children's and young people's survey 2019/20 action plan identified 12 areas for development. Ten actions were completed; the remaining two actions related to discharge summary compliance and conflicting information and knowledge of medical history. In response to the conflicting information action the digital handover programme was to be implemented week commencing 17 May 2021. Discharge summary compliance rate remained sub optimal and was raised through the clinical service unit meeting, governance agendas, performance, consultants' meetings and continued to be monitored.

The diabetes service included service user involvement when they looked at transition services.

Service feedback was also obtained through the young parent and carer forum and young people's council meetings.

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.

Following the last inspection changes in ways of working included changes in safeguarding practices as a daily safeguarding huddle had been introduced throughout the service.

Services for children and young people

The psychological support huddle was introduced to support staff caring for challenging patients'.

The introduction of the safety huddle twice daily led by the medical team.

The introduction of urgent and emergency care weekly meetings at band 7 and monthly management meetings.

Staff said they were proud of the neonatal outreach service and of how well the children's ward had managed throughout the pandemic.

The children's service had just found out that they received funding from 'Baby Friendly Initiative' (BFI) to help them achieve BFI accreditation.

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 and made sure everyone completed it.

Staff received and kept up to date with their mandatory training.

The trust target was 85% and all staff groups met this target for mandatory training, however safeguarding training compliance did not always meet the trust target (see Safeguarding section).

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

Clinical staff completed training on mental health awareness and dementia awareness.

Managers monitored mandatory training and alerted staff when they needed to update their training. Due to staffing pressures, staff across wards could have time allocated on the rota to complete online training outside of their clinical shifts. This was included in their working hours and supported flexible learning.

Safeguarding

Staff understood how to protect patients' from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, however safeguarding training compliance did not always meet the trust target.

Staff received training specific for their role on how to recognise and report abuse, however the trust target of 85% was not met for two safeguarding training modules. Safeguarding adults' level two training was just below the trust target at 84.4%, and safeguarding children level one was below the trust target at 77.7%. Although improvements had been made to compliance from the previous inspection, this continued to have the potential to affect patient care. There were plans in place to improve compliance.

Staff could give examples of how to protect patients' from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Staff demonstrated awareness and understanding of safeguarding. They 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. However, patients' notes folders were not compliant with infection control standards and not all disposable curtains were dated as to when they needed to be changed in line with trust process.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The service had adopted clear curtains between bed spaces, which were wipe clean, to promote social distancing and allow patients' and staff to see each other when their privacy curtains were open.

The service generally performed well for cleanliness. However, patient and records files were torn and non-wipe clean across medical wards. This posed an infection risk to patients' and staff. Disposable curtains were not always dated in line with the trust process. This posed an infection risk as it was unclear how long they had been hung, or when they needed to be changed.

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

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were aware of current infection prevention and control guidelines, including the process for screening patients' for COVID-19, MRSA and Clostridium Difficile prior to and during an admission to wards. Hand hygiene and infection prevention and control audits were 99% compliant which met the trust requirements. Staff observed social distancing where this was possible and wore appropriate PPE. There were handwashing and PPE stations in place across wards which were well stocked and included information on PPE requirements.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. I am clean stickers were used to identify clean equipment.

The service had oversight of infection rates, with processes in place to investigate any confirmed infections which met compliance criterion one of the Code of Practice on the prevention and control of infections. Patients' identified as having a current or previous infection were isolated in side rooms and appropriate signage was used to indicate the potential for infection in order to protect staff and patients'.

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' did not always have call bells in reach.

All patient beds had access to call bells and staff responded quickly when called, however not all call bells were placed in reach of patients', specifically those patients' who were unable to mobilise well. This posed a risk to patients' as they could not always call for assistance when they needed to.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. Other equipment was regularly tested to make sure it was safe to use. The Medicines and Healthcare products Regulatory Agency (MHRA) publish alerts on medical device recalls. The service had processes in place to disseminate MHRA alerts to make sure that recalled equipment was not used.

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

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

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks, however risk assessments were not always reviewed regularly. Staff identified and acted upon patients' at risk of deterioration, however the service needed to make improvements for sepsis treatment.

Staff used a nationally recognised tool to identify deteriorating patients' and escalated them appropriately. Staff responded to deteriorating patients' in a timely way, however audits showed that there were improvements to be made in meeting the key performance indicators for sepsis treatment. When patients' deteriorated, they did not always have the appropriate ceilings of care in place and this meant that patients' who may not need interventions received them. We also saw an example of an incident where a DNACPR (do not attempt cardiopulmonary resuscitation) order was in place, and resuscitation was attempted because there was no clear mechanism to identify this decision. The trust had a mortality and morbidity group in place and there were plans in place to improve recognition of ceilings of care.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. However, risk assessments were not always reviewed regularly including after any incident. Falls care plans were not always reassessed after an incident of falls, and across the medical wards, lying and standing blood pressure was not always completed in line with the trust policy. This was important as it can help to identify patients' at risk of future falls and helps staff to mitigate this risk.

Staff demonstrated knowledge about specific risk issues, such as falls and pressure ulcers.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patients' mental health).

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

Shift changes and handovers included all necessary key information to keep patients safe. There were regular safety huddles and nursing and medical handovers across the wards. Handovers included appropriate level of detail and were holistic, addressing both clinical risks to patients' and other risks, like safeguarding and social concerns.

We told the trust in a section 29A warning notice in November 2020 that improvements must be made in the Acute Medical Unit (AMU), so patients' received timely and appropriate care and treatment. Improvements had been made and the service had taken forward initiatives to improve responses to patients' care and treatment, particularly around falls assessments and nutrition and hydration assessments, however, these changes were still embedding in the service. For example, a review of incidents showed that 37% of patients' had a documented lying/standing blood pressure, compared to 22% in November 2020. Between 9 October 2020 and 15 November 2020, 40% of patients' who had experienced a fall did not have a recalculation of their falls risk assessment. From February to May 2020, this had improved and 51% of falls incidents documented a recalculation of their falls risk assessment. This required further improvement to ensure risks to patients' were assessed in line with trust policy.

Medical care (including older people's care)

Nurse staffing

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

The service did not have enough nursing and support staff to keep patients' safe. The number of nurses and healthcare assistants did not match the planned numbers. Nurse staffing levels were an ongoing issue, one which we identified at the previous two inspections in 2019 and 2016.

Staffing was a key risk for the division and had been escalated to the trust board.

In four weeks of recent nursing rotas, 54.8% of shifts were understaffed and 61% of shifts were either understaffed or had mixed staffing. Medical wards routinely had below the planned staffing levels across the four-week period. Skill mix did not always meet the needs of patients'.

An average of 40.5% of qualified nursing hours that went to bank and agency were unfilled from May 2020-April 2021. An average of 38.5% of unqualified nursing hours that went to bank and agency were unfilled from May 2020-April 2021. This meant that there were unfilled shifts across the medical division, and less staff available to provide safe care and treatment to patients'.

The service had a trust-wide process in place to request special or one to one care for patients' who needed additional support. In a recent four-week period, 61.4% of special/one to one care shifts were unfilled and 38.7% of those shifts requested were filled by bank staff. There were no agency staff requests made in the period. This meant there was not always enough additional care and support available to keep patients' safe.

The service held a twice daily staffing huddle to mitigate the risk to patients', where this was possible, and move staff around the trust to try to provide safer staffing levels across the wards. However, wards were still left with significant gaps against their planned staffing and one to one requests could not always be fulfilled.

The trust had identified a need to move to a sustainable model of enhanced care, had plans in place and were recruiting to an enhanced care team who would be utilised to provide bespoke support to patients'; this work was ongoing.

The service had ongoing trust-wide recruitment for nursing staff and had recruited back to practice and international nurses to increase their establishment, however this impacted on the skill mix of the wards, as there were several nurses who had not fully completed their preceptorship period, and required objective structured clinical examination (OSCE) tests. There continued to be high numbers of unfilled shifts and vacancies across medical wards.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Regular staffing establishment reviews had taken place; however, the service was not able to meet the establishments required to keep patients' safe at the time of the inspection.

The site manager adjusted staffing allocations daily according to the needs of patients' and staffing gaps across the footprint of the hospital, which reduced the risk to patients' across wards, where staffing levels were exceptionally low.

The service had reducing vacancy rates. At the last inspection (2019) the vacancy rate was 19% for nursing staff in medicine, it had reduced to 7.16% at this inspection.

The service had increased sickness rates. At the last inspection (2019) the sickness rate was 5.5%, and it had increased to 7.16% at this inspection.

Ward managers were authorised to use agency staff to fulfil gaps in establishment without additional approvals. Managers limited their use of bank and agency staff and requested staff familiar with the service, where this was possible.

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

We told the trust in a section 29A warning notice in November 2020 that improvements must be made in the Acute Medical Unit (AMU) as there were insufficient numbers of suitably skilled and competent staff to meet the needs of patients on AMU. Improvements had been seen in staffing on the AMU, however there continued to be gaps in the planned versus actual staffing, particularly on night shifts. Staff were moved across wards to meet minimum staffing requirements of more than one registered nurse per ward, however when staff moved from the medical wards to meet AMU staffing requirements often the medical wards were left short. In the three months prior to the inspection there were 41 one to one health care support worker shifts requested on AMU; 22% (nine) were filled by substantive colleagues or bank staff, however 78% (32) shifts were not filled.

Medical staffing

The service did not 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 and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients' safe. There were 13.81 vacant medical staffing posts across the medical division. Gaps in establishment were mostly in the consultant grade. There were 5.64 whole time equivalent (WTE) unfilled posts, and 9.9 WTE posts filled by locum or agency staff and staff acting up. Of the consultant establishment, 40% of posts were either vacant or not substantively filled. This meant that there was reduced senior medical cover across the division. Senior review of patients' did not always happen every day because of staffing numbers; medical staff sometimes had to prioritise patients' new to the ward or those who were clinically deteriorating to review at a senior level.

We could not determine if the actual medical staffing number matched the planned number. We asked the trust for this information, but they did not provide it.

The service had increased vacancy rates for medical staff. At the last inspection in 2018, the medical division had a vacancy rate of 0%. At this inspection, total vacant posts across all medical grades was 9.8%. This meant that there were not always enough staff to provide appropriate medical care to patients'.

The service had increased sickness rates. At the last inspection (2019) the sickness rate was 5.5%, and it had increased to 7.16% at this inspection.

The service had low and/or reducing rates of bank and locum staff. There were 50% of medical staffing shifts unfilled by locum/agency/bank staff from January 2021 to May 2021.

Managers made sure locums had a full induction to the service before they started work. This was done through the agency and locum doctors had access to training modules online. Some staff received a local induction on site, however this was not consistently completed.

Medical care (including older people's care)

The service did not always have a consultant on call during evenings and weekends. On call rota gaps were seen across the medical division in the month of April 2021. This corroborated what staff told us on inspection. In the 4-week period 05 April 2021 to 02 May 2021, 35% (10/28) of night shifts had vacant red flag shifts on the on-call rota. This meant there was not always enough medical cover on call available to keep patients' safe.

The consultant on call rota had changed from one shift in 12 days to one shift in nine days, but the establishment had not increased, meaning medical staff were on call more often. There were often gaps in the medical rota; these were either filled by the good will of staff, or locums, or were not filled.

At the time of the inspection, the respiratory ward was 33 beds and designated as a COVID-19 positive ward. Medical staffing establishment had been increased. However, staff told us there was not enough medical staffing to manage the acuity of the patients' and this impacted on the length of time medical staff were completing ward rounds, discharges, and time available with patients'. This was not an isolated issue to this hospital, however, there was a risk to patients' who were not always receiving regular consultant level care, due to capacity demands.

Records

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

Staff could easily access patient records, however they were not always fully completed. We reviewed 10 full patient records during the inspection; some assessments were partially completed, and recent audits for records showed gaps in recording assessments across different assessment tools. Staff could easily access patient notes.

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

Records were not always stored securely. Patient notes were not always locked away in the lockable trolleys available on wards and computers with patient information were sometimes found left unlocked and unattended. However, the electronic systems had an automatic lock function after a period of inactivity which mitigated some of the risk.

Medicines

The service used systems and processes to safely prescribe and administer medicines. The service did not have systems and processes in place to safely store and manage all medicines. Significant quantities of controlled drugs were unaccounted for or out of date despite daily nurse stock checks. Records did not demonstrate that all medicines were kept at the right temperature, not all medicines were stored securely and staff did not always follow the trust policy when preparing and administering IV medicines.

Systems and processes were in place to safely prescribe and administer medicines. The nine electronic prescription charts we reviewed evidenced that medicines were prescribed in line with trust policy. However, we observed staff not following policy when preparing and administering IV medicines.

Staff reviewed patients' medicines and provided specific advice to patients about their medicines. The trusts pharmacy team provided a clinical pharmacy service to wards five days a week there was a limited weekend service and this affected the medicines reconciliation figures and patients' access to pharmacy advice for medicines.

Staff did not store and manage all medicines and prescribing documents in line with the provider's policy. Controlled drugs were not managed safely. We found that there were unaccounted for controlled drugs despite daily checks being

recorded. In addition, patients' own controlled drugs were not always transferred with the patient from AMU to the ward, in line with the trust policy. Following feedback to the trust actions were taken and during the second visit processes had been amended. Staff told us that although at first changes were challenging, the benefits were now being seen and this had a positive impact. However, the changes required embedding and maintaining.

At the last inspection in 2018, we told the trust they must ensure that all HypoBoxes are checked daily in accordance with trust policy. At this inspection, we found one HypoBox with glucose fast chew tablets that had expired, the HypoBox check had been signed daily by three nurses as correct and therefore the system used to check this box was not effective.

Emergency drugs were accessible and kept in crash trolleys on the medical wards.

Medicines were not always kept securely on the wards we visited. At our second visit we saw that medicines continued to not always be stored securely.

At the last inspection in 2018, we told the trust they must ensure that all medicines fridges were checked in line with the trust policy. At this inspection, the temperature of medicine fridges was not always monitored or recorded in line with the trust policy. This was a risk to patients' as medicines may not have been stored in line with manufacturer's instructions which could impact of efficacy of the medicines. At our second visit medicines fridge monitoring had been reviewed and new forms had been developed which were checked weekly by senior staff.

Staff followed current national practice and guidance to check patients' had the correct medicines and medicines reconciliation was carried out by the ward pharmacy team during the week. Medicines reconciliation figures provided by the trust showed that in the first two weeks in May weekly medicines reconciliation rates were 60.28% and 65.6% respectively this is below the national median and the trust set KPI of greater than 70% within 24 hours of admission.

The service had systems to ensure staff knew about safety alerts, so patients' received their medicines safely. However, the trust did not have an effective system to share learning from incidents to improve medicines safety. We asked nursing staff about learning from incidents on each ward we visited but none could give us an example and pharmacy staff told us they no longer logged interventions by the pharmacy team due to time pressures.

The service had processes in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Risk assessments and care pathways were used to monitor and manage the use of these medicines in patients'.

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. However, action plans were not always robust.

All staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had no never events on any wards.

Medical care (including older people's care)

Managers shared learning with their staff about never events and incidents that happened elsewhere. Staff received regular bulletins and learning from incidents was discussed at ward meetings. There was a trust-wide Organisational Learning and Action Forum (OLAF) which gave opportunity for divisional leaders to meet and discuss themes and trends across the divisions, share patient stories and innovations/changes made through learning from incidents. These key themes fed into divisional meetings.

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

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

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff 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. The trust had started a quality improvement journey relating to themes in incidents. For example, falls week on the AMU had resulted in quick wins that could be applied across wards, and the service had actioned these quickly to benefit patients'. This included yellow socks and blankets to identify patients' who were at risk of falls and falls risk information on patients' above bed boards. The service was in the process of rolling these quick wins out across wards and had plans in place to target each ward, on a risk-based approach, to make improvements to falls management and assessments.

Managers investigated incidents thoroughly. Patients' and their families were involved in these investigations. Serious incidents were investigated, and reports were produced with recommendations and lessons learned that linked to the findings. However, action plans were not always robust, did not always address the recommendations, or were not in enough detail to be measurable. Actions were not given clear measures when the action plan was developed, but were recorded after by the medical division. This meant that actions taken to make improvements may not address the recommendation or learning identified in the report.

Managers supported 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 displayed it on quality boards so that staff, patients' and visitors could see.

The safety performance data service had reduced the incidence of harm within the reporting period, however it was higher than the national average.

Is the service effective?

Requires Improvement 

Medical care (including older people's care)

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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There were systems and processes in place to identify changes to national guidelines and update policies appropriately. Staff had access to up to date policies through the online hub.

There was a sepsis pathway in place and the service used nationally recognised guidance on the management of sepsis to inform the pathway and audit of sepsis management.

Venous thromboembolism (VTE) assessments were completed in line with trust processes and recent, regular audits showed compliance was at 97% which was higher than the national target of 95%.

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

At handover meetings, staff referred to the psychological and emotional needs of patients', their relatives and carers. During the inspection, we observed staffing huddles and saw examples of patients' social and psychological needs forming part of that discussion.

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.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients' at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients' who needed it. There was specialist training to complete swallowing assessments for patients' on the stroke unit to ensure their needs were met in a safe way. When stroke patients' were on non-specialist medical wards, assessments continued to be completed by specialist trained staff.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The medical wards had intentional rounding in place where pain was assessed, as well as drugs rounds. There was a tool in place to support patients' who could not verbalise their pain that staff used to assess if pain relief was needed.

Patients' received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. The medical wards had access to a specialised pain team who took referrals and could also offer immediate advice over the phone.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements to outcomes for patients'. However, the trust's mortality performance was worse than the national average and poor performance was noted in the SSNAP audit relating to the stroke unit. The endoscopy service had been accredited under the Joint Advisory Group accreditation scheme.

The service participated in relevant national clinical audits. The service took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade C in the latest audit.

Outcomes for patients' were improving, however the trust's mortality performance remained a national outlier. The trust had put improvement mechanisms in place across the divisions and were seeing in month improvements, although it was too soon to tell from the data whether significant improvements would be made to the trust's overall score. We saw that the service had action plans in place to address poor performance in the SSNAP audit and they were working towards a model of "right patient, right place".

Managers and staff used the results of audits to improve patients' outcomes. Out of 70 planned audits, only six were cancelled in 2020/2021, due to the impact of the COVID-19 pandemic. Of those audits, 25 audits have been completed and the remainder (39) were in progress or ongoing. High level audit outcomes that we saw linked to improvements that the service intended to make relating to patient care and treatment outcomes.

Managers and staff carried out a programme of repeated audits to check improvement over time. However, we asked to see the service's audit plan for 2021/2022 and this was not provided at the time of writing this report.

Managers used information from the audits to improve care and treatment. High level audit outcomes that we saw linked to improvements that the service intended to make relating to patient care and treatment outcomes.

Managers shared and made sure staff understood information from the audits.

The Endoscopy unit holds full accreditation with the Joint Advisory Group. The service was compliant with waiting times and all actions on their action plan were on track for timely completion.

Competent staff

The service made sure staff were competent for their roles. However, managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development and there were issues for medical staff in receiving the correct training for their grade.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients, however due to staffing vacancies, not all wards had the correct skill mix, and some staff were completing their preceptorship and awaiting key skills exams before receiving their nursing PIN number.

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

Medical care (including older people's care)

Managers did not always support staff to develop nursing and support staff through yearly, constructive appraisals of their work. Nursing and additional clinical services staff appraisals did not meet the target of 90% with an average compliance of 41.83% for nursing and 50.69% for additional clinical services staff of appraisals completed. This had declined from the last inspection where overall compliance for completion of appraisals was 64.7%. Service leaders had plans in place to improve the compliance and provide meaningful appraisals to all staff.

Medical staff appraisal compliance was 91% which met the trust target of 90%.

Managers supported nursing staff to develop through constructive clinical supervision of their work, however not all staff had received this. The service had a training register in place for band 6 nurses to train in providing clinical supervision to other staff, and this was in progress.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

The clinical educators and practice development team supported the learning and development needs of staff. There were quality improvement initiatives ongoing on the medical wards and staff were being given time out for on-ward education during these events. Staff gave examples of clinical skills and training provided on the wards to meet the needs of patients', when this was needed.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, medical staff did not always receive appropriate training opportunities relevant to their training and education needs. Workload, staffing and the COVID-19 pandemic had impacted on some training opportunities for medical staff.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

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. There was input from specialist nurses available across wards to support patients care and the stroke unit had dedicated stroke nurses to assess patients' seven days a week.

Staff worked across health care disciplines and with other agencies when required to care for patients'. When stroke patients' were discharged from hospital, the therapy team member they had seen in hospital followed them up in the community. This provided continuity of care and a positive patient experience.

Staff referred patients' for mental health assessments when they showed signs of mental ill health, depression.

Medical care (including older people's care)

Patients' had their care pathway reviewed by relevant consultants; however, this did not always happen every day. Where this was a challenge, patients' were prioritised based on their clinical risk, and consultants reviewed the higher risk patients', while medical staff reviewed those at a lower risk.

Seven-day services

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

Consultants led daily ward rounds on all wards, however they were only on weekdays. Consultants were available on call at evening and 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.

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. Leaflets were available on a number of differing speciality topics to support patients make the right choices.

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients' to make informed decisions about their care and treatment. They knew how to support patients' who lacked capacity to make their own decisions or were experiencing mental ill health. Staff followed national guidance to gain patients' consent and they used measures that limit patients' liberty appropriately. However, mental capacity and best interest decisions were not always comprehensively documented and the system to review and reapply for a patients' continuing deprivation of liberty was not robust.

At the last inspection in 2018, we told the trust they must ensure that when staff complete a mental capacity assessment, they clearly document the rationale behind the decision. This included the documentation of any decisions made in a patients' best interest which must give details of who made the decision and the options considered. During this inspection, mental capacity assessments were not always fully completed, best interest decisions were inconsistently recorded, and decisions made did not always have a clear rationale documented. This meant that it was not always clear if a patient had capacity to make decisions about their care, or why decisions had been made in their best interest. This did not meet best practice standards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, although there was a full mental capacity assessment available to staff on the electronic patient record, the assessments were not always fully completed and free text boxes were not always contemporaneous. The reason for a decision that a patient lacked capacity was not always documented, and in some cases, only their clinical diagnosis was documented which does not meet the mental capacity act code of practice standards (4.7 and 4.9).

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. However, staff did not always clearly record consent in patient records. They did not always consider that a patient may consent to treatment without having the capacity to do so, and documentation evidencing this was not seen in patient care records.

Medical care (including older people's care)

When patients' could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. However, best interest decisions were inconsistently documented in patients' notes and they did not always correspond with mental capacity assessments. We saw examples of a poor level of detail when best interest decisions were documented, for example, stating the condition the patient was suffering, and not the reason the decision had been made in the best interest of the patient. This meant that there was not always evidence documented for the reason a best interest decision had been made that was individual to each patient.

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

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.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access relevant policies to get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. However, the system for renewing Deprivation of Liberty Safeguarding applications was not robust and renewals had been missed because of this. There was a process in place to review requests for extensions to DoLS, however we heard examples where this process was not robust for expiring orders. This meant there was potential for patients' to have their liberty deprived inappropriately and was not in line with best practice.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet when caring for patients'. Staff took time to interact with patients' and those close to them in a respectful and considerate way. During inspection we observed a number of differing staff and patient interactions including privacy, dignity, and kindness. Staff cared for patients' with compassion.

Patients' said staff treated them well and with kindness. Feedback from patients' confirmed that staff treated them well. We saw that patients' were treated with respect.

Staff followed policy to keep patient care and treatment confidential.

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. The medical division had access to a learning disabilities nurse who could provide in-reach support. Staff showed understanding and a non-judgmental attitude when caring for or talking about patients' with mental health needs, learning disabilities, autism, and dementia.

Staff understood and respected the personal, cultural, social and religious needs of patients' and how they may relate to care needs. We saw recognition of patients' personal circumstances relating to their care needs when we reviewed records.

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. The wards we visited had posters about the Butterfly Scheme, which is a system of hospital care for people living with dementia. The service used the Butterfly Scheme to identify patients' living with dementia and we saw this used in the care of patients' living with dementia on the wards we visited. There was a therapy dog who visited various wards across the trust to give emotional support to patients' and had recently visited the stroke ward.

Staff supported patients' who became distressed in an open environment and helped them maintain their privacy and dignity. However, there were isolated incidents where we saw patient dignity was not upheld. We also saw call bells were not always in reach of patients', particularly for patients' who needed help to move around. This was a risk as it meant some patients' who were vulnerable were unable to attract the attention of staff if they needed to access care or support. We escalated this to the ward manager, however, saw this had not changed on the next day of the inspection.

Staff undertook demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their well-being and on those close to them. Wards had access to quiet rooms to utilise for difficult conversations.

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. During the COVID-19 pandemic, staff had found ways to communicate with families and patients who were not able to be together, particularly when patients were at the end of their life;

Staff talked with patients', families and carers in a way they could understand, using communication aids where necessary. Through the COVID-19 pandemic, visiting was suspended in line with national guidance, however we heard examples of staff doing their best to contact patients' families, including giving access to iPads for video calling. Vulnerable patients', including people living with dementia, were allowed visitors, even when visiting was suspended. During the inspection, the trust was piloting visiting on some medical wards, with plans to roll out visiting across the service, to give patients' access to families and friends.

Patients' and their families could give feedback on the service and their treatment and staff supported them to do this. The service had begun to participate in Friends and Family Test (FFT) in February 2021. Response rates were low, particularly in areas of high throughput, such as AMU where in the month of March 2021, there were only three responses. However, due to the COVID-19 pandemic, visiting was restricted in the service until May 2021, which impacted on response rates.

Medical care (including older people's care)

Staff supported patients' to make informed decisions and work was ongoing to improve information given to patients' to make advanced decisions about their care which was supported by an internal framework.

Patients' gave positive feedback about the service. There were butterfly rooms in place to support patients' and their families when they were at the end of their life and families had given the service positive feedback about them.

Is the service responsive?

Requires Improvement 

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

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. There was a full recovery plan in place and staff had been upskilled to support other areas to their substantive place of work to support its implementation.

The service was working with local partners across the system to make improvements for patients' who needed evening care packages after they were discharged from hospital as this had been identified as a challenge.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We did not see any mixed sex accommodation breaches during the inspection.

Facilities and premises were appropriate for the services being delivered. The endoscopy service was JAG accredited and the service was on track to meet the requirements for this in 2021.

Staff could access emergency support 24 hours a day 7 days a week for patients' with mental health problems, learning disabilities and dementia. The service had a specialist learning disabilities team available for in-reach support.

The service had systems to help care for patients' in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

The service relieved pressure on other departments and wards when they could treat patients' in a day. There was a same day emergency care (SDEC) and short stay facility co-located within the AMU unit. This meant that patients' requiring short term interventions or observations could be seen, assessed and treated outside of the medical wards. The short stay facility was new to the service and embedding; however staff felt it was a positive addition to the service and 80% of patients' admitted to the SDEC were discharged on the same day with 67% of patients' on the short stay unit discharged back to their usual residence rather than go on to stay in hospital.

Meeting people’s individual needs

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

Medical care (including older people's care)

Staff made sure patients' living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was 24/7 access to the psychiatric liaison team and wards had mental health champions. The medical wards cared for patients' with complex mental health needs and worked with local specialist teams to gain additional learning, so staff understood how patients' needed to be cared for in the most appropriate, least restrictive way.

Wards were designed to meet the needs of patients' living with dementia. The service had completed estates work on the AMU to ensure that the facilities and signage were appropriate for people with additional needs, including dementia, and had plans in place to continue this work across the division and the hospital.

Staff supported patients' living with dementia and learning disabilities by using 'This is me' documents and patient passports. All patients' were screened for dementia and there were dementia nurses in place to support patients' that were referred to them.

Staff understood and applied the policy on meeting the information and communication needs of patients' with a disability or sensory loss. The trust had worked with the local deaf community during the pandemic and purchased free standing clear screens to enable people with hearing difficulties to lip read by removing masks.

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

Managers made sure staff, and patients', loved ones and carers could get help from interpreters or signers when needed.

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

Staff had access to communication aids to help patients' become partners in their care and treatment. There were expression tools available to staff to help assess pain in patients and staff and patients' had access to translation services.

The trust had policies in place to allow visiting during the pandemic for patients' who were identified as being vulnerable, requiring additional support or patients who were at the end of their life; we saw examples of this in practice when we visited the wards.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment recovery plans were in place. However, arrangements to admit, treat and discharge patients' were not robust and the division, and hospital had challenges in flow, particularly in outlying patients and discharge.

Discharge and flow was a concern across the medical division. There were non-stroke patients' on the stroke unit while stroke patients' were on other medical wards. There were medical patients' occupying 21 out of the 45 beds on one surgical ward. This impacted on the flow of the hospital and the ability specialist services to care for their own patients'.

Take home medicines (to take orders (TTO)) caused delays in discharges, due in part to administrative oversights. This meant TTOs were delayed as they were not received by the pharmacy team.

Discharge letters had to be signed by the nurse and then the doctor. Rota gaps and workload challenges meant that this was not always completed in a timely way.

These issues impacted on flow and meant patients' who were medically fit for discharge were often delayed, sometimes overnight. We observed an example of a patient in the discharge lounge who was awaiting TTO medication; the patient should have been discharged the day before but their TTO medication was not ready and had still not been delivered.

At the last inspection in 2018, we told the trust they should ensure the patients' medication to take home was provided within a reasonable time scale and did not delay them going home. At this inspection, we found patients' were sometimes told they could go home without TTO medication and come back the next day to collect it, in order to free up beds while patients' were waiting. This was a risk to patients' because they were sent home without prescribed medicines and this had not improved since the last inspection.

The wards identified golden patients' who were ready for discharge that day, with the aim of that patient going to their place of residence, however discharges for these patients' were also delayed, often because of TTOs and discharge letters were not completed. This impacted flow through the hospital as beds that were planned to be vacant were not always available.

When we asked senior managers about their plans to improve access and flow throughout the division, they told us they were looking to increase discharge coordinators to a seven day a week service, improve engagement of medical staff and their representation in the discharge process. They were continuing to work at a local level to arrange care placements for patients'. However, they did not address the challenges to discharges that the wards were facing robustly. The concerns surrounding TTOs and discharge letters were not addressed, which impacted on timely discharge of patients' across all medical wards.

A new discharge lounge where the nursing team were dedicated to discharge was being developed during our first site visit. During our second site visit we saw that area. It had only been open for three weeks, however the service had seen improvements in patients' experiences and the number of patients' that were discharged in a timely way had improved.

Managers monitored waiting times and made sure patients' could access services when needed and received treatment within agreed timeframes and national targets. Due to the COVID-19 pandemic, there was a backlog of patients', nationally, waiting to be seen at NHS hospitals. The 18-week Referral To Treatment (RTT) waiting time met or exceed the forecast in seven out of eight medical specialities in April 2021. There were trust-wide recovery plans in place, and they were realistic and ambitious in their planning.

Managers and staff worked to try and make sure patients' did not stay longer than they needed to, however this did not always happen. There were discharge coordinators on the medical wards Monday to Friday, however, at weekends and during any annual leave, there was no cover for these roles, and this impacted on the wards ability to discharge patients' when they were medically fit.

The service moved patients' only when there was a clear medical reason or in their best interest, however, there were high numbers of non-stroke patients' on the stroke unit, which meant that there was not always room to repatriate stroke patients' from local Hyper Acute Stroke Units (HASU) back to the stroke ward for rehabilitation. We saw four stroke patients' on other medical wards during the inspection, when there were 13 non-stroke patients' on the stroke ward. Best practice is for stroke patients' to be cared for in the right place with timely responses links to improved outcomes for those patients'.

Managers worked to keep the number of cancelled appointments, treatments or procedures to a minimum. This was a national challenge due to the ongoing COVID-19 pandemic. However, there were trust-wide plans in place to recover waiting lists and cancellations across the division and they were progressing as planned.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharges planning was evident when we reviewed records. Medical wards aimed to identify golden patients' who would be ready for discharge by 10am on each day. However, golden patient discharges were often delayed because of TTO medication and discharge letters delays.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There were daily discharge meetings across the hospital site to escalate bed pressures; flow into the community was a challenge as many local area placements were full. The trust worked with system partners in the best way they could to find solutions.

The service had a weekly length of stay meeting where each ward's long stay and right to reside patients' who were discussed and reviewed. There were multidisciplinary representatives at the meeting and there was an escalation meeting the following day to support progression of actions.

The trust had a clinical operations hub which had been recently set up; hospital and health and social care staff were co-located and they were working as a team to establish a digital platform to monitor flow and facilitate patients' being managed in "the right place, at the right time". This was innovative work for which they had won a Health Service Journal (HSJ) award.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Delayed discharges were monitored and discussed at the length of stay meeting. The trust had seen a recent increase in patients' with a long length of stay, however this was in line with national figures and reasons for this were appropriately documented and monitored through this meeting.

Managers worked to minimise the number of medical patients on non-medical wards. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. We saw that the service had effective systems in place to review outlying patients', with clear lines of accountability, however patients' were not always cared for on the most appropriate ward for their needs.

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.

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. The policy set out clear key performance indicators (KPIs) for complaint responses and included supporting information for investigations, writing staff statements and meeting the standards required by regulators.

Managers investigated complaints, staff knew how to acknowledge complaints and patients' received feedback from managers after the investigation into their complaint. The division were meeting KPI for complaints response. This had improved since the last inspection. We reviewed three complaints responses and they were apologetic and described the investigation and its outcome. Responses were timely and in line with the trust policy.

Medical care (including older people's care)

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

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced, however actions were not always effective. 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.

Medical care (including older peoples care) was provided within the division of medicine and was led by a divisional general manager, a head of nursing and a newly appointed divisional director, who also led the urgent and emergency care division. There was a matron of the day structure in place to provide senior nursing support to the division during the evening until 9pm.

Leaders had recognised that they needed to improve succession planning for nursing leadership roles and had a leadership programme in place for band six and seven nurses. They were upskilling nurses internally to support nursing staff due to retire.

We saw some effective ward managers. Most wards were well organised, tidy and appeared calm. Staff spoke positively about their ward managers and matrons said they were well supported. Matrons were visible on wards.

Divisional workforce plans identified consultant gaps and a number of vacant clinical leadership posts. Due to substantive senior medical staffing vacancies, there were medical rota gaps and some clinicians were unable to access training opportunities. This meant that there were not always enough senior clinicians in substantive posts to lead the service and there were increased pressures on clinician's capacity.

Leaders were working to improve medical recruitment, and on call rotas had been amended to allow for medical training, however there was a reliance on bank, agency and locum medical staff to fill these gaps and there was a significant proportion of these shifts unfilled (50%).

The division did not have a mortality lead and there had been no volunteers from staff to take this role. Mortality was a concern across the trust as the performance figures showed a worse position than the national average; although the trust was working on improving this, this role being unfilled meant there was a lack of focus from the ground up.

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, however it linked to staff satisfaction and engagement and there was no clear link to patient experience and outcomes. The vision and strategy were focused on right care, right place, right time, however, this did not explicitly link to local plans within the wider health economy.

Medical care (including older people's care)

The service had a clear vision statement and the trust had developed objectives and divisional workforce plans which linked to the vision. However, measures of success did not link to patient outcomes or improvements but linked to staff satisfaction and engagement in delivering good quality care. Some divisional workforce plan points were not clear, and there were queries in the plan which suggested the plan had not been ratified.

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.

We found staff morale to be generally good. Staff supported each other well and there was good teamwork. We observed good rapport between staff of different professions and teams we spoke with were proud of the services they provided to patients' and the work they had done during the COVID-19 pandemic to care for patients'.

Most staff told us that there was an open culture and they felt able to raise concerns with their line manager.

Governance

Leaders did not always operate effective governance processes, throughout the service. 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 there were gaps in governance tools, governance meetings were not always quorate and actions were not always measurable.

Ward and divisional meetings took place and staff received updates and shared learning at these meetings.

The trust-wide Organisational Learning and Action Forum (OLAF) gave opportunity for divisional leaders to meet and discuss themes and trends across the divisions, share patient stories and innovations or changes made. Action plans were being streamlined to feed into one master action plan where themes and trends could be identified. However, staff on the wards were not aware of this forum and the focus seemed to be on leaders sharing learning across divisions. It was unclear how effectively this was then disseminated to ward level staff.

Perfect Ward audits were newly implemented across most medical wards, excluding AMU which had rolled out the program in previous months. The tool was interactive and allowed for monitoring of issues across the ward from audit to audit. It was new to the service and had not yet embedded. However, actions were not always identified as having been taken, in line with the trust process. When the audits identified actions, they were usually limited only to those directly involved in any identified concern. The potential for wider learning offered by the system was therefore largely underused.

Incidents were investigated and reports were produced with recommendations and lessons learned that linked to the findings. However, action plans were not always robust, or were not in enough detail to be measurable, and timescales varied. Actions often linked to an initial conversation and not a measurable action, for example, to develop a protocol, action or audit.

Trust wide and divisional meetings were not always quorate. The trust-wide mortality meeting had limited representation from the medical division which was noted on 01/04/2021 as being required so had evidently been an issue for some time. These meetings were not always quorate from the minutes we saw.

Medical care (including older people's care)

Two of the last three governance meetings were not quorate. This was important because quoracy is required to make certain decisions and confirm the right people needed to make those decisions are in the meeting, in line with the trust's procedure. Minutes of the meetings showed that discussions related to quality and safety of care, themes and trends of incidents and complaints and risks. However, pace of improvements was not always clear; one theme relating to falls that appeared on all three minutes we reviewed had an action to roll out with no clear timescales or updates.

The medicine division had implemented a Medicine Mortality Subgroup in March 2021. The meeting had representation from medical specialities and was being driven forward by senior colleagues. The meeting was new, and terms of reference were agreed at the April 2021 meeting, however it did give a forum for the medical division to focus on mortality. This new group was not yet embedded in the service but there were structures in place to support the meeting.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, however dashboards had a limited focus on quality. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Each division had a performance meeting where quality, safety, performance was discussed. These meetings fed into the divisional board who looked at areas of concern and escalated them as appropriate.

Performance dashboards were used to measure relative performance improvement, rank against benchmarks, identify improvements in metrics and trendlines for the previous four and 12 months to monitor performance. They gave opportunity for narrative comments as well as data trends, graph imaging and RAG ratings based on targets. However, the performance dashboard in the medical division was at a high level and did not focus on the detail of quality or highlight specific concerns about patient care.

The risk register had clear initial, current and target risk levels and the high risks reflected those that the triumvirate told us about. There were 126 risks on the divisional risk register, and they had been reviewed in the identified timescale. Staffing was the main risk and this reflected the inspection findings. Managers knew how to escalate risks and were aware of the top risks in the division.

The service had recovery plans which were rag rated and included risks and mitigations that were in place. Key next steps and clinical headlines and priorities were highlighted and there were timescales attached.

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, however staff did not always follow the appropriate information governance requirements. Data or notifications were consistently submitted to external organisations as required.

Information management systems were used effectively in patient care and for audit purposes to monitor quality. Managers used information to manage the performance of the department against local and national indicators. Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards.

Staff could access a number of IT systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training and appraisals.

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 service provided evidence of continued patient engagement with patient groups despite the pandemic, for example engagement with the local deaf community, and acting on their feedback.

The service's future engagement strategy was in development for 2021-2023 but had not yet been ratified. The plan had suggested timescales to meet the aims and objectives of the strategy.

Patient feedback was displayed on quality boards on the medical wards. Thank you cards and letters from patients' and relatives were also displayed.

The service had recommenced friends and family test (FFT), which had been suspended during the pandemic, in February 2021 to gain feedback about the service. However, response rates were low, and we did not see any specific plans to improve this.

Staff on the AMU had been involved in service improvement planning as part of the response to the warning notice issued in November 2020. The service was rolling out the improvements across the wards and had plans in place to engage staff across the medical wards in the events, on a ward by ward basis.

During the COVID-19 pandemic, the trust had provided psychologist support to staff and they continued to do so regularly, through drop ins or individual sessions.

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 quality improvement.

The service was undertaking a quality improvement programme as part of their response to the warning notice served in November 2020, and in response to themes and trends across the medical division. They had implemented some quick wins from an initial AMU quality improvement falls week and yellow socks and blankets to help easily identify patients who were a falls risk had been rolled out across all medical wards quickly.

Additional quality improvement work was on going and the service had plans in place to improve key indicators in quality of care.

The division led the introduction and sustainability of a multi professional approach to clinically led length of stay reviews for patients. There were effective regular MDT meetings to address long length of stay and right to reside.

Medical care (including older people's care)

The service had a custom designed integrated discharge team where health and social care colleagues came together in co-located teams in the clinical operations hub. There was real vision and ambition being driven by staff involved. The team won an HSJ award for "Innovations around integrated working in health and social care".

The service developed a palliative care ward to provide multi-disciplinary management for patients' approaching the end of life or requiring symptom management during the first two waves of the COVID-19 pandemic to support patients' and provide the most appropriate care.

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.

All staff received and kept up to date with their mandatory training. The trust target was 85% and all staff groups met this target.

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff did not always protect patients' from abuse and the service struggled to work well with other agencies to do so. However, more staff had training on how to recognise and report abuse and improvements had been made in how to apply it.

Safeguarding processes for adults and children were not always consistently applied. We were not assured that safeguarding referrals were made in a timely manner nor contained all relevant information. The departmental safeguarding policy stated that medical staff must make safeguarding referrals; we found this did not always happen as medical staff routinely delegated safeguarding actions to other members of staff. Staff told us that referrals were often completed by staff who did not know the patient or the circumstances of the concern. We were told that adult safeguarding referrals would frequently be completed by a paediatric nurse.

There were no processes in place to review if any opportunities to make adult and children safeguarding referrals had been missed. We reviewed 20 sets of medical records and found four examples of missed opportunities for potential safeguarding concerns.

Only referrals regarding children were reviewed by the safeguarding team which meant there was no process in place to review adult safeguarding referrals to ensure effective completion.

Safeguarding training compliance for medical staff in primary care area was 62% for adults and 50% for children which meant we were not assured that staff had up to date knowledge and skills to safeguard vulnerable people in the department.

Body maps were not completed in line with departmental policy which stated they must always be used. During our last inspection we identified that the use of body maps was inconsistently utilised to accurately document injury. We reviewed a recent departmental audit from August 2020 which demonstrated that body maps were still only used in 30% of medical notes. We saw in subsequent safeguarding meeting minutes that additional work was to be undertaken but as of May 2021 it was not completed, and we saw no action plan for its completion.

However;

Following the previous inspection improvements had been made in the management of safeguarding children. Compliance for the completion of paediatric safeguarding training had improved across staff groups. Training compliance rates across all staff groups (except for primary care) was in excess of the trust target of 85%.

Safeguarding huddles had been introduced which allowed for staff to raise queries and to receive feedback from previous referrals. We reviewed the huddle minutes which highlighted that they were well attended and opportunities for shared learning were taken.

Safeguarding supervision had previously been undertaken on an ad hoc basis. Processes had recently been introduced to formalise the process to ensure that all staff received supervision.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance was above the trust target of 85% in most nurse staff groups.

Medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance was above the trust target of 85% in all medical staff groups with the exception of primary care.

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 make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service did not control infection risk well. We were not assured that staff used equipment and control measures to protect patients', themselves and others from infection. Equipment and the premises were not consistently visibly clean.

Not all areas were clean; we saw used equipment in cubicles which had not been disposed in line with guidance. We saw used disposable face masks, used blood taking equipment and equipment packaging on the floor in patient cubicles.

The service generally didn’t perform well for cleanliness. Perfect Ward audit scores identified deficiencies in cleanliness. A recent audit undertaken in the department highlighted issues with treatment trays not being cleaned after use. We saw no examples of cleaning records in any of the areas we inspected. The department was unable to demonstrate that all areas were cleaned regularly.

Staff didn’t always follow infection control principles including the use of personal protective equipment (PPE). We saw multiple examples of staff not wearing protective facemasks correctly or not using eye protection when engaging in

patient contact. Audit results from March and April 2021 demonstrated that staff did not always follow the principles of bare below the elbow (BBE). Hand hygiene audits from March and April 2021 had been completed; the results demonstrated 67% staff compliance and we found the results were not displayed in the department. This posed a risk to both staff and patients' of transmission of infectious disease.

Additional audits from March and April 2021 showed that COVID-19 patient screening was only completed on 53% of patients'.

We did not see evidence that staff cleaned equipment after each patient contact. There was no clear system used on equipment to show when it was last cleaned, so equipment had been stored with no way to ascertain whether it was clean and ready for patient use. There were no action plans in place to address this issue.

During inspection we noted there were empty hand gel dispensers within the department. This was raised to senior managers, but no actions had been taken to address the issue and they were still empty the following day. On a following inspection visit we saw further examples of empty hand gel dispensers.

Staff across all grades told us that they were either too busy to maintain an adequate level of cleanliness or that it was someone else's responsibility. We noted an incident report where essential tasks had not been completed even though patient demand was low.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

We saw occasions where patients' could not reach call bells and staff did not always respond quickly when called. Departmental audit results from March and April 2021 had highlighted this as a concern with 67% of call bells being in reach of a patient but there were no action plans in place to address the ongoing issue. This meant there could be a delay in treatment to patients', and some patients' were unable to call for assistance.

The mental health assessment/interview room was not compliant with guidance from the psychiatric liaison accreditation network (PLAN). There were multiple ligature points and the emergency alarm system did not function. We requested copies of any risk assessments to address or mitigate these issues but were told that these did not exist. We raised this with the management team during our inspection.

During a further inspection visit we saw that actions had been taken following the feedback to the department and that the ligature risks within the mental health assessment room had been reduced. We were also told that the alarm call system had been functioning, but it had been silenced by a member of staff on the alarm panel. Staff were still unable to tell us how long it had not functioned and told us that there was no checking system in place to ensure that this would not be repeated.

We were not assured that ligature risks within the department were continually monitored. Staff told us that designated cubicles in the major treatment area would also be used for mental health patients'. We requested ligature risk assessments and only one risk assessment was supplied which was dated after the inspection.

We reviewed the previous four weeks daily safety checklists of specialist equipment and saw that they consistently had omissions and were not completed fully on any day.

Staff did not always dispose of clinical waste appropriately. We saw used clinical waste of the floor of cubicles during the inspection. A recent Perfect Ward audit had highlighted that staff did not always dispose of personal protective equipment (PPE) correctly and that clinical waste was not safely secured prior to disposal.

However:

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

We saw that doors had been fitted to all cubicles to manage infection prevention and control (IPC). A recent Perfect Ward audit reported that cubicle doors were always closed when managing infectious patients', and we saw examples of this during inspection.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. They did not always remove or minimise risks or update the assessments.

Staff did not always complete risk assessments for each patient on admission, using a recognised tool, nor did they review this regularly, including after any incident. We were told by senior staff that departmental audits results from March and April 2021 highlighted incomplete risk assessments as a recurring issue, but we saw no action plans in place to address the ongoing issue.

On review of performance data, we saw a worsening picture in the time to initial assessment on arrival in department. The average wait from May 2020 to April 2021 was 17 minutes but performance data demonstrated increasing waits for triage. There was no system for clinical prioritisation in place for patients' who were in the waiting room.

There was limited evidence of a system for clinical prioritisation for those patients' who remained in ambulances or on the corridor. We were told that an ambulance assessment area had been created to address this issue but due to COVID-19 it had been repurposed and had not yet reverted to ambulance assessment.

Staff did not consistently share key information to keep patients' safe when handing over their care to others. We saw missed opportunities to share information when we reviewed patient notes. Departmental audits from March and April 2021 showed that sharing key information was routinely omitted and there were no action plans in place to address the ongoing issue. We observed that shift changes and handovers were inconsistent with the sharing of all key information.

Staff did not complete initial psychosocial assessments and risk assessments for patients' thought to be at risk of self-harm or suicide. We reviewed 20 sets of notes detailing mental health attendances and found no evidence that mental health risk assessments were being completed at the point of initial assessment. We were told that plans to pilot a new mental health risk assessment had been developed but this had yet to be ratified at board level.

We were not assured that staff had sufficient oversight of those patients in the waiting room. Patients' told us that staff were not a consistently visible presence in the waiting areas and that no-one came to check on their welfare.

There was a hospital policy for intentional rounding, however there was no specific procedure for the implementation of this in urgent and emergency care. We saw no evidence of intentional rounding in the department with regards to pressure areas, dehydration and the observation of patients' potential deterioration. This meant opportunities to manage and mitigate patient risk, and avoid potential harm were missed.

However:

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patients' mental health).

Staffing

Nurse staffing

Managers regularly reviewed staffing levels and skill mix, but not all bank and agency staff received a full induction.

The service did not have enough nursing and support staff to keep patients' safe. The leadership team told us that a staffing review had been completed but they had insufficient staff available to work on each shift due to sickness absence and COVID-19 related issues. This had led to key tasks not being completed on occasions.

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 but had insufficient staff in post to meet this guidance. The number of nurses and healthcare assistants did not always match the planned numbers. During inspection we saw that nurse staffing did not meet planned levels on any day. We reviewed nursing rotas and saw multiple examples of unfilled shifts. The service had an increasing demand for bank and agency nurses to address unfilled hours on the rota. We were told that on average 20% of all shifts were left unfilled despite being open to bank and agency staff.

The department manager could not always adjust staffing levels daily according to the needs of patients'. We were told that staff would be moved out of the department to address shortfalls in other areas of the hospital.

The service had vacancy rates of 8% of qualified staff and 15% of support staff.

The service had sickness rates of up to 10% across all nursing roles. Senior staff told us that short term sickness was not recorded so it was unclear if the sickness rate had increased due to the COVID-19 pandemic.

However,

Managers made sure all bank and agency staff had a full induction and understood the service, and senior staff told us that they only used agency staff who had the correct competencies, which was managed by the agency.

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 and gave locum staff a full induction.

The medical staff did not always match the planned number. We reviewed rotas and saw gaps across all grades which had not been filled between January 2021 and May 2021.

The service had four vacant posts across all medical grades.

Sickness rates for medical staff were up to 17% across all medical grades within the department. Senior staff told us that short term sickness was not recorded so it was unclear if the sickness rate had increased due to the COVID-19 pandemic.

The service had increasing demands for bank and locum staff to address shortfalls in the rota.

We were told that the department did not always have a good skill mix of medical staff on each shift due to staff shortages which meant that patients' did not always see a doctor in the recommended timeframe.

However;

Managers were able to access locums when they needed additional medical staff.

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

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

Records

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

Patient notes were not always comprehensive, we reviewed 20 sets of medical notes and saw examples of omitted information such as risk assessments in 10 sets of notes that we reviewed.

Records were not always stored securely. Recent departmental audits from March and April 2021 highlighted issues with computers being left unlocked when unattended which meant records were not always secure. We saw incident reports which demonstrated evidence of breaches in data security such as staff accessing confidential medical records that they had no justification in accessing. During inspection we saw computers that had been left unlocked which meant that they were not secure and could be accessed by anyone. However, the computer systems had an automatic lock function after a period of inactivity which mitigated some of the risk.

However;

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

Medicines

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

During the inspection we found one person had not been administered their critical medicines for Parkinson's disease in a timely manner, we brought this to the attention of staff. We returned in the afternoon to find that this medicine had still not been administered. Staff were not aware of a specific policy around critical medicine. We were not assured that a policy for critical medicine was available for staff.

The pharmacy department had recently started a pilot for clinical pharmacy input into the department. We were told that although new, they had seen improvements in medicines reconciliation processes within the admissions unit. Clear work plans and defined roles still required development as well as further embedding so that the pharmacy team became part of the multidisciplinary team (MDT).

Staff did not store, prepare medicines and keep prescribing documents in line with the provider's policy. We found medicines that had been prepared for administration and left in the treatment room unattended. Prescription pads were not stored in line with national or trust policy, however, on our follow up visit, actions had been taken to address the prescription pad storage.

During our initial visit, controlled drug registers were not always completed in line with legal requirements. On our follow up visit we saw that actions had been taken, however, gaps in recording were still present. We were not assured that staff were aware of the process for escalating concerns nor were we assured that staff would escalate concerns as required.

There was no oversight or process to support the safe supply of over-labelled take home medicines within the department.

The governance process to manage the oversight of those who were authorised to practice under a patient group directions (PGD) in line with national guidance was not effective.

Systems for sharing learning from medicines safety alerts and incidents was not effective due to lack of MDT working.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients' honest information and suitable support. Learning from incidents was not consistently shared with staff.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

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

We saw no themes or trends when reviewing incident reporting.

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

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

Managers debriefed and supported staff after any serious incident.

However:

Urgent and emergency services

Learning from incidents was not a standing agenda item in any staff meeting minutes that we reviewed. This meant that we were not assured that staff consistently received feedback from incident reporting or to discuss the feedback and look at improvements to patient care. We saw no evidence that managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

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

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

However;

We observed that at handover meetings, staff did not routinely refer to the psychological and emotional needs of patients', their relatives and carers.

Nutrition and hydration

Staff did not always give patients' enough food and drink to meet their needs and improve their health.

Staff did not always make sure patients' had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff told us that they didn't always have time. During the inspection we saw patients' without access to water. Departmental audits from March and April 2021 showed that 20% patients' did not always have access to water and that 30% had no access to food. We saw that senior management was sighted on this issue, but no action plan was in place. We were told that it would be addressed as part of the changes to intentional rounding.

We saw no evidence that staff fully and accurately completed patients' fluid and nutrition charts where needed. Not all staff were able to describe how they would use the nationally recognised screening tool to monitor patients' at risk of malnutrition.

Not all staff were able to describe what specialist support may be required nor what adjustments could be made for patients' religious, cultural and other needs.

We saw examples of patients' not being given adequate food and drink despite having experienced long waits within the department. Patients' told us that they had to wait long periods of time after asking staff for water.

Urgent and emergency services

Pain relief

Staff assessed and but did not consistently monitor patients' regularly to see if they were in pain and did not always give pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and but did not consistently give pain relief in line with individual needs and best practice. Departmental audits from March and April 2021 demonstrated that patients' did not always receive pain relief after it was identified they needed it, or they requested it. We saw no action plans to address this issue.

We did not see evidence and staff could not describe about alternative methods in how pain could be assessed.

Patient outcomes

Staff did not consistently monitor the effectiveness of care and treatment. They did not consistently use the findings to make improvements and achieved good outcomes for patients'.

We were told that the service participated in relevant national clinical audits but could not always demonstrate what work was being undertaken as part of those audits. Outcomes for patients' were unclear as audits had not been completed and therefore could not be said to meet national standards.

We saw no evidence that managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw limited evidence that managers and staff used the results of audits to improve patients' outcomes.

We saw limited evidence that managers used information from the audits to improve care and treatment.

There was limited evidence to demonstrate that managers shared and made sure staff understood information from the audits.

However;

The department had recently implemented a 'Perfect Ward' audit programme but this was not yet fully embedded.

The service had a lower than expected risk of re-attendance than the England average.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always complete appraisals of staff's work performance nor were supervision meetings held to provide support and development. Staff appraisal rates did not meet the trust target in all staff groups.

Staff did not always have opportunities to discuss training needs with their line manager and were not always supported to develop their skills and knowledge.

We saw no evidence nor were we told about any measures that had been introduced to support staff with the emotional impact of the COVID-19 pandemic.

Appraisal compliance at the band six and seven was inconsistent with 60% of those staff receiving an annual appraisal which was significantly below the trust target of 90%. Appraisal rates for all nursing and support staff was 54%.

However;

A newly appointed clinical educator supported the learning and development needs of staff. They had been in post a short time and had not had opportunity to fully embed new practice. Initial feedback from staff was positive.

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

Managers made sure staff had access to full notes and meeting minutes when they could not attend.

Multidisciplinary working

Doctors, nurses and some other healthcare professionals worked together as a team to benefit patients'. Some staff groups were excluded from the process and were not able to contribute to provide best patient care.

Staff held regular and effective multidisciplinary meetings to discuss patients' and improve their care.

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.

However;

Pharmacy staff told us that they weren’t included in any multidisciplinary meetings.

Seven-day services

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

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

Health Promotion

Staff provided patients' with relevant information to lead healthier lives.

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Urgent and emergency services

Staff did not always follow national guidance to gain patients' consent. Staff did not always know how to support patients' who lacked capacity to make their own decisions or were experiencing mental ill health. Staff did not always agree personalised measures that limit patients' liberty.

We were not assured that staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There was no evidence to support that managers monitored the use of Deprivation of Liberty Safeguards.

Staff did not demonstrate that they implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff did not clearly record consent in the patients' records. We reviewed 20 sets of patient notes and consistently found omissions in the assessment of capacity. We were told by junior and senior staff that mental capacity was not always routinely assessed nor recorded. We were not assured that this had been escalated nor did we see any action plans to address this issue.

Staff told us that they didn't always assess capacity and would assume that a patient had capacity unless they were informed differently.

Staff routinely used bed rails as a method to restrain patients' assessed to be at risk of falls without due consideration of consent or deprivation of liberty. We requested a copy of the general falls risk assessment to ascertain if this was a documented action, but this was not provided.

There was no evidence to support that managers monitored how well the service followed the Mental Capacity Act or to demonstrate that they made changes to practice when necessary.

However;

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

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

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

Is the service caring?

Requires Improvement ↓

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

Compassionate care

Urgent and emergency services

Staff did not always treat patients' with compassion and kindness, respect their privacy and dignity, and take account of their individual needs.

Staff did not follow policy to keep patient care and treatment confidential. We observed staff entering patients' cubicles without knocking or requesting permission. Staff also told us that assessment rooms were often entered unannounced.

Staff did not demonstrate how they understood and respected the personal, cultural, social and religious needs of patients' and how they may relate to care needs despite the provider having a process in place to identify these needs. Staff were not able to give examples of this.

We saw examples of patients' being transferred in varying states of undress with no consideration of how staff could maintain the patients' dignity during the transfer. We saw one patient being transferred without trousers and without any method to cover himself.

We saw an example of a patient who required toilet facilities within their cubicle, equipment had been provided but the curtains and door were left open to the main department.

We spoke with the carer of one patient who told they had asked for help with the patients' personal hygiene, but they had waited several hours for assistance before it was provided. They considered leaving the department because of this delay to care.

We saw examples during inspection of call bells not being in reach of all patients', and not always answered in a timely manner.

Results from the most recent staff survey demonstrated that only 48% of staff felt satisfied with the care they gave patients'.

Emotional support

Some staff did not always provide emotional support to patients', families and carers to minimise their distress. Not all staff understood patients' personal, cultural and religious needs.

We saw examples of staff speaking over patients', and not paying them due attention while providing care and treatment, for example having unrelated staff to staff conversations while taking observations.

We spoke with a visibly distressed patient who told us that staff had been rude and dismissive when they had approached them for explanations of what was happening with their care. We escalated this to senior staff, but we were told later by the patient that nothing had been done.

However,

Most 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.

We had no opportunity to observe staff supporting patients' who became distressed however, we did witness staff conversations where distressed patients' were moved to higher observation areas.

Urgent and emergency services

We observed staff demonstrating empathy whilst having a difficult conversation.

Understanding and involvement of patients' and those close to them

Staff did not support and involve patients', families and carers to understand their condition and make decisions about their care and treatment.

Some nursing staff told us that decisions were generally made for patients' with a learning disability or dementia without consideration of consent or capacity. We spoke with several registered nurses who told us that they didn't have time to consider consent or capacity and would just do what they thought was best.

We observed several patients' with communication needs being denied the opportunity to have family support. We saw an example of a patient with speech and communication difficulties not being allowed to have a family member with them.

We saw an example of a family member with Lasting Power of Attorney (LPA) being denied the opportunity to support their relative to make decisions about their care and treatment.

However:

Patients' and their families could give feedback on the service and their treatment and staff supported them to do 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 met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

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

Staff 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 service had systems to help care for patients' in need of additional support or specialist intervention. The department had introduced additional measures to deal with the COVID-19 pandemic such as having separate resuscitation rooms for COVID-19 positive and negative patients'.

The service relieved pressure on other departments when they could treat patients in a day.

However;

Urgent and emergency services

Not all facilities and premises were appropriate for the services being delivered. We saw that the mental health assessment room was not safe. We saw other areas of the department such as the viewing room being used as storage and the relatives' room being used by staff on breaks. On our subsequent inspection visit we did see that steps had been taken to address this.

Arrangements with other specialities to provide medical or surgical review within the department were inconsistently available which meant that not all patients' received the appropriate care on the same day.

Meeting people's individual needs

The service was not always inclusive and could not demonstrate how it took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients' access services. They coordinated care with other services and providers.

The hospital standard operating policy for intentional rounding, made no reference to patients' within the emergency department and was designed for ward-based patients' only. We were not assured that staff within the department knew about intentional rounding or completed it routinely for patients' in the waiting room. We were told during that inspection that this would be addressed with an intentional rounding policy. Following the inspection, we raised this concern and were told that the trust would review the policy, however we did not see any evidence that this had been completed during the reporting period.

The department had not been designed to meet the needs of patients' living with dementia and no adjustments for patients' with dementia were apparent.

We saw no evidence and staff did not tell us about processes to support patients' living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff were not able to articulate the policy on meeting the information and communication needs of patients' with a disability or sensory loss.

We saw no evidence and staff did not tell us about patients' being given a choice of food and drink to meet their cultural and religious preferences.

Staff told us that they did not have access to communication aids to help patients' become partners in their care and treatment. We saw a formal complaint which detailed an example of a patient with communication difficulties being refused family support.

However;

Staff made sure patients' living with mental health problems received the necessary care to meet all their needs.

Interpreters and signers were available; however, staff did not give us any examples of needing to use this service.

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

Access and flow

Urgent and emergency services

People could access the service when they needed it but did not always receive 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 but were not always able to ensure that patients' could access emergency services when needed and that they received treatment within agreed timeframes and national targets.

We spoke with ambulance staff who consistently reported delays in handing over patients, the trust reported 340 black breaches in the previous six months which are ambulances waiting more than 60 minutes to hand over the patient, there were waits in excess of 140 minutes reported.

We saw long waits in the waiting room after initial triage of up to and in excess of 10 hours.

The department failed to consistently achieve the national standard of patients' seeing a clinician within 60 minutes of arrival. The department had achieved the target once within the previous 12 months. The average waiting time from May 2020 to April 2021 was 96 minutes but reporting data demonstrated worsening performance with average waiting times in April 2021 being 125 minutes. During inspection we saw patients' who had been waiting in excess of seven hours following initial assessment before being seen by a doctor. We saw one example of a patient waiting in excess of 10 hours before being seen by a doctor. We were told by senior staff that patients' were not monitored or routinely re-triaged which increased the risk of a patient deteriorating without being observed. We raised this issue during inspection, and we were told that actions would be taken as part of the changes to intentional rounding.

Managers and staff worked to make sure patients' did not stay longer than they needed, but the total time spent in department was increasing and was above the national average. The national average was 160 minutes and the department’s time in department was in excess of 220 minutes

The number of patients' waiting for admission more than four hours, but less than 12 hours had improved from the previous year but was still worse than the national average. The national average was 26% and the department’s average was 31%.

However;

The number of patients' leaving the service before being seen for treatments was 5% which was better than the England average.

There were no patients' waiting more than 12 hours from decision to admit within the last 12 months.

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.

Managers monitored patient transfers and followed national standards.

An innovative and developmental electronic system was in place for the handover of patients' from ambulance crews.

Urgent and emergency services

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.

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

Managers investigated complaints and identified themes.

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

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

However;

The service did not have clearly displayed information about how to raise a concern in all patient areas.

Not all staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Inadequate  

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the service. They understood but were unable to demonstrate how they managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients' and staff. Not all staff felt that they were supported to develop their skills and take on more senior roles.

We saw limited senior leadership response to issues identified within the department. Some senior staff told us it was not their responsibility to address all the issues within the department. When we fed back on the environmental concerns to senior staff, we were told that it wasn't their role to address.

Not all staff reported that they were visible and approachable; 77 staff completed the staff survey in May 2021 and 50% reported that they felt supported by their managers. This was different from the other areas of the hospital that we inspected.

Some staff told us that there was a lack of opportunity to develop their skills in more senior roles. This led to a reported dissatisfaction amongst that staff group with a lack of opportunity to move into more senior roles. We were not told that there had been an organisational decision to put appraisals on hold due to the pandemic. Senior staff told us that pressures did not always allow time for staff to attend for appraisals during work time.

However;

All senior leaders were able to describe their role and how their skills and abilities enabled them to run the service.

All senior leaders could articulate the priorities and issues that the service faced, they acknowledged previous inspection findings and could describe how they wanted the service to improve. We saw an example of changes to the reception and initial assessment area being actioned and completed during inspection.

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.

All senior leaders could articulate the vision and strategy for the service. They could describe quality improvement plans that had been undertaken and could demonstrate actions that had been previously taken that contributed to the services development.

However;

Not all staff could describe what the vision and strategy was for the service nor could they articulate how their role contributed to the strategy. The staff survey from May 2021 had 77 staff respondents, the survey reported that only 39% of staff felt that senior staff consulted them regarding departmental changes.

Culture

Not all staff felt respected, supported and valued. There was a lack of focus on the needs of patients' receiving care.

We observed a culture of staff across all groups not taking responsibility for essential tasks or to address ongoing issues. When an issue was highlighted during inspection, we were consistently told that it was another staff groups responsibility to address, such as safeguarding referrals or ensuring the environment was clean.

We saw internal staff survey results from May 2021 demonstrated that team working was 32% beneath the trust average of 45%. There was acknowledgement from senior managers regarding the negative responses in the staff survey. We requested action plans during inspection that were in place to address the issues highlighted but none were provided.

However;

Equality, inclusion and diversity results from an internal staff survey were consistently high. The trust average reported in May 2021 was 93% and the department response was 97%.

Urgent and emergency services

Governance

Leaders could not always evidence that they operated effective governance processes, throughout the service and with partner organisations. There were regular opportunities to meet, discuss and learn from the performance of the service. However, opportunities for improvement were not always utilised or implemented in a timely way and not all staff were clear about their roles and accountabilities.

Not all staff recognised their role in governance, staff told us that they had no additional time and felt disconnected from governance process.

There was no evidence to support that senior leaders had taken action to address ongoing performance issues within the department. We found evidence that issues had been repeatedly identified but action was not always taken to address them. For example, hand hygiene compliance and completion of appropriate risk assessments.

During inspection we requested copies of policies used within the department. We saw that the intentional rounding policy was not appropriate to the service, and no action had been taken to address this.

We saw evidence of regular governance meetings across all grades and roles. These meetings were minuted and then disseminated by email and through the online hub system to ensure that all staff had access to them. However, any learning discussed at meetings was not evidenced in improvements or subsequent action planning.

During our inspection there were concerns about the oversight of the waiting area. Staff in told us that it was the patients' responsibility to inform staff if they felt more unwell or required assistance. Senior management told us that they were developing plans to improve staff oversight and safety of patients within the waiting room area. We requested the action plan following our inspection visit and this was provided, however, it demonstrated that the majority of actions were still to be undertaken, as it had only recently been introduced.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified relevant risks but there was limited local oversight to action and address any issues. They had plans to respond to unexpected events. However, not all staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We were not assured that all senior leaders were sighted on the issues within the department regarding patient care. The senior leaders were not aware of the concerns and opinions of the staff and we did not see any action plans in place to address previously identified issues.

We saw previously identified issues, such as the use of body maps in paediatric injury, and when we reviewed minutes from departmental meetings, we saw no action taken for nine months from the point of the issue being escalated. We were not assured that senior leaders had ensured a sufficient pace of change when issues were identified.

We were not assured that senior leaders had enough oversight of performance targets, whilst the department were above average in some areas, there were significant issues especially around total time in department, time to initial assessment and time to see a clinician. We saw no action plans to address performance issues.

Some staff told us that they felt disconnected from the decision-making process and that changes were made without consultation across all grades and job roles.

However;

All senior leaders were sighted on the corporate and clinical risk register. They told us about risks being allocated, reviewed and mitigation being in place.

Information Management

The service collected data and staff could access it, however there was limited evidence of analysis of this data to improve the service.

We were told and we saw that performance data was easily accessible, but we did not see any examples of data being analysed to improve performance. We asked for examples during inspection, but these were not provided.

We saw from departmental audits that there were ongoing issues with computer security and staff not securing patient data. We did not see any ongoing processes to improve overall data security.

However;

The service ensured that systems were integrated to facilitate transfer of data with external organisations.

Engagement

There was limited engagement with patients', staff and equality groups. The service collaborated with partner organisations to help improve services for patients'.

Staff told us that engagement with external groups was limited because of the COVID-19 pandemic. We were told plans to improve engagement had been developed but were not yet implemented.

Learning, continuous improvement and innovation

Senior leaders had a good understanding of quality improvement methods and the skills to use them. However, not all staff were committed to continually learning and improving the service. Leaders encouraged innovation and participation in research.

Some staff across all staffing groups told us that there were limited opportunities for improving services due to increased work pressures.

We saw examples of innovation within the department such as changes in the assessment process and the introduction of advanced care practitioners (ACP) but they were still being developed and not all were fully embedded in the service.