Care Quality Commission

Sheffield Teaching Hospitals NHS Foundation Trust

Royal Hallamshire Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Outstanding
Maternity and gynaecology	Outstanding
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Royal Hallamshire Hospital as part of the inspection of Sheffield Teaching Hospitals NHS Foundation Trust from 7 to 11 December 2015. We undertook an unannounced inspection on 23 December 2015. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

Overall, we rated Royal Hallamshire Hospital as good. We rated safe, effective, caring and responsive as good; well-led was rated as outstanding.

We rated critical care, maternity and gynaecology and outpatients and diagnostics as outstanding. Emergency and urgent care, medical care and surgery were rated as good. End of life care was rated as requires improvement.

Our key findings were as follows:

- We found the hospital was clean and staff adhered to infection control principles. The trust scored 99% for cleanliness in the patient-led assessments of care environments (PLACE) report for 2015.
- There was a trust- wide infection control accreditation programme in place. This programme set standards for infection prevention and control practice. Most clinical areas had achieved accreditation; plans were in place where this was not the case.
- There had been four cases of MRSA reported by the trust between June 2014 and June 2015.
- There had been six cases of C.difficile between April 2015 and November 2015 at the Royal Hallamshire Hospital. This was a rate in line with the England average per 10,000 bed days. The trust-wide rate of C.difficile was below the trajectory target with 42 cases against a stretch target of 52 cases at the end of November 2015.
- The trust the safer nursing care tool, professional judgement and nursing hours per patient day to determine appropriate levels of staffing. There were some areas where staffing fell below planned levels on a regular basis, although the trust was mitigating risks as far as possible. Recruitment to vacancies was in progress. Staff were able to use bank or agency staff to fill staffing shortfalls.
- Staffing levels within maternity were monitored and reviewed to keep women safe at all times.
- The neonatal unit had gaps in medical staffing; however these gaps were being covered by advanced neonatal nurse practitioners. Nurse staffing on the neonatal unit was not at current recommended staffing levels.
- The trust was committed to the development of advanced nurse practitioners to ensure patient care was maintained and the potential recruitment difficulties to junior doctor posts mitigated. This also allowed good advancement opportunities for nurses. The neonatal unit worked in a family centred way, to promote the confidence of parents in caring for their baby. This helped facilitate the unit's strategy of early discharge, with the support of the neonatal outreach team and the rapid access clinic. Within the maternity unit, there was excellent multidisciplinary working that promoted integral care.
- Mortality indicators showed no evidence of risk. However, following the inspection, the hospital was identified as an outlier for the incidence of puerperal sepsis. The trust reviewed case notes and responded appropriately: an action plan was put in place.
- Patients were assessed for their nutritional needs. The trust had introduced HANAT (hydration and nutrition assurance toolkit) to encourage good nutrition and hydration best practice in the hospital environment.
- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring. The trust used a Microsystems Coaching Academy which worked well to support small scale service improvements.
- The trust's vision and values were embedded in practice. These informed performance reviews and staff felt they were meaningful.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.

Summary of findings

- There was variation in the quality and completeness of Do Not Attempt Resuscitation (DNACPR) forms.
- There were evidence based nursing care guidelines, which fulfilled the function of care plans, available for reference for a wide range of possible care needs. However, these were not printed and available at the patients' bedside or with the patients' care record. Some wards had printed reference files available for staff to use, however we did not observe staff using these. Other wards referred us to the intranet to view these guidelines and again we did not observe staff referring to these. Staff told us computers were not always easily accessible and that new, bank and agency staff did not always have an individual log on. This meant that care plans / guidelines were not always accessible for staff delivering care.

We saw several areas of outstanding practice including:

- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- The use of duty floor anaesthetist role in theatre, developed in Sheffield, was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The operating services, critical care and anaesthesia care group developed "The Magnificent 7" a document outlining seven areas for achievement in the department. The seven areas included zero harm, making every operating minute count and transformation through technology. Each area had a lead, an executive sponsor, an action plan and a review date.
- One of the urology consultants held the most senior position at the European Association of Urology, the international authority on urological research.
- A robot used in urology surgery had given superior outcomes compared to traditional surgical techniques. The robot was used by surgeons across the specialities of urology, ENT and gynaecology.
- The neurosciences directorate introduced an electronic referral tool "Refer a patient." This shared referral information between the referrer and neurosurgeon who could give an immediate decision and feedback to the referrer.
- The podiatry service had been awarded Customer Service Excellent Award for the 15 consecutive years.
- A neuro simulation team-training programme for anaesthetists was being piloted on neuro critical care. This was training for the whole MDT and aimed to prepare staff for the challenges of managing acutely unwell patients. It introduced staff to crisis resource management non-technical skills.
- An innovative clinic providing medico-legal expertise was available to patients and their families. The service gave access to experienced legal professionals able to give advice across a breadth of areas including managing the personal affairs of a patient.
- The one to one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- The rapid access clinic reduced readmissions of babies with feeding problems.
- The GRIP project responsible for getting research into practice improved services for maternity and gynaecology.
- The termination of pregnancy service gave women continuity of care in an appropriate caring environment. The seven day service gave women choice and improved accessibility.
- The use of the Enhanced Recovery programme in both maternity and gynaecology improved the service for women.
- 'Devices for Dignity (D4D) Healthcare Co-operative' was hosted by the trust. This is a national initiative to drive forward innovative products processes and services to help people with long-term conditions'. The Devices for Dignity (D4D) Healthcare Co-operative' had been recognised with a number of awards including; 2012 Advancing Healthcare Awards and Allied Health Professionals and Healthcare Scientist; Leading Together on Health Award.
- Sheffield ophthalmology was the only centre in the country that carried out stereotactic radiosurgery (SRS). This treatment uses radiation therapy and focuses high-power energy on a small area of the body. The service had been carrying out this procedure for the past 25 years. The service also carried out photodynamic therapy (PDT) to treat cancer and audits showed this treatment had an 85% success rate. Photodynamic therapy is a treatment that uses a drug, called a photosensitizer or photosensitizing agent.

Summary of findings

- Staff in the diabetes service had just started a six-year National Institute for Health Research (NIHR) programme to further develop education about type 1 diabetes.
- Histopathology was using digital pathology. Six biomedical scientists at the NGH site had been trained to prepare frozen sections of tissue; this preparation used to be undertaken by histopathology consultants. The biomedical scientists dissect and prepare the samples while on video link to the RHH so that the technique can be checked and quality maintained. Staff scanned and digitally transferred the resulting image to the histopathology consultants at the RHH site. This technique was time efficient and speeded up the process for the patient.
- Cancer services at the trust had won awards from the Health Service Journal and the Nursing Times. For example, in 2014 the service had received the Cancer Care Award.
- The development of the Sheffield 3D imaging lab is unique to the NHS and provides improved quality of scans and detail of brain tumour growth. Images could be processed quicker, in seconds rather up to an hour, saving time and money. The 3D lab was a finalist in the Yorkshire and Humber Medipex NHS Innovation awards.
- In addition to walk in services for general plain film imaging GP's could refer patients directly for CT, MRI, ultrasound, fluoroscopy and other specialised imaging examinations.
- There was a state of the art Medicines and Healthcare products Regulatory Agency (MHRA) Licenced Radiopharmacy, serving all of the trusts locations.
- Nuclear medicine staff were finalists in the Medipex NHS innovation awards 2014 after developing a new system for diagnosing debilitating digestive disorder that freed up the gamma camera, so reducing patient waiting times.

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

Importantly, the trust must:

- Ensure the safe storage of intravenous fluids.
- Ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- Ensure that guidance is followed in the documentation of fetal heart rate monitoring's. In 86% of 39 CTG records, there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6).
- The trust must ensure that DNACPR records are fully completed.
- The trust must ensure a strategy for end of life care is implemented.

In addition the trust should:

- The hospital should ensure that staff have attended mandatory training in accordance with the trust target.
- The MIU should improve the monitoring of time to be seen and total time in department.
- Although the MIU works closely with the A&E at NGH, audits specific to the MIU should be completed to show effectiveness and to monitor improvement to services and treatment offered in this location.
- Review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.
- The trust should improve the compliance rates for medical and nursing staff receiving an annual appraisal.
- The trust should continue to take action to reduce the number of medical outlier patients across the trust.
- The trust should continue to take action to reduce the number of bed moves patients experience during their hospital stay.

Summary of findings

- The trust should try to reduce the movement of staff to clinical areas outside of their speciality.
- The trust should introduce a robust process to share lessons learnt from incidents and mortality and morbidity reviews across directorates and care groups.
- The trust should review the labelling of babies prior to their removal from the obstetric theatre.
- The trust should ensure that the neonatal resuscitaires in labour suite has documented checks. We identified checklists that had signatures missing 22% of the time for the month examined.
- The trust should continue to improve consultant medical staffing on labour ward in accordance with Royal College of Obstetrician and Gynaecologists guidelines.
- The trust should review data collection methods and introduce a system to collect patient outcomes by surgical speciality within care groups.
- The trust should review the waiting times for patients with learning disabilities requiring dental treatment under general anaesthesia against the 18 week standard.
- The trust should ensure appropriate medical and nursing staffing on the neonatal unit to reflect current national guidelines for safe care.
- The trust should review patient centred care planning on the neonatal unit.
- The trust should consider improving the way in which medicines are constituted within the neonatal unit to ensure there is a safe environment to do this, and reduce risk of medicine errors.
- The trust should monitor preferred place of care for patients at the end of life.
- The trust should review access and the environment of the chapel and prayer room.
- The trust should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.
- The trust should undertake regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks.
- The trust should review oversight of the area and facilities for patients waiting for transport following the clinic appointments.
- The trust should monitor access to records in the outpatient departments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	The provision of urgent and emergency services at the RHH is of a consistently high standard. The service provided was safe, in that it protected service users from avoidable harm and abuse. Staff provided care in environments that were suitable and well maintained. People's care and treatment had good outcomes, was based on the best available evidence and promoted good quality of life. Staff were highly qualified, experienced and worked in specialist roles effectively and efficiently. The services available were carried out by staff in a caring, compassionate and respectful way, with dignity at the forefront of treatment. The urgent and emergency care services available at the RHH were not twenty four hour services, but were available every day of the week except Christmas day. Services met the needs of the community served, and alternative services were available when the MIU was closed. Services took account of the needs of different people, including those with complex needs and strived to remove barriers and offer timely, effective care to all. The urgent and emergency services were run effectively, by dedicated leaders with a clear vision and strategy.
Medical care (including older people's care)	Good	There was good evidence that safety issues were identified and addressed, incidents were investigated appropriately and improvement actions implemented. There was good management of escalation of deteriorating patients. There was no evidence of increased risk of mortality in any of the medical specialities. There was good evidence of effective multi-disciplinary team working and good provision of seven-day services. Patients pain relief and nutritional needs were met. There was good evidence of learning from audits and the improvements being made. Staff received training relevant to their role to develop expertise. Staff had

a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, appraisal rates for both nursing and medical staff were below the trust's targets.
We observed staff in all areas treating patients with kindness and respect. Privacy and dignity was maintained at all times and patients were satisfied with the services and care delivered.
There were many examples of service planning and delivery to improve services for patients. However, high numbers of patients were moved to a ward outside of their speciality ward and 20% of patients were moved twice or more during their hospital stay. The process for transferring and receiving patients from NGH was not robust and could lead to delayed review and treatment or investigation of patients.
All services had a clear vision and strategy for service delivery and improvement. There were clear governance structures and managers were confident about how to escalate risk. Managers and staff had a good understanding of the risks their services faced and mitigated against these wherever possible. There was strong leadership of services and wards from clinicians and ward managers.
There was a well-embedded culture of learning and improvement and there were examples of innovation, improvement and sustainability.
However, there were some areas of poor practice relating to medicines management. There were some areas where staffing fell below planned levels, although the trust was mitigating risks as far as possible. Compliance with mandatory training was below trust targets in some areas and across staff groups and there were some concerns about accessibility of nursing care guidelines (care plans).

Surgery **Good**

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. However, there was limited evidence of learning from incidents across directorates at ward level.
Systems and processes for infection control, medicines management and patient records were mostly reliable and appropriate to keep patients safe. Staffing levels and skill mix were planned and

Summary of findings

reviewed to keep people safe. Staff recognised and responded promptly and appropriately to risks and deteriorating patients, including overnight and at weekends.
Care and treatment was planned and delivered in line with evidence based guidance and best practice. The service participated in relevant local and national audits. Patient outcomes were monitored. Staff were qualified and had the skills they needed to carry out their roles effectively. They were supported to maintain and further develop their professional skills and experience.
Patients were treated with dignity and respect and involved in their care and their needs were met through the way services were organised and delivered.
Directorates had clear strategies driven by quality and safety aligned to the trust's vision and values. Governance structures and processes within the directorates functioned effectively. There was a high level of staff engagement and satisfaction.

Critical care **Outstanding** ☆

Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Performance showed a good track record and steady improvements in safety. Staffing levels and skill mix were planned and reviewed to keep people safe at all times.
There was a truly holistic approach to assessing, planning and delivering care and treatment to patients. The systems to manage and share the information (needed to deliver effective care) was fully integrated and provided real-time information across teams and services. Staff were qualified and had the skills they needed to carry out their roles effectively.
Patients were treated with kindness, dignity and respect. Governance and performance management arrangement were proactively reviewed and reflected best practice. There was collaboration and support across all areas with a common focus on improving quality of care and patient experience. Leadership strategies were in place to ensure good care delivery within a supportive and open environment. There were high levels of staff satisfaction. Staff were proud of their

Summary of findings

units and spoke highly of the culture. The services proactively engaged and involved staff and ensured that the voices of all staff were heard and acted on. Staff innovation was supported.

Maternity and gynaecology	**Outstanding**	☆	Overall we rated maternity and gynaecology services as outstanding. Patients were protected from the risk of avoidable harm and when concerns were identified staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary actions were taken to prevent reoccurrence. Staff delivered evidence based care and treatment and followed NHS England and National Institute for Health and Care Excellence (NICE) national guidelines. Staffing levels were monitored and reviewed to keep women safe. There was excellent multidisciplinary working that promoted integral care. Staff worked together to make changes to improve the outcomes for women and babies. Staff were thoughtful and responded compassionately to women, treating them with kindness dignity and respect. Partner and relatives felt included in the care given. The variety of specialist services in maternity and gynaecology met the needs of women both locally and nationally. People's individual needs and preferences were central to the planning and delivery of tailored services. The importance of flexibility, choice and continuity of care was reflected in the services. Leaders and senior managers had an inspiring shared purpose, they strove to deliver and motivate staff to succeed. They were motivated, visible and accessible and participated in the day-to-day running of the service.
Services for children and young people	**Good**	●	Overall, we rated the service as good. The service had a good culture of incident reporting, and there was evidence of lessons learnt from incidents. The neonatal unit had implemented a programme of simulation training to apply changes in practice following learning from incidents. The service promoted a culture of improvement. There were competency frameworks for nursing staff and medical staff received good clinical support and training.

Summary of findings

The neonatal unit worked in a family centred way, to promote the confidence of parents in caring for their baby. This helped facilitate the unit's strategy of early discharge, with the support of the neonatal outreach team and the rapid access clinic.
Staff working at the trust were aware of the trust's values and there was a strategy to promote staff engagement. There was a supportive culture, with open door access to senior management. Staff participated in the research activity of the service.
The neonatal unit had gaps in medical staffing; however these gaps were being covered by advanced neonatal nurse practitioners. Nurse staffing levels did not meet the current national guidelines and were not achieving national recommendations for staff having a qualification in speciality.
The environment of the unit was not ideal and was not compliant with Government best practice guidelines. However, work was underway to commence reconfiguration of the unit to address the constrictions on space.

End of life care

Requires improvement

We found do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always made in line with national guidance and legislation. The trust did not monitor if patient choice around preferred place of care or death was met. The chapel was noisy and the Muslim prayer room was poorly signed. There was no internal strategy in place for end of life care at the trust. In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance. However, this had not been made available until October 2015.
However, we also found patients received safe care and treatment, which met their needs. The specialist palliative care team of nurses and doctors were skilled and knowledgeable. In the year from April 2014 – 2015, over 97% patients were seen within 24 hours of referral to the specialist palliative care team. There was seven day cover from the team. There was evidence of compassionate and understanding care on all the wards at the hospital.

Summary of findings

Outpatients and diagnostic imaging	**Outstanding**	☆	The services had a positive safety culture; there were clear management responsibilities and accountability for safety and governance. The services promoted continuous quality improvement. There were enough qualified, skilled and experienced staff to meet people's needs. Staff received good support, staff appraisals and mandatory training was up to date. Radiology services provided well-established, highly regarded training programmes for medical staff at every stage of their five-year programme and for student radiographers from local universities. All of the staff were passionate about their work and staff teams worked well together to provide an excellent experience for their patients. All of the patients and relatives we spoke with gave positive feedback about the staff and the services. Staff were aware of the trust values; there was good staff engagement and an open culture. Staff participated in research activities and there were numerous examples of innovation and improvement.

Royal Hallamshire Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Royal Hallamshire Hospital

The Royal Hallamshire Hospital is part of the Sheffield Teaching Hospitals NHS Foundation Trust. The hospital has around 850 beds for the care of inpatients and a number of specialist outpatient clinics.

A minor injuries unit offers services for people with injuries that that can be treated without the need for emergency care. There are two intensive care units; General Critical Care (GCC) which had eight beds and the Neuro Critical Care (NCC) that had 20 beds. The hospital employs approximately 6,000 members of staff.

Sheffield Teaching Hospitals NHS Foundation Trust provided services for neonates in their specialised unit at the Jessop Wing. This unit comprised of 18 intensive care cots, eight high dependency cots and 18 special care cots. There were also six transitional care cots, based on the postnatal ward of the Jessop Wing. The unit provided a neonatal outpatients department for follow up appointments for babies discharged from the neonatal unit or transitional care.

Maternity and outpatient gynaecology services at Sheffield Teaching Hospital were located in Jessop Wing.

Gynaecology inpatient services were provided on a day case ward and inpatient ward within the Royal Hallamshire hospital. There were 129 beds dedicated to women's and maternity services.

Sheffield Teaching Hospitals NHS Foundation Trust provides acute and community services to a population of 640,000. The trust provides specialist services for the populations of Yorkshire & Humber, parts of Mid-Yorkshire and North Derbyshire.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis, Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, student nurses, community nurses, therapists, medical directors, nurse directors and experts by experience.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The inspection team inspected the following six core services at:

• Urgent and emergency care

• Medical care (including older people's care)

• Surgery

• Critical care

• End of life care

• Outpatients and diagnostics

Before the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the hospitals. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a listening event on 1 December 2015 at St Mary's Church and Conference Centre and attended focus groups in Sheffield for people with learning disabilities and older people to hear people's views about care and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services community clinics, hospice and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records. We undertook Short Observational Framework Inspections to watch how staff provided care for patients.

We carried out an announced inspection on 7 to 11 December 2015 and an unannounced inspection on 23 December 2015.

Facts and data about Royal Hallamshire Hospital

Between July 2014 and June 2015, there were 648,438 outpatient appointments at the Royal Hallamshire Hospital (RHH). Between January and December 2014 there were 30,200 surgical episodes of care carried out at RHH.

During January to December 2014, the hospital had 6703 deliveries.

Sheffield is the 26th most deprived local authority area in England and have over 22,000 children living in poverty. Obesity in children is the same as the England average.

The population of Sheffield have a health and life expectancy are generally worse than the England average including the rate of hospital stays due to drug and alcohol related harm; smoking related deaths; teenage

Detailed findings

pregnancy and a higher than average mortality rate in the under 75 age group for cardio-vascular and cancer disease. Smoking rates and adult obesity are slightly worse than the England average

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Royal Hallamshire Hospital (RHH) had a nurse led minor injuries unit (MIU) which was managed within the emergency care directorate.

The MIU was open seven days a week, from 8am to 8pm. The service was nurse-led and delivered by qualified Emergency Nurse Practitioners (ENP's) who were senior nurses with specialist knowledge and training. Health care assistants also worked in the department supporting the nursing staff and patients.

The service was used by an average of 52 people daily for a range of minor injury needs such as minor burns, cuts, sprains, strains and uncomplicated fractures. The department does not provide a minor illness service, however staff stated that they assessed patients and offered treatment or referral to GP services or Northern General Emergency Department, as required. Children are not routinely treated within the department and are transferred to Sheffield Children's Hospital by ambulance if required.

Whilst in the department we spoke with two ENPs, a health care assistant and a receptionist. We also spoke to a nurse consultant. We inspected the environment of the department, reviewed records and observed the management of patients and relatives.

Summary of findings

The provision of urgent and emergency services at the RHH is of a consistently high standard. The service provided was safe, in that it protected service users from avoidable harm and abuse. Staff provided care in environments that were suitable and well maintained.

People's care and treatment had good outcomes, was based on the best available evidence and promoted good quality of life. Staff were highly qualified, experienced and worked in specialist roles effectively and efficiently.

The services available were carried out by staff in a caring, compassionate and respectful way, with dignity at the forefront of treatment.

The urgent and emergency care services available at the RHH were not twenty four hour services, but were available every day of the week except Christmas day. Services met the needs of the community served, and alternative services were available when the MIU was closed. Services took account of the needs of different people, including those with complex needs and strived to remove barriers and offer timely, effective care to all.

The urgent and emergency services were run effectively, by dedicated leaders with a clear vision and strategy.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated the safety of the minor injuries unit as good. This was because:

- Incidents were reported, investigated and lessons were learned.
- The department was clean and well maintained. The treatment areas were clean and tidy and a regular cleaning regime was followed and documented effectively.
- Record keeping was of a good standard. Forms were completed accurately and in line with professional standards.
- There was identification and management of risks. Plans were in place for the management of deteriorating patients, assessment of paediatric patients and escalation plans for staffing shortfalls.
- Nurses were highly trained, experienced and motivated. The department was always fully staffed and where unexpected shortfalls occurred, plans were in place to manage this.
- The department had utilised major incident plans in the past to good effect, including dealing with extreme weather situations.

However, we found:

- Patient documentation was duplicated as the department had recently introduced electronic record keeping.
- Mandatory training compliance rates were well below the trust target of 90%.

Incidents

- The department had reported no never events or serious untoward incidents and had reported only one incident in the period August 2014 to August 2015 relating to a delay in treatment.
- Safety performance figures across the emergency care directorate were identified as being about the same as other NHS trusts. However, this figure was across to the emergency care directorate, not just the minor injuries unit.
- Members of staff we spoke with understood the process and importance of incident reporting as well as their responsibilities. Staff were aware of the type of potential incidents to report, such as drug errors, assaults and clinical errors.
- Staff used an electronic reporting system for formal reporting, but also stated that concerns would be raised with a senior member of staff to deal with incidents as soon as possible.
- Incidents were dealt with quickly and appropriately. We saw examples of incidents reported and investigation outcomes discussed with staff of all grades. The trust provided documents stating that all incidents were reported and that this was used to create reports (including trend and theme information).
- People using the MIU were told when things had gone wrong, the circumstances were explained and apologies given. Patients were kept aware of changes that may occur because of mistakes. Staff were able to explain Duty of Candour and give examples of practice, such as apologising for delays in care. All staff were keen to be open, honest and to accept ownership of mistakes.
- The emergency directorate investigated incidents centrally, and line managers discussed outcomes with relevant staff. Lessons learnt were shared centrally by email, monthly newsletters and verbally in meetings held at all staff grades across all sites. The “fortnightly focus” meetings were used to focus on themes identified by incidents and feedback, such as improving safeguarding knowledge and referrals.
- Mortality and morbidity meetings were carried out for the whole emergency care directorate. Findings were shared and applied within the MIU, as required.
- Hospital security could be contacted by phone and monitor CCTV in order to keep staff and service users safe.

Cleanliness, infection control and hygiene

- There was no incidence of MRSA and C.difficile recorded in the MIU for the period of February to July 2015.
- Information provided by the trust indicates that 67% of clinical staff have completed infection prevention and control training of a targeted 90%.
- Infection prevention and control audits showed 100% compliance in almost all areas. This was supported by the Patient-led Assessments of Care Environments (PLACE) report which gave the RHH 98.9% for cleanliness.

- The hospital had an infection control accreditation programme that set standards for infection prevention and control practice. The aim was to optimise and assess infection prevention and control practices in clinical teams throughout the hospital in order to reduce infection rates. The unit had received infection control accreditation. Weekly and monthly audits were carried out as part of this accreditation.
- We observed staff adhering to trust policy and national standards for infection prevention and control.
- Cleaning was carried out regularly by nursing staff as well as domestic staff. There was a cleaning log which was implemented and documented daily and soiled areas were cleaned after each patient use. These logs were seen to be completed regularly and fully.
- Hand basins were appropriately sited; soap and alcohol gel dispensers were working and well stocked. Paper towels were available for drying hands.
- Where appropriate the plaster or resuscitation room could be used as an isolation room for infectious patients, however the nature of the department and the injuries they treat meant that this rarely occurred.

Environment and equipment

- The design, maintenance and use of facilities were appropriate. The PLACE inspection awarded RHH 90.2% for condition, appearance and maintenance.
- Equipment maintenance assurance records indicated that 89% of devices were assessed prior to one month before due date.
- The reception area faced the waiting area and reception staff could observe members of the public from their desk. There was a seat for patients booking in and the reception was away from the seating area to make booking in as confidential as possible.
- All patient assessment areas were well equipped and privacy was managed as effectively as possible with curtains to the front only. Equipment observed appeared to be in good condition and portable appliance testing (PAT) testing was up to date.
- The plaster room was very clean, well-stocked and tidy. This room was also used for the treatment of deteriorating or seriously ill patients. A defibrillator was present and checked daily. Airway management equipment was available, well maintained and fully equipped along with other resuscitation equipment.
- Medical gasses were available in appropriate quantities.
- Sharps bins were available in several areas and were not over filled.
- Bedside IT equipment was in place throughout the unit for electronically ordering diagnostic tests and completing prescriptions.
- The MIU had access to its own ultrasound machine, allowing rapid access to diagnostic information.
- The MIU was located on the ground floor, near to main doors and was accessible by all.

Medicines

- There were appropriate arrangements for managing medicines. This included obtaining, prescribing (where appropriate), recording, handling, dispensing, safe administration and disposal. Drugs were kept in locked cupboards and records were kept relating to their administration and disposal. Drugs that we checked were in date and the packaging was intact.
- Medication that should be refrigerated was kept in a locked fridge and temperatures were checked daily. Records were kept to ensure temperatures were within safe ranges. A supply of commonly used drugs was kept in the department, however, where appropriate patients were given prescriptions to take to either the hospital pharmacy or a community pharmacy.
- Controlled drugs were not used within the department.
- Staff administered medication either via patient group directives or with prescribing rights where the ENP was suitably qualified. These were checked by the nurse consultant to ensure they were up to date. A senior charge nurse had a pharmacy link role.
- Annual and quarterly checks were in place in relation to medicines management, which provided assurances on the robustness of the medicines management process. Evidence was provided of ongoing audit, but figures were not yet available.

Records

- Patient documentation was duplicated as the department had recently introduced electronic record keeping. Standard emergency department patient assessment documents were used in the MIU and then the information was entered onto the computer system manually. This increased the risk of information not being entered fully or accurately, however staff felt this approach was best as it allowed them to note take during patient assessment and check the information whilst typing it up.

- All interactions recorded on the electronic record would be auditable to see standards and trends, however the system was too new for this currently.
- We reviewed four patient records and found that areas of documentation were being left blank by Emergency Nurse Practitioners where they considered the information to be not relevant due to the level of injury or how the patient presented to the minor injury unit. However, the type of patients attending a minor injuries clinic did not routinely require significant documentation and this was reflected in the patient notes observed. Information relating to assessment and treatment was recorded adequately in line with trust and professional standards.
- Hand written patient records were observed as being legible, and reflective of history, assessment, diagnosis and treatment plans were recorded.

Safeguarding

- The department had a robust safeguarding arrangement in place for adults, children and domestic violence victims.
- All staff had received training in safeguarding and staff were able to offer a number of examples of safeguarding concerns they had had, and had acted on including actions taken and outcomes where appropriate. For example, in the support of victims of domestic violence.
- Staff we spoke with were aware of the trusts safeguarding policy. They knew how to make referrals, types of incidents that they would refer to the safeguarding team and how to recognise safeguarding concerns.
- Staff had received the required training in safeguarding and emergency nurse practitioners were trained to level 2 as a minimum in line with their mandatory training. The trust provided information indicating that 67% of staff were up to date with mandatory safeguarding training of a targeted 90%.
- Safeguarding links within the department were excellent, with a number of specific pathways reflective of the needs of the service users. For example, in substance misuse.
- Staff worked closely with the paediatric liaison nurse and police in a project to protect teenagers at risk of involvement in drugs or gang violence. Although the unit did not generally treat paediatric patients, there was high usage of the unit by teenagers and young adults.
- There was a link nurse for safeguarding issues available.
- Staff are aware of domestic violence risks and information was provided in several locations offering victims support. The unit also had everyday items, which were given to patients at risk of domestic violence, where the barcode numbers were a help line number.

Mandatory training

- Access to mandatory training had been improved through the provision of computers in staff rest areas to access e-learning.
- Staff spoken with had completed all mandatory training and felt well supported to do so. This included information governance, fire safety and handling and moving. Across the whole emergency care directorate, 46.2% of staff had completed mandatory training. Specific data for the MIU was not available as most of the staff rotated through the emergency department at the Northern General Hospital.
- Time was given for staff to complete training and staff were reminded verbally by the nurse consultant if mandatory training was not up to date.

Assessing and responding to patient risk

- Risk assessments had been carried out to minimise risk to people who used the service. Plans were in place to manage situations that may occur which would interrupt normal and safe service such as deterioration of a patient.
- Patients were seen on a first come first served basis unless concerns were raised by the reception team to nursing staff as having more urgent needs or identified by Nurse Practitioners via the electronic patient record system.
- Although children were not routinely seen in the MIU, ENPs assessed any children that did present and referred them either to the children's hospital or called the ambulance service as appropriate, in line with trust policy.
- When waiting times were increased, ENPs carried out a rapid triage in the waiting area to ensure risk was managed whilst waiting was minimised. Privacy and dignity was respected whilst doing this.
- Deteriorating patients were managed in the unit's resuscitation room. This area was equipped with a trolley, defibrillator and airway management

equipment. There was a policy in place to contact the on call doctor in such cases and contact the ambulance service, if transport to the Northern General Hospital was likely to be required.
- Observations such as blood pressure and heart rate were not routinely taken or recorded, unless clinically indicated. This was in line with the nature of the injuries presented by patients. Where observations were required, they were documented appropriately.
- The Sheffield Hospitals Early Warning Score (SHEWS) system was used to provide early warning of deteriorating patients, however, as observations were not carried out on arrival and were not routinely completed on assessment, unless clinically indicated the use of SHEWS was of limited value within the department.
- Robust clinical deterioration pathways were in place, with a well-equipped resuscitation area with access to fluids, airway management tools, defibrillation and ECG monitoring. A separate radiography department, located in the next room provided imaging, as required.
- Due to the nature of the work carried out by the department, patients were not routinely escorted to the radiography department. However, if escort care were required a health care assistant was available.

Nursing staffing

- An Emergency Department nurse consultant led the MIU at RHH.
- The department required a minimum of two ENPs to be on duty. This was managed through a rota system combined with the rota system used at the NGH. Where this did not occur, for example due to short notice sickness, an ENP was transferred from NGH or bank staff were used to ensure a full complement of staff was available.
- Planned and actual staff numbers always matched. This was reflected in rotas observed on in the department.
- The MIU did not use agency staff due to the specialist nature of the staff working there. The department did use bank staff, however, this was their own staff or staff who had worked in the department previously.
- There was currently no need for an acuity tool to be used in MIU. However, the department was currently working with other member of the Shelford Group to develop a national tool for emergency department nurse staffing.
- Nurse staffing had increased within the MIU from 78 Whole Time Equivalent (WTE) in 2001 to 134 WTE in 2015.
- There was no formal handover procedure in place. However, a communications book was used for staff to alert the next shift coming on duty of any issues or concerns. Staff stated that communication between staff was excellent.
- Aside from the permanent provision of two ENP's, the unit was often also staffed by health care assistants for part of the day and advanced nurse practitioners in training.

Major incident awareness and training

- A yearly audit was undertaken with the ambulance service. The emergency department had close links with the emergency planning team. Nursing and medical business continuity and emergency planning leads were in post within the main emergency department.
- Major incident and chemical, biological, radiological or nuclear (CBRN) training was ongoing for all staff and staff were aware of their roles should a major incident occur.
- We observed major incident packs, which outlined plans for potential major incidents or threats to business continuity.
- Staff told us that the department had effectively managed two major incidents. One related to flooding and one related to heavy snow, where many patients could not reach the main emergency department due to road closures and transport problems. The department was able to provide effective support to the main emergency department and still carry out its normal function.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the effectiveness of services as good. This was because:

- A robust system of evidence based care and practice was in place with the unit following nationally recognised standards.

- Management of pain was effective and suitable for the patient groups treated. Patients were satisfied that appropriate pain relief was offered and given.
- The MIU did not provide food or drinks, however, the nature of the service meant that the majority of patients would be within the unit for a short time and facilities were available within the hospital.
- The staff were highly trained and competent. Training opportunities were excellent and well supported.
- Appraisals were held annually and staff were supported in carrying out development plans.
- The MIU showed excellent multidisciplinary working with other departments and services which benefitted the patients seen by this service.
- The MIU participated in national and trust-wide emergency care audits, as appropriate. However, they did not carry out any audits specific to the service they provided.

Evidence-based care and treatment

- The unit followed guidance including NICE (National Institute of Clinical Excellence) guidance as standard, for example in the assessment of head injuries or ankle injuries.
- Clinical governance meetings were used as an approach to monitor outcomes and ensure use of evidence based care and treatment.
- We observed evidence based clinical guidance on the trusts intranet. We also observed staff using NICE guidelines to assist with decision making. There was good access by telephone to medical colleagues either within the RHH or in the emergency department at NGH as required.
- The MIU met the minimum requirements for units that see the less seriously ill or injured as outlined in the College of Emergency Medicine document "unscheduled care facilities".

Pain relief

- Staff were caring in their management of pain, offering analgesia appropriately, in time and ensuring that it had been effective in controlling the pain.
- A pain score assessment was required in triage and the unit undertook regular College of Emergency Medicine audits in pain management. Action plans were developed and implemented following each audit, for example improving consistency of recording pain scores before and after analgesia.
- Pain scores were documented, where appropriate along with any pain relief given, allergies and consent to treatment where appropriate.
- Patients who were in pain were observed to receive pain relief in a timely manner, including those in the waiting area who were identified as requiring pain relief prior to full assessment. All patients we spoke with stated they had either received timely pain relief or had been offered it and had declined.
- In patient's notes that we observed, a pain score was recorded, if appropriate. Where it was recorded, it was on a scale of 1-10. ENP's spoken with stated that they used a pain score when they considered it relevant in line with the patient's needs. In cases where no pain score was recorded, we observed "pain free" written in the free text area.

Nutrition and hydration

- There was provision for drinking water within the unit. There was no provision for food, however the nature of the service offered meant patients visiting the unit could use a selection of vending machines, the hospital canteen or shops as required.

Patient outcomes

- The emergency and urgent care directorate was involved in a number of recent audits which showed areas of development and the effects of changes on service (for example the NGH becoming a major trauma centre, pain management audits and hand injuries referred to hand specialists). There were no current audits specific to the MIU however, information from department wide audits was fed back to staff through regular governance meetings and sisters meetings. Information was available for staff on the intranet. This was not accessible at the time of the inspection.
- As this was a nurse led service, all patients were reviewed by an ENP prior to discharge. Where x-rays had been taken, they were reviewed by a consultant post discharge at the NGH via the electronic patient record system. There was an ongoing audit on missed fractures; however there was no audit on x-ray reporting.

Competent staff

- In the period August 2014 to August 2015, the appraisal rate for nursing registered staff was 80%. The trust target was 90%.

- Staff had the right qualifications, skills, knowledge and experience to carry out their roles. All staff spoken with were qualified as ENPs as well as being experienced nurses. They had completed non-medical prescriber's courses and were undertaking further training to ensure they were constantly developing and improving. The unit aimed to have all ENPs trained as non-medical prescribers. Currently there was one member of staff enrolled on each course that ran, and there was a total of 17 staff trained to this level within the department so far, however information was not provided for total number of staff.
- Staff received job specific training prior to commencing the role and were expected to meet minimum education standards.
- Emergency and advanced nurse practitioners received regular training to maintain competence.
- Education and training was considered a high priority within the department, and staff were encouraged and given time to complete training in areas of interest relevant to the role such as mentorship training.
- Where staff were in training, they were directly supervised by qualified staff.
- All staff rotated between the RHH MIU and the NGH A&E, to ensure consistency in competence. They also worked routinely as emergency department senior nurses as part of their normal rota to ensure they maintained these skills. We were shown an example of a rota that showed shifts across both sites and in both ENP and senior nurse roles.
- Fortnightly focus sessions were used to highlight areas of training need and to introduce new equipment or training opportunities.
- Learning needs were identified in annual appraisals, one to one meetings and development meetings. Support from the head of the unit was excellent and they had very strong links to the university through the nurse consultant who was the professional lead for advanced practice nurses for the trust.
- All staff spoken with were satisfied with the quality, availability, support and appropriateness of training received and available. One member of staff stated that the support for training opportunities was part of the reason they chose to work for this trust.

Poor or variable staff performance was managed through one to one meetings with the nurse consultant, annual appraisals or through the creation of ongoing development plans. There was capacity to provide support for staff that needed it.

Multidisciplinary working

- There were good examples of multidisciplinary working, for example between specialities including onsite therapists and radiographers. We observed evidence of good working relationships with the radiography team which allowed for effective and efficient working within the unit. Staff stated there was a good informal relationship with staff from other departments based at the RHH.
- We saw evidence of good external multidisciplinary working. For example, paramedics stated that they contacted the MIU to ensure patients could be treated within the MIU before bringing them; GP surgeries contacted the department for advice as to whether to refer patients to MIU or the emergency department; and the staff in the department had good contact with staff at the emergency department at NGH, if they required further advice or needed to refer a patient for further treatment.
- Staff liaised with other providers, such as the ambulance service, to address any service concerns that they had.
- Referrals were made to other services and staff stated that this was a smooth process and that other specialities accepted referrals without challenge. Where appropriate, there was an established process to admit patients requiring further treatment or care.
- The department had excellent links with social services and safeguarding teams and were involved in a project identifying young people at risk of drug abuse or gang violence. Staff were particularly proud of this project.
- Patients with acute psychiatric or mental health needs were not routinely seen at the MIU. Where psychiatric support was required, patients were advised to attend the main emergency department at NGH as there was no service available at RHH beyond initial assessment.

Seven-day services

- The minor injury unit was open from 8am to 8pm seven days a week, only closing on Christmas day. Outside of these times, no urgent care service was available at the RHH site.

- X-ray facilities were available throughout the opening times of the MIU and the department kept pre-labelled packs of common medicines on site to dispense when the pharmacy was closed. Information was available for local pharmacies, including late opening pharmacies.

Access to information

- The electronic document management system ensured immediate access to notes. Staff were able to access patient details and previous attendance details as required.
- The introduction of the electronic patient record system allowed notes to be shared with appropriate services also using the system, for example the emergency department at NGH and outpatient departments.
- On discharge, patients were made aware of plans of any follow up care needed and appropriate referrals were made to ensure continuity of care. Where required, medication was dispensed or prescription requests given to ensure medication can be obtained. Letters were generated by the electronic patient record system to send to GP's to advise of attendance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that staff understood how and when to obtain consent. Staff were observed obtaining informed consent prior to assessment and treatment and documenting this appropriately. Assessment and treatment was thoroughly explained prior to starting and where pain was likely to be caused, we observed ENP's warning patients and stating "let me know if it hurts too much and I'll stop."
- All staff spoken with were aware of the rights of people and their role in protecting the rights of people in relation to the mental health act.
- The requirements of legislation and guidance relating to mental capacity were understood by all staff spoken with. Staff stated that mental capacity for adults was determined during verbal interaction. Staff were able to explain assessment and treatment in several ways and stated that where they felt a patient lacked capacity they would act in the best interests of the patient and make safeguarding or GP referrals, as appropriate.
- Where concerns regarding cognitive function were raised, a patient would be referred to the emergency department at NGH for further assessment and treatment.
- The nature of the patients treated routinely at the minor injury unit meant that staff did not need to restrain or deprive liberty. However, as staff work across both sites, they were aware of policy and had completed mandatory training as required by their roles.

Are urgent and emergency services caring?

Good

We rated the minor injury unit as good for caring. This was because:

- We observed several examples of compassionate care and staff treating other people with kindness, dignity and respect. A large number of thank you cards and letters from patients and their carers indicate that patients were happy with the care that they had received.
- Staff showed an encouraging, sensitive and supportive attitude to patients who use the service and those close to them. Patients and their carers were involved as partners in care and planned treatments and options were discussed.
- Staff considered patients privacy and dignity and did their best to protect them, however the location of the waiting room on a main corridor and the proximity of the reception to the waiting area raised confidentiality and privacy issues.

Compassionate care

- Respondents to the NHS website rated the MIU highly, with an average rating of 4 out of 5 stars.
- The friends and family test showed scores were lower than the England average. However, there was an improving trend of percentage of service users who would recommend the emergency department services (up 6.4% in last 9 months). These figures were for emergency department services as a whole for the trust.
- The 2014 A&E national survey showed the trust was performing "about the same" or better than other trusts is all areas.
- We observed staff interacting with patients and family members in a considerate and respectful manner, acting in a friendly, approachable and professional way.

Urgent and emergency services

- Staff spoken with stated that they always challenged disrespectful, discriminatory or abusive behaviours. The trust had a zero tolerance policy towards violence and aggression.
- Due to the layout of the department, it could be difficult to fully maintain privacy and confidentiality. Cubicles were curtain fronted so did not block sound, the reception area was on an open corridor and the waiting area was small and open to passers-by. However, privacy and dignity was maintained, as much as possible, within the department. We saw that the curtains were drawn when patients were being assessed and treated. When speaking with patients staff used suitable volumes to avoid being over heard by other patients.
- Where assessment or treatment required exposure of body parts, a chaperone was used, if requested.
- Staff showed respect for confidentiality and were aware at all times of the need to protect confidentiality.
- When a patient was distressed, staff made an effort to take them to a private space and offer support as required.

Understanding and involvement of patients and those close to them

- Staff were observed communicating effectively with people, ensuring that care, treatment and conditions were understood. Where a patient required further advice or support after treatment they were advised to contact their GP as long term care was beyond the scope of a minor injury service.
- Staff were observed ensuring patients fully understood their care and treatment. This was checked by asking "do you have any further questions" at the end of a treatment.

Emotional support

- Staff understood the impact relatively minor injuries may have on people's physical and emotional wellbeing. They offered emotional support in the department and referred patients to GP's and social services, when required.
- Staff gave patients advice about the services available and how to access them.
- Patients and service users were encouraged to manage their own health care and wellbeing, Self-care advice and worsening advice was given on discharge.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated the minor injury unit as good for responsive. This was because:

- The unit responded well to the needs of the local population and in the provision of assessment, management and treatment of minor injuries. The unit was also able to work beyond its purpose when required by providing resuscitation equipment and staff who were trained to provide immediate life support.
- Waiting times within the department were low, and effective plans were in place to manage the needs of patients when waiting times increased. Flow through the department was good and allowed for people to be seen quickly and spend minimal time waiting between assessment and treatment.
- Staff responded well to the needs of patients with learning disabilities or dementia. Plans were in place to minimise the impact of treatment on these groups.

Service planning and delivery to meet the needs of local people

- The RHH MIU provided a convenient and effective service for adults suffering from minor injuries, particularly for those in the south side of the city of Sheffield.
- The MIU was open 8am to 8pm, every day except Christmas day.
- Staff told us that they have good working relationships with local care homes that would rather bring their residents to the MIU than attend A&E due to the quieter environment and shorter waiting times.
- The location of the RHH was an area with a high student population. The service worked closely with these groups to provide injury care without the need to travel to the north of the city. Close links with the university ensured facilities were well advertised and used appropriately.

- Staff stated that they understood the cultural needs of the diverse population of Sheffield and went to great lengths to meet those needs, including liaising with members of staff from those communities to establish cultural, social and religious needs.
- Information leaflets relating to common injuries and treatments were available within the department. Patients were also directed to utilise NHS advice services, either via the NHS111 line or through use of the NHS website.
- Services offered were available to any person over the age of 16 who had suffered a minor injury. People outside of this scope were not turned away, but assessed and referred to more appropriate services, for example the A&E at NGH, their own GP or other appropriate services.
- The trust had identified that parking was an issue at the RHH, however public transport links to the hospital were good and the hospital was located close to residential areas.

Meeting people's individual needs

- Services were delivered in a way that took into account the needs of different people. Where a patient was living with dementia or learning disabilities, staff made efforts to assess and treat them quickly to minimise distress and anxiety.
- Respect was shown to people of different faiths or cultures and staff had investigated how to best meet the needs of the multicultural population of Sheffield, for example around the use of chaperones.
- Patients with mobility needs or disabilities were treated, where possible, in the most comfortable position for them.
- All staff spoken with stated that they were active in providing non-discriminatory care and decision-making. We were told by staff that the unit had a good reputation within the community for providing an excellent service to patients with learning disabilities and dementia as it was often quieter and patients can be seen and treated much quicker than attending the A&E at NGH.
- The department had access to an interpreter's service by telephone.
- Due to the nature of the work carried out by the minor injury unit, hoisting equipment was not used. However, the department had good links with other areas of the hospital and should specialist handling and moving equipment or bariatric equipment be required, this could be facilitated quickly and easily

Access and flow

- Due to the implementation of a new nationally recognised computer, administration system the department was unable to provide any data, or confirm accuracy of data to report on performance activity in the emergency department post implementation of the system on the 28 September 2015. Data we have commented on and used was data collected prior to the implementation of the new system.
- There is a national target for patients to be seen within four hours. Data was not available for the MIU, instead it was provided for the whole directorate. The directorate achieved 94.5% against a target of 95% in September 2015.
- In order to minimise waiting times, patients were assessed whilst other patients were having diagnostic tests, such as an x-ray. The department was also staffed by health care assistants and trainee advanced nurse practitioners to assist the ENPs and reduce waiting times for treatment and care by carrying out procedures and treatments on behalf of ENPs.
- Care or treatment was only cancelled if the patient required greater clinical care than was available in the MIU, or the patient became a risk to staff or other patients, in which case the patient would be transferred to NGH or security would be contacted.
- Staff reported that they stayed late to see to patients in the department if required, but that patients booking in near to closing time were advised to attend the A&E department at the NGH.
- Services ran on a first come first served basis, and patients were advised of potential waiting times when the department was busy. Waiting times were reported by staff to be consistently less than two hours; patients spoken with agreed that waiting times were low. However, specific data was not available.

Learning from complaints and concerns

- Information leaflets and posters in relation to making a complaint were available.
- Complaints and concerns were monitored and followed up as appropriate.

Urgent and emergency services

- Staff stated they provided advice and support in making a complaint where appropriate. We were provided with an example of this.
- Complaints were handled effectively and confidentially. Staff attempted to deal with complaints at the time, apologising, explaining reasons for any failings and developing plans to rectify problems as best as possible. Staff said this level of complaint management minimised the number of complaints made formally, but that patients and their relatives were not discouraged or prevented from making formal complaints.
- Following a complaint, information and changes to practice, if required, were shared with individual staff. If the issue had a wider impact then information was shared in team meetings, in the governance newsletter and by email.
- We saw examples of changes made as a result of complaints, such as the introduction of health care assistants to improve caring and reduce waiting times.

Are urgent and emergency services well-led?

Good

We rated well-led of the service as good. This was because:

- The service had a strong vision and strategy that was relevant to the work and reflective of the service provided.
- There was strong leadership and a positive culture; staff felt valued and respected.
- A culture of improvement was driven by the nurse consultant and was well supported by the staff.
- Service user's views and experiences were gathered and consideration was given to these when improving services. Staff were also actively involved in making decisions relating to service provision.
- There was a supportive approach to professional development and staff were focussed on improving the quality of care through treatments available and care offered.

Vision and strategy for this service

- The MIU shared in the wider vision and strategy of the emergency department, in line with the trust's 5 year strategy.
- Recruitment and selection strategy for the unit was underpinned by core values.
- The unit followed the "PROUD" values along with the rest of the trust. These values (Patients first, Respectful, Ownership, Unity and Deliver) were reflected in the work carried out by the staff and in the leadership they were shown by the nurse consultant.
- All staff spoken with were aware of the PROUD values and the role they played in this. We discussed the impact this had on their work and staff were able to provide examples of how the PROUD values related to their work.
- Staff rotated through the MIUs at both sites and the emergency department at NGH and so were aware of the vision and strategy across the emergency directorate.

Governance, risk management and quality measurement

- Governance frameworks and management systems were regularly reviewed and improved. A nursing lead had been appointed in a governance role for emergency care services. Regular governance meetings were held, where staff discussed governance issues. Governance was a consistent agenda item at monthly directorate meetings.
- The unit had made a number of changes to practice following incidents including the implementation of an electronic patient record system to standardise triage and support good communication and a communication book for information that needed to be handed over at the end of shift.
- Staff were clear about their roles and responsibilities in relation to governance and risk management. The ENPs had good working knowledge of accountability in relation to governance and risk management.
- We discussed items on the risk register. These reflected the concerns of staff and were identified as areas that the trust was working to resolve, such as increased recruitment and working with partner organisations regarding transfer of patients.
- Quality and performance of emergency care were measured by the service and trust leaders through audits and performance figures. However audits specific to the MIU were not being carried out at present.

- Information gathered for performance monitoring was in line with the data protection act and was appropriate for the needs of the service.

Leadership of service

- The MIU was a led by a nurse consultant who had a background in the provision of urgent care through their work history and their involvement in the establishment of the ENP role and the training of staff through Sheffield University. The nurse consultant maintained skills and knowledge with regular work within the MIU and also the emergency department. Staff stated that the nurse consultant was a regular part of the clinical team and well respected amongst colleagues.
- The minor injuries staff also had close links with the emergency care matron and felt that all members of the leadership team were visible, approachable and well respected by staff.
- When we spoke with the nurse consultant, it was clear that they understood the challenges to good quality care within the unit and they had a number of plans and ideas to improve services for both patients and the staff working within the department. The nurse consultant valued the staff working within the department and was keen to support them in professional development.
- The trust had a close working relationship with partner services and third party providers through the emergency care service.

Culture within the service

- Staff were proud of the good reputation of the department and stated that they felt a responsibility to their colleagues and patients to maintain high standards and this good reputation.
- Staff told us that the Emergency Nurse Practitioner team felt like a family and that they all felt valued and appreciated.
- There was a culture of service development within the unit. Staff were encouraged to share ideas and develop professionally. Where the needs of groups of patients were not being met, staff had developed plans to improve care or knowledge, including liaising with staff from other cultures to discuss potential barriers and how best to overcome these.
- As part of the PROUD values, staff were encouraged to take ownership of problems and staff we spoke with felt supported in doing so.
- The safety and wellbeing of staff was important to the staff and management of the MIU. Support plans were in place, where needed and security carried out regular patrols of the area and could be called by staff in an urgent situation.
- Staff gave several examples of working collaboratively with other departments or parties. We were told of GP's and ambulance crews ringing for advice, and of ENPs being able to contact other clinicians for support or advice where required. Staff stated that they felt they were part of the emergency care pathway, rather than a standalone unit, and as such, they shared responsibility for providing the best quality urgent care.

Public engagement

- The emergency department as a whole had introduced patient leaflets setting out the emergency department journey from start to finish improving communication with patients.
- Following challenges faced over winter 2014/15, the trust had undertaken a public communication campaign, advising of treatment options, including publicising the location, working hours and treatments available at the MIU.
- The friends and family test was used to monitor how service users felt about the minor injury unit. Results of this were used to influence change, where required.

Staff engagement

- Staff told us that they felt involved in the development and provision of services in the MIU. Ideas were shared within the senior nurse forum and often these ideas would be put into practice, for example changes to rotas or handover processes.
- Staff stated that the management team were approachable and had often asked staff for opinions or ideas before implementing changes.
- Trust wide staff engagement approaches had included, "You said, we did" engagement work, staff stress surveys, close work with staff around shift patterns and hours and staff engagement workshops.

Innovation, improvement and sustainability

- The unit had a strong track record of trialling and implementing new and innovative schemes to address pressures, deliver continuous improvement and to promote sustainability. These included introducing a nurse lead for the ENP service, the "Hello my name is"

project and the electronic patient record system. Where there was a risk of negative impact, training, back up plans and strategies were introduced to ensure the risk was minimal.

- Both the leadership and the staff were constantly striving for increased education and development.

Every staff member spoken with was undertaking further training beyond that required for their role. This was well supported by the nurse consultant and staff said they felt encouraged to better themselves and the care they offered.

Medical care (including older people's care)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Medical specialties for Sheffield Teaching Hospitals Foundation Trust (SHFT) are based at both the Northern General Hospital (NGH), Weston Park Hospital (WPH) and Royal Hallamshire Hospital (RHH).

Medical services at this trust are spread across six different care groups or business units:

The Emergency care group includes diabetes and endocrinology, respiratory and gastroenterology services. Combined Community and Acute Care includes integrated geriatric and stroke medicine, therapeutics and palliative care. Head & Neck includes neurosciences incorporating the hyper-acute stroke unit. The Musculoskeletal care group incorporates pain services and rheumatology. Specialised Cancer, Medicine & Rehabilitation includes communicable diseases and specialised medicine, spinal injuries rehabilitation and specialised cancer services. South Yorkshire Regional Services includes cardiac and renal services. The care groups above also provide other non-medical services not listed here.

Specialities based at the RHH include neurology, infectious diseases, rheumatology and haematology. The neurology hyper-acute stroke service and the stroke unit are at RHH although geriatric and stroke medicine directorate is mainly on the NGH site. Stroke rehabilitation was also provided at Beech Hill community hospital.

Between September 2014 and August 2015 there were 121,200 medical admissions to Sheffield Hospitals Foundation Trust (SHFT), 42,600 were at RHH. Medical admissions to RHH were 13% emergency cases, 8% elective admissions and 77% day cases. The top three specialities with the highest admission rates were gastroenterology 25%, clinical haematology 26% and neurology 19%.

RHH was last inspected by the CQC in September 2013 and was found to be compliant against the outcomes inspected: care and welfare of people who use services, supporting workers, assessing and monitoring the quality of service provision.

We visited a number of medical wards including the planned investigations unit (PIU), P2, 3 and 4, M2, Q1, 2 and 3 (the neurology day unit), E1, L1 and L2 which houses the hyper-acute stroke unit.

We spoke with 18 patients and carers, and more than 35 staff. We attended a number of focus groups and we observed staff deliver care on the wards. We looked at 8 care records and 13 medicine prescription / administration cards and reviewed the trust's performance data.

Medical care (including older people's care)

Summary of findings

Overall, we judged this service as good.

We found there was good evidence that safety issues were identified and addressed, incidents were investigated appropriately and improvement actions implemented. There was good management of escalation of deteriorating patients. There was thorough medical clerking and assessment of patients, which was well documented. There was no evidence of increased risk of mortality in any of the medical specialities.

There was good evidence of effective multi-disciplinary team working and good provision of seven-day services. Patients pain relief and nutritional needs were met. There was good evidence of learning from audits and the improvements being made. Staff received training relevant to their role to develop expertise and competence was assessed and documented. Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However, appraisal rates for both nursing and medical staff were below the trust's targets.

We observed staff in all areas treating patients with kindness and respect. Privacy and dignity was maintained at all times and we saw staff answering patients' questions patiently and cheerfully with a caring manner. Patients were very happy with their care and information from all professional groups. Patients told us they understood the information that was given to them and what was happening to them.

There were many examples of service planning and delivery to improve services for patients including initiatives to improve patient access, flow and discharge. Staff worked very hard to meet patients' individual needs.

However, high numbers of patients were moved to a ward outside of their speciality ward and 20% patients were moved twice or more during their hospital stay. The process for transferring and receiving patients from NGH was not robust and could lead to delayed review and treatment or investigation of patients.

All services had clear vision and strategies, which were known to staff at all levels of the service. The services were visionary and innovative and there was a well-embedded culture of service improvement. There were clear governance structures and managers were confident about how they could escalate risks to senior managers and the executive team. Managers and staff had a good understanding of what risks their services faced and mitigated against these wherever possible.

Risk registers were comprehensive and up to date. There was strong leadership of services and wards from clinicians and ward managers. Staff recommended the trust as a good place to work and would be happy for relatives to receive care here. There was a strong culture of learning and improvement and there were examples of innovation, improvement and sustainability.

There were areas of poor practice relating to medicines management such as unlocked stores of IV fluids, inconsistent prescribing of oxygen therapy and there was a lack of patient assessment for self-medication. There were some areas where staffing fell below planned levels on a regular basis, although the trust was mitigating risks as far as possible. Compliance with mandatory training was below trust targets in some areas and across staff groups. Nursing care guidelines (care plans) were not easily accessible to all nursing staff providing care. This posed a potential risk to patient safety and clinical accountability.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safe as good because;

- There was good evidence that safety issues were identified and addressed, incidents were investigated appropriately and improvement actions implemented.
- There was good management of escalation of deteriorating patients.
- There was thorough medical clerking and assessment of patients, which was well documented.
- There was clear evidence of winter planning for surge in numbers of patients needing admission

However;

- There were areas of poor practice relating to medicines management such as unlocked stores of IV fluids, inconsistent prescribing of oxygen therapy and there was a lack of patient assessment for self-medication.
- There were some areas where staffing fell below planned levels on a regular basis, although the trust was mitigating risks as far as possible.
- Compliance with mandatory training was below trust targets in some areas and across staff groups.
- Nursing care guidelines (care plans) were not easily accessible to all nursing staff providing care. This posed a potential risk to patient safety and clinical accountability.

Incidents

- There were no never events in this service between August 2014 and July 2015 (Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.)
- During the same period, there were nine serious incidents for the medical service trust-wide. Two of these incidents were unexpected deaths; two were medication incidents, one diagnostic incident, one slip/ trip/ fall, one communication issue and two others.
- Medical services at RHH reported 680 incidents in the six months March to August 2015. Of these, six resulted in moderate harm and the remaining 674 were low or no harm incidents. The major categories of incidents were; slips, trips, falls, medication incidents, general care and pressure ulcers.
- Falls incidents were investigated by senior nursing staff and were presented to a falls meeting to look at the root causes and identify areas for learning and action for all wards and staff.
- Staff were aware of how to report incidents using the electronic incident reporting system and how to escalate incidents to their line manager.
- Incidents reported on the IT system went automatically to the ward manager for attention and investigation.
- Staff felt they were encouraged to report incidents and be open and honest with patients if they made a mistake or a patient suffered harm.
- The majority of staff we spoke with told us they received feedback from incidents. All staff had received written information regarding duty of candour with their payslips and were able to tell us what this meant. Staff had been able to access awareness sessions regarding duty of candour and managers involved in responding to patients had attended additional training.
- Staff on one ward were able to tell us how the duty of candour had been met in relation to a patient who had suffered a fracture because of a fall. The patient's family had been telephoned initially, and visited in person on the ward by the matron. The spouse of the patient had been written to following completion of the investigation.
- We saw that serious incidents were investigated using root cause analysis methodology and the documentation of the incident, investigation and root causes was comprehensive, open and honest. We also saw that the patient's family had been communicated with and offered apology in line with the duty of candour principles.
- Pharmacists monitored trends of prescribing errors and shared learning by incorporating this information into induction sessions for junior doctors. Information was also discussed at monthly governance meetings.
- Clinicians attended regular mortality and morbidity meetings to take part in and learn from discussions of specific cases, including near misses. Mortality of medical patients were regularly reviewed by a number of clinically led speciality groups which met every three months.

Medical care (including older people's care)

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- Some wards displayed their safety thermometer information for patients and visitors to see.
- For the period July 2014 to Jul 2015, across the trust, there were 201 pressure ulcers Grade 2, 3 or 4. The prevalence rate showed a steady decline between November 2014 and July 2015.
- There were 261 falls and the prevalence fluctuated over the year however, in July 2015, it was four times higher than July 2014.
- There were 98 catheter urinary tract infections and since August 2014, there had been a general downward trend of the prevalence rate.

Cleanliness, infection control and hygiene

- Overall practice in relation to infection prevention and control was good. Handwashing facilities were available throughout the wards and we observed hand gel dispensers at the entrance to the ward, each bay and side room.
- We observed staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in most of the areas we visited.
- Patients commented that they saw them washing their hands and using hand gel.
- We observed MRSA colonised patients appropriately isolated and other patients barrier nursed in a bay where there was no single rooms available.
- If patients with infections were barrier nursed in side rooms there were visible STOP warning signs on the doors. There was infection control information displayed outside of isolation rooms for visitors.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- We saw that sharps were disposed of safely and correctly.
- The wards at RHH participated in the SHFT "Infection Control Accreditation Programme" which set standards for infection prevention and control practice. The programme aimed to optimise and assess infection prevention and control practices in clinical teams and comprised of a regular audit schedule using bespoke audit tools. Areas audited were; hand hygiene, cleanliness of commodes, high impact interventions, standard precautions, mattresses, aseptic technique, disposal of linen and anti-microbial prescribing. Wards had to achieve three consecutive months of audits at 95% compliance or above and had to have a named infection prevention champion.
- Three of the wards E1, E2 and Q2, accreditation had lapsed by September 2015. The IPC team was supporting these areas to become re-accredited.
- We saw on L1 and L2 that compliance with the last three hand hygiene audits was 91%, 100% and 100%.
- There was one case of MRSA infection / colonization attributed to the medical services at RHH and one further case was associated with the hospital, between April 2015 and Jul15. There were no cases of bacteremia during this time.

Between April 2015 and July 2015 there were three cases of Cdiff attributed to the medical wards at RHH and a further two associated cases.

Environment and equipment

- The environment in the ward areas appeared clean and well maintained. Daily cleaning checks were displayed and up to date.
- Results in the Patient-led Assessments of the Care Environment (PLACE) the trust consistently had higher scores than the England average in all four sections over the last three years. In 2015 SHFT achieved a cleanliness score of 100% against the national average of 98%, a food score of 93% against the national average of 88%, privacy and dignity score of 90% against the national average of 86% and a facilities score of 94% against the national average of 90%.
- A site overview assessment of RHH using PLACE criteria (Feb 2015) showed that improvements were need on some wards with regard to being "dementia friendly". Common issues related to signage, flooring, lack of contrast colour for toilet doorways and seats. On ward, P2 taps and flushes were of an unfamiliar design, there was no contrasting colour for toilet doorways and seats on P1 and F2.
- All wards received passes for the other criteria relating to food, cleanliness, privacy and dignity and maintenance.

- Staff said that equipment to meet patient needs was available; however, staff on E1 told there were sometimes delays in receiving high-low beds for patients at risk of falling.
- Resuscitation trolleys were available along with portable oxygen and suction. We saw that in most cases, daily and weekly checks of this equipment were up to date, and that trolleys were clean. We noted that checks between September and November 2015 on P4 were spasmodic.
- Other equipment such as commodes, hoists and mobile computers were clean and labelled as ready for next use.

Medicines

- In the main, medicines were appropriately prescribed, administered and recorded.
- Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records kept. Staff performed daily balance in line with the trust policy except for M2 where balances were checked once weekly.
- We reviewed 13 medication records and saw that patients received their medicines in a timely way, as prescribed, and that records were completed appropriately.
- We saw two patients who were managing their own medicines on ward M2, however their ability to self-medicate had not been assessed and assessment documentation had not been completed. This meant that we could not be sure that patients were able to take their own medicines, safely or effectively, and that staff were not following the trust policy on self-administration.
- To ensure the safety and effectiveness of medicines, fridges must stay within the temperature range of 2-8C. In most areas, we saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range. However, the monitoring of medicine fridge temperatures was incomplete on some wards. On ward P3, staff did not record the maximum and minimum temperatures as per the trust policy and national recommendations.
- The safe and secure storage of IV fluids was a concern during our visit. Doors to medicine rooms on M2 and P4 were unlocked and wedged open on M2 meaning that access to fluids was not restricted to authorised staff.
- We checked medicines and equipment for emergency use and found that they were readily available, stored appropriately, and that regular checks had been performed to ensure that they were fit for use in line with the trust policy.
- We checked the prescriptions of patients who were receiving oxygen and found that this was not always prescribed in accordance with trust policy. We saw one patient on P3 and another on M2 who were receiving oxygen therapy that had not been prescribed.
- There were a small number of records (two of 13 charts reviewed) where antibiotic review or stop date was not recorded.

Records

- Patient's records were a combination of both electronic and paper records. A range of risk assessments were included within the records for example; falls, manual handling, Waterlow, nutrition and body mass index (BMI), bed rails, early warning scores and neurological observations to manage the deteriorating patient.
- At RHH, we looked at eight care records and 13 medicine prescription cards that were completed to a good standard. We saw that risk assessments were complete, alerts were visible and documentation was legible and signed appropriately.
- There were evidence based nursing care guidelines, which fulfilled the function of care plans, available for reference for a wide range of possible care needs. However, these were not printed and available at the patients' bedside or with the patients' care record. Some wards had printed reference files available for staff to use, however we did not observe staff using these. Other wards referred us to the intranet to view these guidelines and again we did not observe staff referring to these. Staff told us computers were not always easily accessible and that new, bank and agency staff did not always have an individual log on. This meant that care plans / guidelines were not always accessible for staff delivering care. We felt this posed a potential risk to effective care delivery and there was a potential for elements of required care being forgotten, missed or incorrect care being given. It was unclear how staff or the trust could be fully accountable for care given when the relevant guidelines were not easily accessible to all staff providing care and were not held as part of the contemporaneous records.

- The risks above were mitigated to some extent by a tracker sheet, which referenced the care guidelines applicable to each patient. The tracker sheet was an integral part of the patient record.
- The risk was also, less where staff used a documented handover, which was electronically stored and printed for staff use. However we observed that not all wards were using formal handover sheets and in some areas planned care was communicated verbally at handovers.

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Safeguarding

- There was a dedicated lead for safeguarding and staff were aware of this. Staff we spoke with were able to give examples of recent safeguarding issues and how they had dealt with them.
- Staff were clear how to escalate safeguarding concerns and had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff new who the safeguarding team were and how to contact them when they needed advice or support.
- Staff had good links with the mental health crisis team and the vulnerable adults' team.
- The MDT undertook MCA assessments and held best interest meetings when needed. Independent mental capacity advocates (IMCAs) were involved where needed and staff knew how to access this service on behalf of patients.
- Three out of seven reporting units had exceeded the 90% target adults' safeguarding training compliance for nursing staff. Another unit had achieved 78% at the end of quarter two and the other units had achieved 67%, 53% and 38% compliance.
- Nursing staff compliance with children's' safeguarding training at level one was above the trust 90% target for all services except gastroenterology at 69% and communicable diseases and specialised medicine 84%. Compliance with children's' safeguarding training at level two was below the trust 90% target for all services except neurosciences.
- Compliance with adult safeguarding training for medical staff at RHH was around 67%, just below the 70% trust quarter 1 target at the end of quarter 2.
- Compliance with children's' safeguarding training for medical staff at level one was between 68% and 100%. At level two, compliance was 56% and at level three 88%. The quarter 2 target for all training compliance was 90%.

Mandatory training

- Most of the staff we spoke with told us they were up to date with their mandatory training.
- At RHH, mandatory and statutory training data showed that many areas that had exceeded the 70% quarter 1 target but only about half had reached the 90% quarter 2 target. There were some areas where compliance with specific modules of training was poor. For example, compliance in gastroenterology and integrated stroke and geriatric medicine was poor for infection prevention and control, basic life support and moving and handling. Therapeutic and palliative care had poor compliance for moving and handling. However, Communicable diseases and specialised medicine compliance with moving and handling was 100% for level 1, 77.14% for level 2a and 74.63% for level 2b.We were told that a high number of vacancies in geriatric and stroke medicine made it difficult to release nurses for training.
- Staff told us they had a two-week intense induction when they started working at the hospital.
- Medical staff groups across this service were not compliant with the trust target of 90% for quarter 2. Only a few areas had reached the 70% quarter 1 target, by the end of quarter 2.

Assessing and responding to patient risk

- All patients were routinely risk assessed on admission and these were on the electronic record patient system.
- All wards used the SHFT early warning score (SHEWS) system to identify patients' whose condition was deteriorating. Nurses recorded observations appropriately and escalated concerns in accordance with the guidance.
- We saw there were standard operating procedures and escalation procedures displayed for managing the deteriorating patient. The staff we spoke with were able to explain the procedures for managing the deteriorating patient.
- We saw in records that deteriorating patients were identified clearly and escalation instructions were documented.
- Nurses told us that doctors documented parameters for guidance relating to individual patients where it was expected that their SHEWS would be outside of the normal escalation thresholds.

- SHEWS audits were undertaken on a monthly basis to ensure that trust policy was adhered to, recognition of acute deterioration was documented appropriately, SHEW scores were accurately calculated, patients who triggered were appropriately communicated and escalated to the medical team in a timely way, patients who triggered received close monitoring as per policy and received a full assessment. The audit also noted whether the patient's condition improved and if not whether they received further assessments and treatment and were escalated to a senior trainee doctor or consultant. Audits also covered whether there was a management plan in place.
- In addition to SHEWS, the nurses assessed unconscious patients using the Glasgow Coma Scale.
- Audit data was entered into e-CAT the trust clinical assurance toolkit. The ward manager or a delegated deputy follows up any issues highlighted at a local level. The ward manager on the stroke unit told us that she and the matron developed an annual action plan from the audit results to ensure improvements were made.
- All members of the hospital at night team held bleeps so the night coordinator could alert staff when a patient's SHEWS was deteriorating and needed immediate assessment or if any tests or blood samples were needed.
- Ward managers identified patient falls as the greatest patient safety risk for stroke and geriatric medical patients.
- All patients were risk assessed for falls, nutrition and hydration and for skin pressure damage.

Nursing staffing

- STHFT used the national "Safer Nursing Care Tool" to determine the number and skill mix of staff needed on the medical wards, based on acuity and dependency of patients.
- Ward managers told us that patient acuity and staffing levels were reassessed every six months.
- Staff told us that at times there were not enough staff on duty, but they could get bank staff or staff would work additional hours if they were available. Matrons monitored staffing levels and workload demand regularly throughout the day and staff were moved from one ward to another if this was necessary. Although staff did not think this was ideal, they understood why this needed to happen and appreciated the help they received from other wards when they were struggling.
- Ward managers were able to book bank and agency staff if shortfalls in advance and at short notice, although it was not always possible to fill shifts.
- We looked at staffing fill rates for the medical wards (all sites) May 2015 - August 2015 and found that overall, the fill rate for registered nurses (RNs) was between 88% and 95% and the fill rate for support staff was between 102% and 120%.
- The data for fill rates demonstrated that although on the majority of occasions extra support workers were in place to mitigate for fewer qualified nurses this was not always possible.
- At RHH, qualified staffing levels fell to between 70% and 80% on wards L1, L2 and P3/4 in June 2015, L2 in July 2015 and L1 and P3/4 in August 2015. In August 2015 L2, registered nurse (RN) fill rate fell to 66% however; the fill rate for support workers was 148% to provide what cover was available.
- Managers for the medical services told us there were approximately 30 whole time equivalent vacancies; however, this figure includes community and spinal injuries' staff not working at RHH.
- There had been some recent recruitment of newly qualified nurses from Spain.
- The trust operated a staff transfer register, where staff could register a wish to move to a post in a different area. This was well received by some staff but others felt that this exacerbated staffing difficulties in the less popular areas.
- Senior managers were well aware of the risks of staffing shortages and were trying to address this as far as possible by proactively recruiting from abroad, undertaking recruitment activities at local universities and by over recruiting to HCA posts to assist the RNs where this was appropriate.
- There was an escalation plan in place for staff to implement when they were faced with an acute staffing issue and matrons continually assessed risk across a number of wards so they were able to move staff if needed. Matrons and senior nurses also worked on the wards if necessary to maintain patient safety.
- Patients told us that they didn't always feel there were enough staff as they appeared very busy and overworked at times.
- We observed a number of nursing handovers and found that communication was clear and comprehensive and included information about complex discharges, best interest meetings, outstanding nursing and medical

tasks, patient care incidents such as seizures and falls risks, patients' nutritional status and areas for improvement such as documentation regarding central venous catheter site inspection.
- Handovers were generally verbal with little in the way of written communications. Some wards had a handover book which contained handwritten information, in other areas nurse made their own notes from the verbal information given. We saw that E1 did use a printed handover sheet.

Medical staffing

- Medical staffing skill mix across the trust was similar to the England average. Consultants, middle career and registrar groups made up 32%, 3% and 46% respectively, of the medical workforce and junior doctors 19%. The England averages were 34%, 6%, 39% and 22% respectively.
- There was medical cover for all specialities Monday to Friday between 8.30am and 8.30pm.with a multi-disciplinary hospital at night team with the ability to call in specialist expertise when needed. Most specialities had consultants onsite at the weekend, between three and nine hours on Saturdays and Sundays with two onsite consultants in haematology. Twenty-four hour, seven-day on-call cover was available in all specialities outside of these hours.
- At RHH, the hospital at night team covered medical admissions and inpatients between 8.30pm and 8.30am. The team consisted of one general medical speciality registrar (SpR), two core medical trainees / general practice vocational trainees (one 8.30pm until 12.30am), one core surgical foundation year two doctor (FY2), one core neurosurgical trainee and two foundation year one or two (FY1/ FY2) doctors.
- On HASU and L2, the consultant on call reviewed all post take patients on their ward round and took ownership of their care.
- Junior doctors confirmed that consultants were easily accessible if needed.
- We observed a day to night medical handover. The handover was led by the SpRs and was organised and well structured.
- We saw how SHEWs information and tasks came through to the electronic board in the hospital at night base room and that the night coordinator and members of the team could easily see this information. The most appropriate member of the MDT undertook jobs from the list in order of clinical priority. The advanced nurse practitioner acted as coordinator overnight and could bleep the support workers or doctors, as appropriate when new tasks came through or when SHEWS indicated a patient deterioration on one of the wards.
- Specialist registrars were allocated to medical teams and received good support from their consultants. Senior house officers and foundation year one doctors were ward based which they told us in the main, worked well however this could create challenges for senior house officers (SHOs) , contacting the correct SpR, when they were covering two or three specialities.. Junior doctors told us there was good team working and cross cover among the geriatric teams.
- There was little locum use across the medical specialities with between 0% and 4.4% locum use across the specialities. Gastroenterology and respiratory medicine were the highest users of locum support at just over 4%.
- Sickness rates for medical staff were low at 2% or less across all services.
- Vacancy rates for medical staff were low across most services with gastroenterology, specialised rehabilitation and communicable diseases and specialised medicine being the worst affected areas at 12%, 16% and 15% respectively. Musculoskeletal services and neurosciences had vacancy rates of 5% and 4% with other services
- Staff on the medical wards told us consultant ward rounds took place every day and patients commented that a consultant saw them every day.
- Support workers were employed to complement the medical teams with tasks such as cannulation, blood sampling and ECGs.

Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions needed when a major incident occurred.
- Staff were aware of the major incident plan and business continuity and knew where to access these online.
- A winter management plan was also in place to manage increased bed pressures over the winter period. Winter plans were thorough and proactive and included identification of additional nursing resource (nursing staff working in non-clinical areas) to assist wards if needed.

Medical care (including older people's care)

- Clinical leads told us that it was also planned to increase consultant cover over the Christmas period to support with the anticipated increase in demand.

Are medical care services effective?

Good

We rated effective as good because;

- There was good evidence of effective multi-disciplinary team working and good provision of seven-day services.
- Patients pain relief and nutritional needs were met
- There was good evidence of learning from audits and improvements were being made.
- Staff were competent and received training relevant to their role to develop expertise.
- Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However;

- Appraisal rates for both nursing and medical staff were below the trust's targets.
- We observed one incident of incomplete recording of a mental capacity assessment.

Evidence-based care and treatment

- Policies and pathways were based on NICE and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.
- Staff demonstrated awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward.
- We observed on L2 that the printed guidance relating to central venous catheters was out of date.
- All doctors took part in clinical audit and each speciality had an audit lead.
- Local audit had identified a need to improve compliance against venous thrombo-embolism guidance in relation to prescribing of prophylactic (preventative) medicines. Audit results had been cascaded to staff and would be re-audited to evaluate improvement.
- Ward staff had access to specialist nurses for additional support, training and expertise. Specialist nurses included; heart failure nurses, asthma / respiratory nurses, diabetes specialists, pain specialists and others.
- Matrons audited wards against compliance with a number of "nurse sensitive" quality indicators such as staffing, sickness, appraisals, capacity, friends and family test, patient harm and infection control practice. This helped identify areas where improvements were needed and wards were supported with any action needed.
- Audit results were displayed on wards for staff information.
- There was a well-embedded stroke pathway for patients from A&E attendance through diagnostics, treatment, HASU, rehabilitation and into the community.

Pain relief

- We observed nurses asking patients about pain and need for pain relief comfort rounds.
- Patients told us they received pain medication when they needed.
- The inpatient survey, published in May 2015, found the trust performed about the same as other trusts for staff doing all they could to help control pain.

Nutrition and hydration

- Nursing staff used a nutritional screening and assessment tool incorporated into the patient admission record to assess patients' nutritional needs and risk factors, on admission.
- Patients could choose from a range of options, which included healthy choices and special diets such as gluten-free or diabetic and soft diets.
- Dieticians devised nutrition protocols for patients for nurses to follow feeding regimes.
- One patient told us that their complex dietary needs were not always met and they sometimes received the incorrect meal. However, the catering team leader came to talk to her about this to apologise and try to ensure the issues were addressed.
- Patients we spoke with told us that the food was good.
- We saw that drinks were available within reach of patients most of the time and that staff provided patients with assistance to eat and drink when needed.

Patient outcomes

- There was no evidence of any increased risk of mortality in any of the medical specialities. The most recent 12-month rolling Hospital Standardised Mortality Ratio (HSMR) 1 June 2014 - 31 May 2015 was "as expected" for all medical admissions when compared with hospital

trusts nationally. The most recent 12-month rolling Summary Hospital-level Mortality Indicator (SHMI) 1 January 2014 - 31 December 2014 showed an "expected" number of deaths which was on the edge of the "lower than expected" range.

- The Sentinel Stroke National Audit Programme (SSNAP) (2014) scored RHH as D overall. The local reports regarding the SSNAP results show a clear understanding of issues affecting patient outcomes and plans to improve future patient outcomes and audit results. The main area for improvement is the level of therapy input for stroke patients, particularly speech and language therapy. Mood screening had shown improvement since the previous audit results.
- In the National Diabetes Audit 2013, RHH performed better than the England median in 15 indicators and worse than the England median in four indicators. The areas highlighted for improvement were; visit by a specialist team, foot risk assessment and seen by the multidisciplinary team in 24 hours, meal choice and staff awareness. Additionally the trust has undertaken other actions to improve outcomes for diabetic patients. The trust aimed to review the structured education, restructure the adolescent pathway, improve on BP and cholesterol targets and improve the percentage of patients completing all eight care processes.
- Staff told us that one of the diabetic specialist nurses saw all new type one insulin dependent diabetic patients and that this team worked weekends. Some of the wards had a diabetic link nurse and training days were available four times a year.
- The trust had undertaken a self-assessment against the recommendations from the National Pain Audit. The MSK service had used these recommendations to develop a 5-year plan to improve pain services.
- For non-elective admissions, RHH had lower readmission rates than the national averages.
- At a trust level, the standardised relative risk of readmission in elective admissions is higher than the England average. The top three specialties with the highest count of activity are clinical oncology, medical oncology and clinical haematology and they all had a rate around one third higher than the England average.
- RHH had a lower rate of elective readmissions than the England average for respiratory medicine and higher readmission rates for gastroenterology and clinical haematology.
- The trust's standardised relative risk of readmission for all non-elective admissions is in line with the national average. However, RHH had a lower readmission rate overall for non-elective admissions and for clinical haematology and infectious diseases. RHH had a higher readmission rate for neurology.
- Performance and quality of care was monitored on all wards using nurse sensitive indicators: complaints, incidents, infection control, falls, MRSA, CDiff and drug errors.

Competent staff

- Staff at SHFT received an annual appraisal to facilitate personal development and maintenance of skills and competence. The target for nursing and medical staff groups was that 85% of staff would have received an appraisal between April and September 2015.
- Appraisal rates for nursing staff at RHH were split by speciality and ranged from 85% to 100% with the exception of respiratory medicine who had a rate of 71% (April -September 2015).
- Appraisal rates for medical staff in this core service were split by speciality and only available at trust level as some doctors worked across more than one site. Most specialities had appraisal rates above 75%, however, gastroenterology, therapeutic and palliative care, had appraisal rates of 53% and 60%, respectively, for the period April 2015 to September 2015.
- Most of the staff we spoke with told us they had received an appraisal in the last 12 months. Staff told us there were great development opportunities offered to staff and they had a personal development plan.
- There were various educational forums for medical staff to attend such as breakfast clubs and mini training sessions in the ward environments. Junior doctors felt that education and support was good.
- There were practice educators on some of the wards such as the stroke unit and ward. Evaluation of this role indicated that the post had increased competency, retention, safety and morale.
- Newly qualified staff were supported by a six-month preceptorship programme and the ward manager on the stroke unit and neurology ward aimed to provide a one-month period of being supernumerary if possible.

Medical care (including older people's care)

- Staff on P3 told us they had peer supervision, which had been initiated following an incident where a patient had died to enable staff to reflect on what had happened, what was working well and what needed to be improved or done differently.
- Clinical support workers in the hospital at night team had been trained to undertake clinical tasks such as cannulation, venepuncture and ECG.
- Clinical support workers on the wards told us they had been through a two week 'prepare to care' course when they started work at the hospital. This gave them all of their mandatory training and taught them skills they would need on the ward. Training included practical caring skills and use of basic equipment.
- The hospital also supported health care apprentices and work placements.
- A CSW had been supported to undertake registered nurse training.
- Volunteers who worked on the wards had received training to enable them to support patients who needed feeding assistance and special diets.
- Staff nurses working in the stroke unit and on the neurology wards were supported to undertake additional training relevant to their specialist area.
- Nurses on the stroke ward had been trained to undertake basic swallow assessments and referred to the speech and language therapists where further assessment was needed.

Multidisciplinary working

- We observed good multidisciplinary working in all areas and staff spoke very positively about working relationships with members of the multidisciplinary team (MDT).
- MDT discussions and advice were clearly documented in patient records.
- Staff on HASU had good links and networks with staff from wards at Northern General Hospital, other district general hospitals and Beech Hill hospital. This facilitated the transfer and repatriation of stroke patients requiring rehabilitation.
- Staff on HASU and the neurology ward were working with a neuropsychologist to set up peer supervision for staff caring for patients with neuro-psychological problems.
- Board rounds and handovers took place between professionals on L2 at different times of day. Staff told us this could have been more effective by having all MDT members at one round or handover rather than multiple handovers taking place.
- The ward board was accessible to all members of the MDT who input their patient updates for the whole team to see.
- Consultants told us there were many different types of multidisciplinary work, which involved discussion with other specialists from both within the hospital and with consultants from other hospitals across the region.
- Pharmacists were allocated to wards and took part in multiagency discussion to help prioritise the needs of new patients, reconcile medications from community to hospital, facilitate discharge and flag any pharmaceutical issues such as omitted doses or prescribing errors.
- Patients told us they had received input from many different professionals in hospital and that they would have multidisciplinary follow up when they returned home.
- We saw that patients on the Q wards had good access to psychology and speech and language therapy. Staff on L2 ward told us that they felt access to these services, which was from the "acute ward team" was limited due to capacity and funding issues.

Seven-day services

- All medical specialties at Sheffield Teaching Hospitals Foundation Trust (STHFT) had a 24 hour, 7 day a week emergency service. There were separate specialities for geriatric and stroke medicine, diabetes and endocrinology, gastroenterology, respiratory medicine, acute medicine, neurology, haematology, infectious diseases and acutely unwell patients were admitted under the appropriate speciality team.
- In addition to the admitting medical teams, there were nominated staff / wards that provided support for out of hours emergency services. For example, the stroke nurses facilitated the patient journey from emergency admission to discharge.
- Medical patients had access to seven-day diagnostic and imaging tests.

Access to information

Medical care (including older people's care)

- Medical, nursing and allied health professional staff had access to patient information, risk assessments, test results and diagnostic images via electronic systems, which were accessible on all medical wards and departments.
- There were some IT issues with the new electronic patient record system. The record system did not connect to the electronic whiteboard system, which meant that information needed to be specially uploaded or input on to a second system.
- Staff completed an electronic discharge letter that included medications. The GP and patient received a copy and staff put a copy in the patient record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training about Mental Capacity Act and DoLs, as part of their safeguarding of vulnerable adults training.
- Staff were aware of how to gain both written and verbal consent from patients and their representatives. Members of the MDT usually undertook mental capacity assessments and best interest decisions in discussion with each other.
- Staff we spoke with demonstrated a clear understanding of consent, mental capacity and deprivation of liberty safeguards. However, we observed one set of records on M2 where a patient had been transferred from NGH using the best interest decision process. Documentation of a mental capacity assessment had still not been documented two weeks following admission to hospital. This was highlighted to the ward sister for action.
- We observed staff informing patients what they wanted to do and always asked for permission first before starting tasks or personal care.
- Staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.

Are medical care services caring?

Good

We rated caring as good because;

- We observed staff in all areas treating patients with kindness and respect.
- Privacy and dignity was maintained at all times and we saw staff answering patients' questions patiently and cheerfully with a caring manner.
- Patients were very happy with their care and information from all professional groups.
- Patients told us they understood the information that was given to them and what was happening to them.

Compassionate care

- We observed staff in all areas treating patients with kindness and respect.
- Patients looked well cared for and they told us their needs were met.
- Staff spoke to patients in a reassuring manner and maintained privacy and dignity when delivering personal care.
- We saw staff answering patients' questions patiently and cheerfully with a caring manner.
- Patients told us they felt safe and well cared for.
- Patients we spoke with told us the staff were extremely caring, courteous and knowledgeable.
- Staff told us they would be happy for their relatives to receive care at this hospital.
- We saw that doctors and nurses introduced themselves and asked patients their preferred name.
- Patients said staff were friendly, understood their treatment and kept them informed.
- Staff carried out regular comfort rounds asking patients if they were comfortable or had any pain. Other needs were also checked at this time such as if drinks were needed or if the patient needed assistance going to the toilet or with changing position.
- We observed staff closing curtains and doors to maintain confidentiality and privacy.
- The medical service at this hospital had a Friends and Family Test response rate of 35 % between July 2014 and June 2015 that was slightly better than the England average of 34.5%. Q1 and E2 were the only wards, with over 100 responses not managing to achieve a response rate higher than the England average during this time. The average response rate for both of these wards was 29%.
- More recent data; for October 2015 showed that RHH had an average recommendation score of 97% in the NHS Friends and Family Test, which was better than the

England average of 95%. All medical wards had a higher recommendation rate than the England average; however, there was incomplete data for Q1, P3 and Q2 wards, for this month.

- SHFT "Frequent feedback inpatient results" (April 2014 to March 2015) showed that overall patients thought that care on the medical wards at RHH was excellent / very good and that they were always treated with dignity and respect. The majority of patients in all areas indicated that they received enough help with eating and drinking, toileting and hygiene needs.
- Of the 34 indicators in the Cancer Patient Experience Survey, the trust is in the top 20% for three indicators, the bottom 20% for one indicator and in the middle 60% for the remaining 30.
- In the CQC In-patient Survey 2014, the trust is performing about the same as other trusts for 11 of the 12 indicators.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were well informed and were involved in decisions about care.
- We observed staff ask patients what they wanted regarding their care and treatment and saw that patient choice was respected.
- Patients understood what was happening to them and why.

Emotional support

- Clinical nurse specialists were available for a range of services such as; Infection prevention and control, tissue viability, Macmillan nurses and the cancer specialist team.
- There was a chaplaincy service across the trust.
- Patients told us they received good emotional support from ward staff.

Are medical care services responsive?

Good

We rated responsive as good because;

- There were many examples of service planning and delivery to improve services for patients.
- There were a number of initiatives to improve access, facilitate patient flow, and discharge. Some of these were well established with further improvements planned. For example, geriatric medicine had historically been part of acute medicine but was now combined with community services. It was hoped this would help improve integrated pathways for elderly patients between acute and community services and facilitate provision of services in the community to enable elderly patients to be cared for at home whenever possible
- Staff worked very hard to meet patients' individual needs and were responsive to patients concerns and complaints.

However

- High numbers of patients were moved to a ward outside of their speciality ward and 19% patients were moved twice or more during their hospital stay.
- The process for transferring and receiving patients from NGH was not robust and could potentially lead to delayed review and treatment or investigation of patients.

Service planning and delivery to meet the needs of local people

- There were many examples of service planning and delivery to improve services for patients. For example, work was ongoing to improve front door access to services and improve discharge, community and integrated geriatric and stroke medicine had recently merged into one care group to improve integrated pathways of care for elderly patients to enable better care at home and in the community.

Access and flow

- The average length of stay at RHH was shorter (better) than the England overall average for elective medical patients, 3.7 compared to 4.5. The lengths of stay for two of the three top specialities were; neurology 3.1 and gastroenterology 1.8 which were better than the England averages of 6.8 and 3.1 for these services. Clinical haematology patients had a stay of 11.5, which was longer than the England average of 5.2.
- The average length of stay in this hospital was longer (worse), 7.5, than the England overall average of 6.8 for non- elective medical patients. The specialities of

neurology and clinical haematology had similar lengths of stay to the England averages, 8.3 and 6.0, and patients suffering from infectious diseases had a shorter stay at 4.5 compared to the England average of 6.9.

- Non-elective / emergency stroke patients were admitted to the hyper-acute stroke unit following a CT scan. Outreach stroke nurses from the HASU followed patients through the pathway from A&E to the unit or ward. Patients were also accepted directly onto HASU to be considered for thrombolysis.
- Consultants advised on the treatment of stroke patients out of hours using telemedicine. The junior doctors in contact with the consultant would prescribe the thrombolysis drugs for the patient, which the senior stroke nurse would administer.
- Staff told us transfer from HASU to the rehabilitation wards Q1 and Q2 could be slow and this would adversely affect prompt delivery of the speech and language therapy and physiotherapy aspects of rehabilitation.
- Routine / elective medical patients and outpatients were admitted directly to the relevant base ward.
- Wards had access to a transfer of care nurse to facilitate timely discharge and the discharge team also covered weekends.
- For delayed transfers of care between April 13 and May 15, 52% of delays were due to 'Waiting Further NHS Non-Acute Care' and 32% were due to 'Completion of Assessment.' These reasons corresponded to the top two reasons seen nationally however the percentages seen nationally were 21% and 19%.
- The trust consistently exceeded the standard for referral to treatment times and was above the England average.
- Referral to treatment times (RTT) for five of the seven specialty groupings were above the 90% standard for the 18-week wait. Dermatology was not achieving this standard, 84% of dermatology patients received treatment within 18 weeks.
- Bed occupancy levels have consistently been lower than the England average and fluctuated between 76% and 83% whilst following the national trend. The England average had fluctuated between 86% and 91%. A trust audit of the number of beds in May 2015 found significant data quality issues with the bed occupancy data that has been provided to Department of Health. This was compounded by the migration to a new patient administration system. The trust was taking urgent action to address this issue but had concerns about the quality of this data.
- We saw that some patients were transferred to RHH as outliers from NGH and a locum consultant or covering registrar provided medical review and any further, required interventions until those patients were discharged.
- Action cards were used to ensure patients met clinical criteria before transfer to ensure the patient was safe to be moved. Patients were also clerked and had medications prescribed before transfer and only general medical and elderly patients were transferred to RHH to ensure appropriately trained doctors were readily available to provide ongoing treatment and assessment for discharge.
- Service leads told us that wards at RHH and receiving medical staff were made aware of transfer prior to this happening. It was intended that a list of patients for transfer was emailed from the bed manager office at NGH every day to a manager and the receiving clinician on the RHH site. However, discussion with managers, nursing and clinical staff indicated that this process was not always effective.
- Staff told us that sometimes a patient would arrive without them being aware they were on the way and the covering consultant sometimes discovered patients through discussions with the nurse in charge of the ward and by actively looking for these patients, rather than through a formal notification. These patients may have arrived at the hospital the previous day or within the previous 48 hours.
- There was no system in place for a doctor to see transferred patients immediately on arrival or to receive a verbal handover, although handover documentation was available in the patients' record.
- The risks of the current process were that not all outlying patients may be identified in a timely manner and outstanding medical issues or tests may not be addressed as soon as they should. Delays in doctors receiving handover information or initiating treatment or tests would increase risks to patient safety.
- Information regarding bed moves at RHH between September 2014 and August 2015 indicated that, across the medical wards, 22% of patients were moved once

during their stay, 11% were moved twice, 4% three times and 4% of patients were moved 4 or more times. This equated to 360 patients being moved four or more times during their hospital stay.
- The percentage of inpatients that have had to make two or more ward moves has increased from 16% between September 2013 and August 2014 to 19% between September 2014 and August 2015.
- Staff told us that sometimes people were transferred during the night to free up a bed at NGH. Trust data indicated that an average of 213 patients were moved after 10pm, every month. This equated to around 25% of patients moved, being moved late at night.

Meeting people's individual needs

- STH provided an interpreting service to support the communication needs of people who are non-English speakers, people for whom English is a second language, and people who are deaf. Language Line was contracted to provide telephone, face to face and British Sign Language interpreting. Bookings for face to face interpreters were made through a central team within the Trust
- All leaflets included a standard paragraph promoting the availability of other languages / formats on request and posters promoting communication support were displayed across the trust. There was some translated material available on the trust website.
- We saw a wide range of information leaflets were available to patients on all of the wards.
- A patient told us how staff on E1 worked with their carer and family to enable them to provide some of their care while in hospital.
- We observed that, in the main, buzzers were within reach of patients and nurses responded to them quickly. Patients told us that nurses answered buzzers quickly.
- Staff gave us examples of where they had made adjustments for patients with a learning disability, dementia, or other cognitive impairment, when receiving care. For example, patients with a learning disability were encouraged to attend the planned investigation unit (PIU) for a pre-visit prior to attending for their own investigation. They could meet the doctors and nurses who would be caring for them which, helped reduce anxiety and stress among this group of patients.
- We observed that handovers included a discussion of patients' individual needs.
- Recovering stroke patients had access to a therapy gym and occupational therapy kitchen on the Q floor.
- Toilets on the Q wards were not ideal for stroke patients as they were higher than standard due to the wards previously being orthopaedic wards. We were told they were too high for some patients.
- Patients told us that therapists were very good at explaining what they were going to do and why.
- A wheelchair user told us that disabled access was an issue in many parts of the hospital.
- Relatives of extremely ill patients or who lived a long way from the hospital could be accommodated overnight.
- Staff had an understanding that patients may have different needs and expectations due to religious or cultural beliefs and they would accommodate these needs.

Learning from complaints and concerns

- Staff were encouraged to deal with patients and families concerns as they arose and many issues were dealt with, without escalation to formal processes.
- Patients told us they did not know how to make a formal complaint but they would be happy to speak to the nurse in charge and were confident any issues they had would be sorted out.
- We looked at a small number of complaints investigations and found they had been thorough. Staff had met with the families concerns and had been responsive to the issues raised.
- A patient told us that she had raised a concern about missed doses of antibiotics with a member of staff and had been unhappy about the nurse's attitude. However, when the patient raised concerns with the sister and consultant her concerns had been addressed to her satisfaction.
- Tell us what you think' leaflets were available across the medical wards. These told, patients and families how they could provide feedback, positive or negative, and advised on how to make a complaint.
- We saw information regarding making a complaint displayed on the information posters at the entrance to wards.
- Staff told us that concerns were resolved informally whenever possible and few needed to be escalated to formal processes.

Medical care (including older people's care)

- Senior managers led investigations for their area. This was a consultant for medical issues, matron for nursing issues or department head for department-specific issues.

Are medical care services well-led?

Good

We rated well-led as good because;

- All services had clear vision and strategies, which were known to staff at all levels of the service.
- The services were visionary and innovative and there was a well-embedded culture of service improvement.
- There were clear governance structures and managers were clear about how they could escalate risks to senior managers and the executive team.
- Managers and staff had a good understanding of what risks their services faced and mitigated against these wherever possible.
- Risk registers were comprehensive and up to date.
- There was strong leadership of services and wards from clinicians and ward managers.
- Staff recommended the trust as a good place to work and would be happy for relatives to receive care there.
- There was a strong culture of learning and improvement and numerous examples of innovation, improvement and sustainability.

Vision and strategy for this service

- There was a strategic business plan in place for all medical services.
- We saw that the trust PROUD (Patient first, Respectful, Ownership, Unity and Deliver) values were on display throughout the wards and hospital and staff talked about what this meant to them.
- Ward managers told us that the PROUD values were integral to staff appraisal.
- There was a clear vision for the provision of medical services including the further development of integrated geriatric and stroke medicine.
- Managers, clinicians and ward staff told us of the stroke services improvement plan, the changes and improvements already made and what further changes were planned. The vision for the service was to become a regional centre for stroke patients.
- Strategies for services included research aspirations and opportunities.

Governance, risk management and quality measurement

- Trust wide and service wide risk registers were in place and were regularly reviewed and updated.
- Ward managers and matrons were aware of the risks in their areas and new how to escalate risks through the organisation if needed.
- Ward managers were aware of key issues on their wards and worked with matrons to improve the services they delivered through regular cycles of audit, monitoring of quality indicators and improvement actions.
- Key issues for integrated geriatric and stroke medicine included nurse staffing and occupational therapy staffing / provision.
- Ward managers told us there were monthly meetings with the matrons, which included discussion of governance and operational issues such as incidents and safeguarding alerts and investigations.
- Ward managers in turn held monthly meetings with the ward staff to cascade learning from the above and to share other relevant information regarding improvements needed, training opportunities and any other improvements to be made.
- We saw from the minutes of these two meetings that this governance framework offered the staff an opportunity to raise and or escalate any risks or issues they identified, share learning from incidents and complaints and keep staff updated with changes to services, policies or protocols. Patient safety alerts, audit results and areas for improvement were also discussed, as was training and appraisal compliance.
- Senior managers were clear about the risks their departments or services faced and minutes of governance meetings clearly demonstrated discussion, escalation and actions taken.

Leadership of service

- At ward level there was clear leadership of the services. Ward managers told us they had two office days a week to undertake their management and leadership roles.
- Some wards held "consultant business meetings" weekly with all members of the ward team to discuss current issues and improve services.

- Matrons gave good support to the ward managers regarding day to day operations as well as monitoring performance against nurse sensitive indicators.
- Ward managers told us that there was ongoing monitoring and work to look at reasons for staff sickness to help improve sickness rates. Regular meetings had been introduced where managers looked at sickness levels, this had made it easier to escalate raised sickness levels and the impact this had on staffing wards.
- Staff told us they felt supported and knew who to escalate problems to if they could not solve something themselves.
- Newly qualified staff told us they had an identified mentor for support.
- A member of the domestic staff told us they were included in team briefings, felt supported and could raise concerns.
- Staff on P3 told us there was a weekly improvement meeting. They gave an example of how a staff member had collected patient feedback, and shared it with this meeting to improve communication with patients regarding waiting times to receive discharge medications and test results.
- Staff and volunteers told us they enjoyed working for the trust and support staff such as porters and domestics told us they felt part of the team.
- There was a senior sisters' development programme for ward managers and staff were supported to undertake other leadership programmes and courses.
- There were clear lines of accountability from the service leaders to the frontline staff.
- Staff spoke highly of clinical leadership and the clear direction they provided for service developments.

Culture within the service

- Staff told us they felt proud to work for the trust and they would be happy for their friends or family to receive care there. They told us they were well supported by their managers and there was good teamwork and support in all areas we visited.
- Sickness absence rates have followed the national trend however; peaks have been slightly higher than the peaks in the England average. Jan 11 to Jan 15
- Staff gave positive feedback regarding the culture of the organisation and as a good place to work. They felt the culture was one of improvement and staff were encouraged to report incidents and learn from them. Staff felt the culture was open, learning and not a blame culture when things went wrong.
- Staff felt confident to raise any concerns they had about patient safety, that managers would listen and would take appropriate action.
- The service leaders and managers encouraged learning and development and supported staff through career development. Support workers wishing to gain experience and then move on to professional training were encouraged and there were sponsorship opportunities for RN training.
- Ward managers told us they had recently started to use strength-based recruitment to ensure they appointed staff with the right values and beliefs.

Public engagement

- The wards displayed the FFT results notice boards so patients and public could see changes made because of their feedback.
- Patient feedback was taken seriously and the trust undertook its own patient survey twice a year.

Staff engagement

- Staff talked about a 'productive forum', which enabled frontline staff to identify areas for improvement. An example of an improvement from this forum was the use of a red mat system to identify patients who needed assistance with eating and drinking.
- Staff were rewarded for good practice and innovation at an annual events ceremony. Staff also received long service awards and a voucher.
- Ward managers described how they valued the views of their staff and sought their opinions before making changes.

Innovation, improvement and sustainability

- Managers viewed recent changes to the care groups positively and felt that these were designed to facilitate improved pathways of care for patients. For example, geriatric and stroke medicine had historically been part of acute medicine but was now combined with community services. It was hoped this would help improve integrated pathways for elderly patients between acute and community services and facilitate provision of services in the community to enable elderly patients to be cared for at home whenever possible.

Medical care (including older people's care)

- Advanced nurse practitioners were being developed in many areas to support clinical assessment, delivery of patient care and provide opportunities for career advancement.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Eight clinical directorates across four care groups managed surgical services at the Royal Hallamshire Hospital (RHH).

The hospital provided mainly elective (planned) inpatient surgical treatment and day surgery for a range of specialities including ear, nose and throat (ENT), ophthalmology, orthopaedics, urology, neurosurgery, plastic surgery and breast surgery. There were 20 operating theatres at RHH and one at Weston Park Hospital (WPH). The operating theatre at WPH was managed by the team from the RHH and care was provided by RHH staff.

Between January and December 2014 there were 38,300 surgical episodes of care carried out at RHH. Day cases accounted for 59% of all episodes, elective cases 23% and emergency cases 18%.

During this inspection we visited the following surgical wards; F1 (elective orthopaedic), F2 (general, plastic and breast surgery), H1 and H2 (urology), I1 and I2 (ENT, maxillo facial and ophthalmology), J2 (pre-operative assessment), N2 (neurosurgery), the theatre admissions unit, the operating theatres and recovery.

We spoke with 15 patients, four relatives and 50 members of staff. We observed staff deliver care and looked at five patient records and 14 medication charts. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Summary of findings

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. However, there was limited evidence of learning from incidents across directorates at ward level.

Systems and processes for infection control, medicines management and patient records were mostly reliable and appropriate to keep patients safe. Staffing levels and skill mix were planned and reviewed to keep people safe. Staff recognised and responded promptly and appropriately to risks and deteriorating patients, including overnight and at weekends.

Care and treatment was planned and delivered in line with evidence based guidance and best practice.

The service participated in relevant local and national audits. Patient outcomes were monitored. Staff were qualified and had the skills they needed to carry out their roles effectively. They were supported to maintain and further develop their professional skills and experience.

Patients were treated with dignity and respect and involved in their care and their needs were met through the way services were organised and delivered.

Directorates had clear strategies driven by quality and safety aligned to the trust's vision and values. Governance structures and processes within the directorates functioned effectively. There was a high level of staff engagement and satisfaction.

Surgery

Are surgery services safe?

Good

The safety of this service was good. We found;

- Staff understood their responsibilities to raise concerns and report incidents and near misses. We saw evidence they reported concerns and incidents appropriately.
- Systems and processes for infection control, medicines management and patient records were mostly reliable and appropriate to keep patients safe.
- Staffing levels and skill mix were planned and reviewed to keep people safe.
- Staff recognised and responded promptly and appropriately to risks and deteriorating patients, including overnight and at weekends.

However we found;

- There was limited evidence of learning from incidents across directorates at ward level.
- We reviewed minutes of directorate clinical governance meetings and found inconsistent attendance of senior ward staff.
- None of the clinical staff we spoke to on the wards were familiar with the term “safety huddles” or the planned introduction of safety huddle meetings.

Incidents

- The trust had reported four never events in surgery in the 12 months prior to inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Two of these occurred in April 2015 at WPH theatre during ophthalmic surgery and were the insertion of incorrect lenses. Staff had put a new procedure in place and received training to complete a second check as part of the cataract surgery safety checklist. We saw this new procedure displayed in theatre during our inspection and staff we spoke to explained the changes to their practice that had taken place as a result of the never events.
- All staff in theatre at RHH and WPH had a clear understanding of the other two never events in theatre at the Northern General Hospital (NGH) and explained the change in practice that had occurred across all three sites.
- The trust had reported 10 serious incidents between August 2014 and July 2015; one incident happened at RHH and one at WPH. We reviewed investigations that all contained recommendations and action plans. We saw evidence during our inspection of changes made to practice as a result of the incidents.
- Nine hundred and thirty nine incidents had been reported in the service between November 2014 and October 2015, 73% of these were graded as no harm and 27% minor harm or damage. Themes of the incidents falls, pressure ulcers and medication incidents.
- Staff reported incidents on an electronic system. Staff we spoke to were aware of how to report an incident. Staff gave examples of changes that had happened on wards following incidents, for example, the introduction of different syringes following medication incidents, a change to beds after a patient hit the mechanism on the bed during a fall and additional staff on duty when ward N2 had patients with challenging behaviour.
- Senior ward staff investigated incidents with expert input from the directorate governance lead and specialist teams in tissue viability and infection prevention and control.The tissue viability team completed root cause analysis on pressure ulcers and the infection prevention and control team completed root cause analysis on incidences of methicillin resistant staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile).
- Most staff we spoke to received feedback about incidents from ward managers and through team meetings. Ward H1 displayed a “what I learnt today” board in the staff room to share learning. We saw evidence of weekly half hour huddle newsletters in theatre where safety performance information and lessons learnt were shared.
- There was limited evidence of learning from incidents in other directorates at ward level. Four members of staff on ward F2 were unaware of any never events that had occurred in the trust. Senior ward staff were invited to attend the directorate clinical governance meeting and did when time allowed. We reviewed minutes from 12 of these meetings and found there was limited recorded discussion of learning from incidents in other

directorates. However, it was acknowledged that key notes from the trustwide safety and risk management board where lessons from serious incidents were shared were circulated to staff.

- One of the trust's key objectives linked to the improvement priorities 2015/16 was to introduce "safety huddles" (a small meeting focussed on patient safety, to ensure that patient safety is at the forefront in every clinical handover). None of the clinical staff we spoke to on the wards were familiar with this term or meeting.
- Staff attended morbidity and mortality meetings within the clinical directorate. We reviewed six sets of meeting minutes from two clinical directorates over the last six months. Most directorates reviewed morbidity cases as well as mortality cases. However, where the outcome of the review affected another clinical directorate, it was not clear from the minutes how this was communicated and the actions reviewed.

Duty of Candour

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm.
- The trust had updated their incident management policy to include the process for reporting Duty of Candour cases.
- The trust had developed a Duty of Candour education plan consisting of three levels of education. All staff we spoke to were aware of the importance of open and honest care. Ward managers had attended a trust training session.
- Senior staff demonstrated a clear understanding of the Duty of Candour. They were able to describe specific incidents they had been involved in and the actions they had taken to meet the requirements of the Duty of Candour.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- All wards did not display safety thermometer information in the clinical area. This meant staff, patients and relatives could not see the amount of harm free care that was provided.
- In the reporting period December 2014 to December 2015, the service reported 50 incidents of harm at RHH. Twenty seven pressure ulcers, four falls with harm, 15 CUTIs and four VTE. The incidence of harm had reduced over time

Cleanliness, infection control and hygiene

- All wards and theatre areas were visibly clean.
- Clinical areas displayed infection prevention and control information visible to patients and visitors.
- Information submitted by the trust showed there had been no trust attributable episodes of MRSA in the service in 2015/16 up to July 2015.
- Information submitted by the trust showed there had been no trust attributable episodes of C. difficile in the service in 2015/16 up to July 2015.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- We reviewed the documented checks which had been completed daily, weekly and monthly checks for the anaesthetic and scrub rooms. This provided assurance that staff completed daily cleaning, flushing of water systems and monthly deep cleaning of the areas.
- Information submitted by the trust showed 73% of staff had completed infection control training. This was lower than the trust target of 90%.
- The trust had an infection prevention accreditation programme to provide a framework for assessment and standardisation of infection prevention and control practice in clinical areas. Ward managers completed monthly and quarterly audits in line with the programme schedule and evidence was reviewed with the Infection Prevention and Control Team. Accreditation was awarded annually when the evidence supporting achievement of the requirements was satisfactory and re-accreditation was required annually. Information provided by the trust showed that at 29 September 2015, all but four areas in the service had current infection prevention accreditation; ward H1, pre-operative assessment, WPH theatres and day surgery. Ward managers in these areas worked closely with the ICPT to achieve the actions required.

- Pre-operative assessment staff completed MRSA screening on elective surgical patients. Ward F1 isolated non-elective patients that were transferred to the ward and rescreened for MRSA.
- The trust participated in the Public Health England (PHE) surgical site infection surveillance scheme. The infection rate for cranial surgery at June 2015 was 0.4%.This was better than the national figure of 1.4%
- The infection rate for hip arthroplasty was 0% and knee arthroplasty was 0.9% at June 2015. This was better than the national figure of 0.8% for hips and worse than the national figure of 0.7% for knees.
- The ophthalmology directorate completed surveillance of infection following cataract procedures. The incidence of infection from October 2010 to date was one in 6626 procedures.

Environment and equipment

- Access to wards and theatres at RHH was secure and via an intercom.
- The theatre at WPH had limited space and a small recovery area. It was used to provide additional capacity for ophthalmic surgery based at RHH.
- During our unannounced inspection on 23 December 2015 we found the theatre at WPH was unsecured. Outside of theatre we had access to theatre uniform and a variety of medical equipment such as scalpels, needles, chest drains and out of date local anaesthetic medication. Inside theatre we had access to a variety of medical devices and equipment including oxygen, intravenous fluids and the resuscitation trolley. We highlighted this to the Operating Services Lead Nurse and the Governance and Risk Manager and by the end of our unannounced inspection the theatre environment had been secured with locks on the doors.
- Equipment was visibly clean and stored appropriately.
- We reviewed completed documentation for anaesthetic rooms and scrub rooms. This provided assurance that staff completed equipment, stock levels and waste disposal checks.
- The trust had consistently had higher scores than the England average in the Patient-led Assessments of the Care Environment (PLACE).
- Staff checked the resuscitation equipment, oxygen and suction daily. Records for this were complete.
- We checked seven pieces of equipment, for example, blood pressure monitors and hoists on the wards; they had all been appropriately tested and were within their service date.

Medicines

- The service had appropriate systems to ensure that medicines were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- We reviewed 14 drug prescription and administration records, 12 of which were complete. One was not legible, signed or dated consistently and one did not have VTE prophylaxis correctly prescribed.
- Of the 14 drug prescription and administration records we reviewed one patient on ward F2 was managing their own medication. Staff had not assessed or documented the patient's ability to self-medicate which was not in line with trust policy on self-administration of medication.
- Intravenous fluids were stored safely and securely.
- We checked medicines and equipment for emergency use and found that they were readily available, stored appropriately, and that regular checks had been performed to ensure that they were fit for use in line with trust policy.
- The service completed quarterly antibiotic prescribing bundle audits. Results ranged from 22% to 100% compliance. The main omissions were a lack of stop or review date on the drug prescription and administration record and a lack of indication written in the patient record. Information provided by the trust did not include an action plan for the audits.
- The trust completed a quarterly drug related incident report. Results were trustwide and not broken down into core service.
- NICE guidance recommends in an acute setting medicines reconciliation is carried out within 24hrs. The trust monitored medicines reconciliation in 24hrs monthly. The trust submitted information that showed 80% of medicines reconciliation was completed, less than 60% within 24 hours.

Records

- Records were not always stored securely; on two of the wards we visited staff had left patient records out on the

nurses station. We found loose sheets in the record, which meant that notes may not always be contemporaneous, and there was a risk that part of the record could get lost.
- Nursing staff on ward N2 had a project to review paperwork underway to reduce the number of pieces of paper at the bedside.
- We reviewed five sets of records. The content of four of them was accurate, complete and in line with professional Nursing and Midwifery Council standards. None of the records we reviewed met General Medical Council guidance on keeping records as medical staff did not record their GMC number.
- Following the introduction of an electronic patient record, slim notes had been developed in pre-operative assessment. Staff told us the slim notes did not contain enough information as the record started at pre assessment and did not contain the original referral letter or any outpatient notes.
- The trust completed hospital wide documentation audits to assess the quality and standard of the completion of records. We did not review the results of these audits in the service.
- Information governance training was included as part of the mandatory training programme. Information submitted by the trust showed 82% of staff had completed this training. This was lower than the trust target of 90%.

Safeguarding

- All staff we spoke to were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff we spoke to knew how to access the trust's safeguarding policy and the safeguarding lead.
- Wards and theatre had safeguarding link nurses.
- Information submitted by the trust showed 90% of staff had completed safeguarding adult's level one training. This was in line with the trust target of 90%. Seventy seven percent of staff had completed safeguarding adults level two training. This was below the trust target of 90%.
- Information submitted by the trust showed 88% of staff had completed safeguarding children level one training and 47% of staff had completed safeguarding children level two training. This was below the trust target of 90%.

Mandatory training

- The trust had a comprehensive package of mandatory training for staff. This included modules on topics such as adult basic life support, moving and handling, equality and diversity and health and safety. Compliance was below the trust target in all topics except health and safety and safeguarding adults level one.
- Staff told us they were given protected time to attend mandatory training.
- Information submitted by the trust showed that overall compliance with mandatory training in surgery was 83%. This was below the trust target of 90%.

Assessing and responding to patient risk

- The trust used a local adaptation of a national early warning tool called Sheffield Early Warning Score (SHEWS) which indicated when a patient's condition may be deteriorating.
- The trust had a pathway for the deteriorating patient. Clinical areas we visited displayed the pathway at the nurses' station which included staff contact details.
- The records we reviewed had completed SHEWS scores and appropriate responses to them. Staff put an orange sticker in the patient record to easily identify a deteriorating patient's management plan.
- Nurses told us there was no delay in medical staff reviewing patients; we observed doctors on the ward responding promptly to their bleeps.
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. In the five records we reviewed two of the risk assessments were incomplete. Where the assessment had been completed and risks were noted, staff had completed appropriate care plans.
- The World Health Organisation (WHO) surgical safety checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in the patient record.
- Audit data on the WHO surgical safety checklist provided by the trust prior to the inspection was for 2013/14. We saw evidence during the inspection of spot check audits that took place. Twenty eight spot check audits had been completed across the trust up to 30 November

2015; 13 at RHH. Compliance was between 61% and 100% with the lowest compliance being the planned start and end times being discussed and issues raised and escalated appropriately at debrief.
- We saw evidence in theatre at WPH that the surgical safety checklist for cataract surgery was used and changes following the two never events had been made on the form.
- Staff at the weekly ophthalmic planning meeting reviewed the patients that were planned to have their cataract surgery at WPH. Low risk anaesthetic patients without any moving and handling needs were operated on at WPH. The theatre team had access to a cardiac arrest team on site.
- Patients that underwent day surgery received care in line with best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011. Staff gave patients an information leaflet which contained 24 hours contact numbers and telephoned patients who had a general anaesthetic the following day.

Nursing staffing

- The trust used three tools to determine appropriate levels of staffing; the safer nursing care tool, professional judgement and nursing hours per patient day. The trust target was for there to be an average ratio of 70/30 registered nurses to clinical support workers across all inpatient areas. The chief nurse prepared a monthly staffing report for the board and highlighted areas that had a variance of greater than 15% against either day or night staffing for nurses or support workers.
- Wards displayed the planned and actual staffing figures. During our inspection the actual number of staff on duty was lower than the planned number of staff on most of the wards we visited. Senior staff told us they assessed the staffing situation across the trust, and made a clinical decision about re-deployment of staffing resources. The requirement to move registered nurses was to ensure the safety of all patients across all inpatient areas.
- Information submitted by the trust showed clinical areas in the service had 32 whole-time equivalent (WTE) nursing vacancies from their established level. Recruitment was ongoing.
- Sickness in the service was 5.7% against a trust target of 4%.
- We reviewed the monthly staffing report for October 2015; no wards in the service had a variance of greater than 15% for registered nurses.
- The trust did not collect staffing data in isolation and took account of quality aspects of patient care using national Nurse Sensitive Indicators (NSIs). These were infection rates (hospital acquired MRSA infection and colonisations and C.difficile rates); formal complaints related to nursing care, falls, medication errors and pressure sore rates. The trust submitted evidence that NSI's were recorded and reported. This shows that care groups monitored quality indicators that may cause patient harm.
- The total NSI's for the year showed that complaints were highest on ward N2.
- Staffing levels in urology was on the risk register and the ward manager told us there were seven registered nurse vacancies on the ward. We observed a three week rota on the noticeboard in the staffroom on ward H1 which, for that period, had 54 unfilled shifts. The ward manager told us this was normal and 40 to 50 shifts a week were put out to the nurse bank and an agency; the shifts did not always get filled. The average bank staff usage on H1 and H2 was 7.7%.
- All registered nurses and clinical support workers we spoke to reported they were unhappy that they were moved to cover other wards across hospital sites regularly and at short notice. Staff recognised the need to keep patients safe; however it was clear this had an impact on staff morale.

Surgical staffing

- Consultant medical staff were accessible 24 hours a day, seven days a week. Senior medical staff reviewed patients daily.
- Information submitted by the trust showed that the medical and dental vacancies in the service were in the neurosciences and ophthalmology clinical directorates at 5.3 WTE and 4.7 WTE.
- Within surgery, similar rates of medical staffing to the England average levels were noted: Consultant staffing at 45% trust level versus 41% England average, registrar grade medical staff at 38% versus 37% England average and junior medical staff 13% versus England average of 12%. However, from data up to September 2014, there was a lower number of middle grade staff at 3% to 11% England average.

Surgery

- Surgical cover at RHH encompassed a significant range of specialties. During daytime hours Monday to Friday each speciality managed its own team of doctors.
- Overnight a Hospital at Night model was in place. This consisted of a multidisciplinary team of ANPs and junior doctors that had the competence to cover a wide range of interventions with the capacity to call in specialist expertise when necessary.

Major incident awareness and training

- Senior staff clearly explained their major incident and business continuity plans. The actions described were in line with the trust's major incident plan.
- Staff knew how to access the major incident and continuity plans on the intranet and explained the steps they would take to seek instruction from senior staff.

Are surgery services effective?

Good

The effectiveness of this service was good. We found;

- Care and treatment was planned and delivered in line with evidence based guidance and best practice.
- The service participated in relevant local and national audits. Patient outcomes were monitored.
- Staff were qualified and had the skills they needed to carry out their roles effectively. They were supported to maintain and further develop their professional skills and experience.
- Multidisciplinary teams worked together to understand and meet people's needs.
- Consent to care and treatment was obtained in line with legislation and guidance. People were supported to make decisions.

Evidence-based care and treatment

- Staff were aware of relevant policies and guidelines and showed us how they would access them on the trust intranet.
- Policies and guidelines were based on relevant and current evidence base and best practice from appropriate professional bodies, including National Institute of Health and Clinical Excellence (NICE), Royal College of Surgeons (RCS), Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Association of Day Surgery Guidance.
- Pre-operative assessment was in line with NICE CG3 (pre-operative tests). Pre-operative practitioners completed an assessment in line with national guidance. They had immediate access to an anaesthetist. A smoking cessation volunteer was based in pre-operative assessment.
- Staff followed the enhanced recovery programme (NHS Institute for Innovation and Improvement). Wards H1 and H2 displayed information on the programme for staff, patients and visitors.
- Surgical pathways were in line with NICE CG92 (venous thromboembolism: reducing the risk for patients in hospital).

Pain relief

- As part of the SHEWS observation chart and intentional rounding (a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs) staff regularly asked patients about their pain levels and recorded the scores.
- All the wards in the service scored excellent (85% or above) in the question "staff definitely doing everything they can to help control patients' pain" on the frequent feedback inpatient survey from April 2014 to March 2015.
- Staff had access to an acute pain team. The acute pain team routinely reviewed patients with an epidural or patient controlled analgesia (types of continuous pain relief used post-operatively) and other patients on request.
- We reviewed patient records and observed staff assessing pain and giving support to patients requiring pain relief.
- Six patients told us that their pain was managed effectively and kept under control.
- Patient information included a section how to manage pain symptoms following discharge from hospital.

Nutrition and hydration

- Staff screened patients on admission using the Malnutrition Universal Screening Tool (MUST). If the assessment triggered a risk or concern staff completed a referral to the dietician.
- The MUST assessment was complete in four of the five records we reviewed. Both of the fluid balance charts we reviewed were complete.

- Dieticians routinely reviewed all patients with a diagnosis of cancer.
- The trust had introduced HANAT (hydration and nutrition assurance toolkit) to encourage good nutrition and hydration best practice in the hospital environment. Staff on ward F1 demonstrated a good understanding of the tool.
- Staff told us they contacted a catering manager and the dietician to accommodate patients' allergies, religious beliefs and preferences with meals.
- Wards used protected meal times. We saw staff supported patients with menu choices and assisted with feeding if required. Patients told us staff offered food and water regularly. We observed patients had water and drinks within reach.
- All the wards in the service scored 74% or above in the question "patients always receiving the help they need to eat or drink" on the frequent feedback inpatient survey from April 2014 to March 2015.

Patient outcomes

- The hospital had higher than the standardised relative readmission rates (2014) England average for elective surgical patients for urology, ophthalmology and neurosurgery. During our inspection we spoke with the urology ward manager who told us that when elective patients attended the urology admissions unit following discharge, for example, for a wound check and this was recorded as a readmission.
- The Head and Neck Cancer National Audit (2013) showed better than England average results for eight of the twelve standards. These included multi-disciplinary team discussion, pre-treatment investigations were undertaken and less than 21 days from biopsy to reporting. The trust had worse than the England average results for being seen by a clinical nurse specialist (CNS) prior to first treatment, a CNS present when breaking bad news and pre-treatment dietetic assessment. The trust developed an action plan, improvements had been made to the dietetic service prior to the results of the audit and it was thought that patients were seen by a CNS. However, the data wasn't captured in the current database so this was to be reviewed to ensure the activity was recorded.
- The National Prostate Cancer Audit (2014) showed the trust provided nine of the twelve required criteria. The three criteria the trust did not provide were a joint specialist multidisciplinary clinic, high dose brachytherapy and psychological counselling. The action plan in the audit report explained clinics ran in parallel for discussions around treatment, a local NHS trust provided brachytherapy as a tertiary centre and CNS's provided emotional support. It was acknowledged this was not formal psychological counselling and the CNS's had a pressured workload so the service was exploring working patterns and other methods of delivering this service.
- The trust underwent an Anaesthesia Clinical Services Accreditation review in 2015. This review assessed performance against 95 standards. The review concluded satisfactory evidence was supplied to meet 89 of the standards. We saw evidence that the trust was working towards the recommendations of the review to meet the remaining six standards. The unmet standards included administration support, trust support for audit and research, evidence of training in the use of equipment and a dedicated daytime emergency theatre. The trust was subsequently awarded accreditation.
- The National Joint Registry (NJR) summary data for 2015 showed the consent rate for patients to have their details entered into the NJR was 90%, which was below the national average of 93%.
- The trust's overall performance record for Patient Reported Outcomes Measures (PROMs) for hip and knee replacements and varicose vein surgery was in line with the national average. A PROM for groin hernia procedures (EQ-5D Index) had seen smaller improvements and showed worse results than the national average.
- Staff on ward F1 had completed audits on pain relief and dressings. The dressings audit led to a change in the dressing used post-operatively and the pain audit showed there was a lack of consistency in post-operative pain relief on the ward. Staff recognised this needed to be addressed and told us they planned to do this with the multidisciplinary team.
- Overall, the trust carried out 52% of procedures as day case surgery. RHH had a day case rate of 59%.

Competent staff

Surgery

- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. Information submitted by the trust showed between 81% and 100% of staff had completed their appraisal. The trust target was 95%.
- Staff that led appraisals completed "PROUD training." One member of staff told us using the trust values changed the way they led appraisals.
- We reviewed theatre staff's equipment log. This was a record of their medical device training. These were completed and up to date.
- New members of nursing staff had up to a four week supernumerary period with an allocated mentor. They received mandatory training and ward specific training, for example training on tracheostomies on wards I1 and I2.
- Clinical educators worked in clinical directorates and facilitated teaching sessions and training. Wards displayed training opportunities for staff and a training matrix of link nurses, training and revalidation dates
- Staff told us the trust supported their training and development, for example, a housekeeper trained to become a clinical support worker, nurses on ward F2 spent time in clinic to learn about dressings and nurses on ward N2 had the opportunity to complete a nationally recognised qualification in neurosurgery.
- Junior doctors had protected teaching weekly. A senior doctor covered their workload on the ward and it was mandatory for the junior doctors to hand their bleeps in to stop them from being disturbed. During our inspection we observed informal teaching directed at individual doctor's needs.
- Band five staff in theatre completed competencies and a surgical first assistant training programme.
- Wards and theatres provided placements for student nurses; theatres also provided placements for trainee operating department practitioners (ODPs).
- Senior staff were confident to manage performance issues in line with the trust policy and with support from human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this during our inspection.
- There was effective daily communication between the ward and theatres this ensured patients were being transferred to and from theatre efficiently. We observed staff informing patients of their plan of care
- The five records we reviewed had evidence of a multidisciplinary treatment plan.
- Clinical areas carried out daily multidisciplinary ward rounds or handovers, staff discussed discharge plans as part of these.

Seven-day services

- Elective surgery was performed Monday to Friday.
- Most emergency surgery was done at NGH, but staff at RHH had access to an emergency theatre 24 hours a day, seven days a week in line with National Confidential Enquiry into Patient Outcome and Death guidance.
- Consultants were available on-call out of hours on a rota and attended to see patients at weekends in most specialities.
- Physiotherapy, imaging services and pharmacy provision was available on an out of hour's on-call basis seven days a week.

Access to information

- Staff were able to access blood results and x-rays using electronic results services.
- Staff told us the radiology service was responsive and reported images promptly.
- Staff completed an electronic discharge letter that included medications. The GP and patient received a copy and staff put a copy in the patient record.
- Wards displayed clear guidance for staff on VTE prophylaxis, endocrine emergency, writing discharge medications and controlled drugs and referral to the pain team both in and out of hours.
- Nurses referred patients to the community nursing team through a single point of access. Urology staff had produced information for district nurses on specialist procedures, for example flushing nephrostomy tubes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated an understanding of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLs).
- We observed staff obtained verbal consent from patients before carrying out an intervention.

- All the patients we spoke to told us staff explained their care and treatment to them and sought consent prior to delivering the care.
- Consent forms were complete in four of the five records we reviewed.
- The trust audited the completion of consent forms. The audits submitted by the trust were completed in specialities at NGH not RHH.
- Staff told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity. All staff knew how to access MCA and DoLs guidance. Some wards displayed an example of a completed DoLs application.
- We reviewed medical clerking proformas. They included cognitive assessment.

Are surgery services caring?

Good

The care provided to patients was good because patients were treated with dignity and respect and involved in their care. We found;

- Feedback from patients and relatives was positive.
- Staff communicated in a kind and compassionate way with patients.
- Staff treated patients with dignity and respect and maintained their privacy
- Patients and relatives told us staff kept them informed of their treatment and progress and involved them in decision making.

Compassionate care

- The NHS Friends and Family Test (FFT) showed a response rate in line with the England average. Between 93% and 100% of patients would recommend the service to their family or friends.
- Prior to the inspection the trust provided results of the frequent feedback inpatient survey from April 2014 to March 2015. The survey was split into three sections; hospital environment, doctors and nurses and care and treatment. Scores on the surgical wards ranged from 55% to 100%; the lowest score on every ward was the question "patients rating ward as excellent". Patients scored the majority of the rest of the questions as good or above.
- Some wards displayed patient feedback. On wards H1 and H2, 93% to 96% of patients felt staff treated them with respect and dignity. One hundred percent of patients felt they received excellent, very good or good care.
- Staff treated patients with dignity and respect and maintained their privacy. During all interventions, staff drew curtains around patients and patients were kept covered with sheets and blankets.
- All staff communicated in a kind and compassionate way with patients.
- We observed patients' call bells were placed within reach and staff responded in a timely and respectful manner to patients' requests.
- A patient on ward N2 was very happy with the caring attitude of staff, particularly that a member of staff from the ward went to introduce themselves to the patient in clinic prior to their admission to hospital.

Understanding and involvement of patients and those close to them

- Most wards displayed visiting times and information on how to make an appointment with a doctor.
- All the patients and relatives we spoke to told us staff kept them informed of their treatment and progress and that they were involved in the decisions made by all members of the multidisciplinary team.
- Information displayed on wards H1 and H2 showed 79% to 81% of patients felt they had been involved in decisions.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- We observed staff involving patients in their care.
- Two patients we spoke to specifically told us of the positive experience they had pre-operatively. Staff in pre-operative assessment took time to explain procedures, including the emotional aspect of the surgery.
- Ward F2 had side rooms where camp beds were available for relatives to stay with patients.

Emotional support

- We observed staff interacting with patients in a supportive and reassuring manner, encouraging them to regain their independence in line with their post-operative progress.

- Clinical Nurse Specialists provided support services that patients accessed pre-operatively, during admission and after discharge. One patient and relative that we spoke to spoke about excellent care they received from the stoma care team.

Are surgery services responsive?

Good

We found the responsiveness of this service to be good. People's needs were met through the way services were organised and delivered. We found;

- The needs of different people were taken into account when planning and delivering services.
- The facilities and premises were appropriate for the services being delivered.
- Cancelled operations and the length of stay were lower than, or in line with, the national average.
- Complaints and concerns were dealt with in an open, transparent and timely manner.

Service planning and delivery to meet the needs of local people

- The trust engaged with internal and external stakeholders, patients, governors, members, partners and staff to plan services.
- Local clinical commissioning groups and the NHS England commissioned services within the trust. Some specialist services were provided regionally and nationally.
- The musculoskeletal care group had developed a new contractual framework in partnership with Sheffield clinical commissioning group. This had resulted in the development of a single clinical triage point that directed patients for care in the right place at the right time.
- There was a shortfall in capacity for ophthalmic surgery. A purpose built cataract centre was being built at the Northern General Hospital (NGH) as a long term plan to address the capacity issue.
- The trust provided a bus service for patients and relatives to access across hospital sites.

Access and flow

- The target referral to treatment time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment time. Since July 2013 the trust's RTT performance had generally been below the trust's 90% standard. Data reviewed for May 2015 showed general surgery, trauma and orthopaedics, urology, ophthalmology and neurosurgery did not meet the standard. ENT, oral surgery and plastic surgery met the standard. However, overall the trust performed better than the England average during this period.
- Senior staff told us the complexity of patients referred for regional and national treatment contributed to their not meeting RTT standards. For example, local trusts sometimes referred patients with multiple medical problems that needed treatment before they would be fit enough for a major operation.
- Staff told us that a small number of patients with learning disabilities referred form the community dentists waited longer than 18 weeks for surgery.
- Twenty theatres were available at RHH and mostly provided elective surgery. Data submitted by the trust showed the average theatre utilisation rate was 74% between June and August 2015.
- The patient flow matron in theatre was responsible for scheduling. A duty floor anaesthetist worked across the theatres every day to recognise and trouble shoot problems such as capacity, overruns and pain relief issues.
- The total number of cancelled operations treated within 28 days had decreased since July 2014. The percentage of patients whose operation was cancelled and then were not treated within 28 days had consistently been lower than the national average. Cancelled operations as a percentage of elective admissions had been lower than, or in line with, the national average since March 2013.
- The main reasons for cancelled operations were due to a lack of ward and critical care beds, a lack of theatre time or a more urgent case took precedence. A member of the pre-operative assessment team routinely contacted patients four days prior to their operation date to confirm they were well enough for surgery and planned to attend. Cancellations had been reduced to less than four percent following the introduction of this service.
- One of the reasons patients had not been treated within 28 days of a cancelled operation was that a type of surgery, for example, ENT surgery with a robot only took place once a month.

- Senior staff monitored cancelled operations and completed a root cause analysis for patients that were not treated within 28 days. Clinical directorates held a weekly patient tracking list meeting.
- The overall average length of stay for elective and non-elective patients was less than the national average.
- No patients had stayed overnight in recovery in the last 12 months.
- There had been no mixed sex accommodation breaches in the last 12 months.
- Medical outliers were on most of the wards we visited. Nurses told us doctor's reviewed the patients daily and kept the ward informed of the discharge plan.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. Wards worked with the discharge coordinator and transfer of care team to reduce delays for patients with complex needs

Meeting people's individual needs

- The trust produced standardised up to date, cross site information for patients on specific conditions or aspects of being in hospital, for example, preparing for your operation and laparoscopic anti-reflux (GORD) surgery including dietary advice following surgery.
- Pre-operative assessment staff gave information leaflets to patients to ensure they fully understood their treatment and gave valid consent. The information for patients was broken down into four phases. Staff gave it to patients at the relevant point of their journey.
- Leaflets were available in alternative languages and formats on request.
- Interpreting services were available for patients whose first language was not English. Staff explained the process of booking an interpreter to us.
- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses who provided advice and support with caring for patients with learning disabilities and dementia had been identified in all areas including theatre.
- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- Staff on ward F2 had access to training on gender reassignment.
- Patients attended joint school on ward F1 prior to their operation where staff provided education about joint replacements, care on the ward and self-management following discharge.
- Patients had access to ward F2 by telephone for advice following discharge or they could visit the ward and be seen by a doctor, clinical nurse specialist or ward nurses.

Learning from complaints and concerns

- The trust had an up to date concerns and complaints policy in place.
- Seven of the eight clinical directorates met the target of answering 85% of complaints in 25 days.
- All areas displayed information on how to make a complaint and leaflets were available to patients and relatives.
- Staff were able to describe complaint procedures, the role of the Patient Partnership Department and the mechanisms for making a formal complaint.
- Ward managers told us they would listen to informal complaints to try and resolve them. The service kept a log of informal complaints.
- A ward manager gave an example of a response to negative FFT feedback. Patients and relatives had commented that consultants were not always available to speak to. Staff put posters up on the ward with consultants' contact details on.

Are surgery services well-led?

Good

The leadership of the service was good. We found;

- Directorates had clear strategies driven by quality and safety aligned to the trust's vision and values.
- Governance structures and processes within the directorates functioned effectively.
- There was a high level of staff engagement and satisfaction.
- Staff were engaged in quality and service improvement. There was a strong focus on continuous learning and innovation.

However;

- Where issues had been identified they had been investigated. This included undertaking external reviews. Actions were not always implemented in a timely manner.

Vision and strategy for this service

- The trust had a vision and a set of values and staff we spoke to knew what these were.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.
- The clinical leads and directorate management teams were able to explain individual strategies to us. There was no overarching surgical strategy encompassing all specialities so it was difficult to identify the trust's top priorities within surgery.
- The nurse leads and clinical directorate leads met separately and informed the executive team of any key issues.

Governance, risk management and quality measurement

- Clinical directorates held monthly multidisciplinary governance meetings. We reviewed twelve sets of meeting minutes and noticed mixed levels of attendance. There was evidence of key themes around incidents and lessons learnt, complaints and a review of risks in clinical directorates, however, there was limited evidence of lessons learnt being shared across clinical directorates and care groups or mechanisms to enable this to happen.
- Where issues had been identified they had been investigated. This included undertaking external reviews. Some reviews had taken longer than expected and this meant findings and actions were not always implemented in a timely manner.
- Directorate governance leads told us medical engagement in governance had improved. Senior nurses and governance leads met across directorate with care groups, however, there was not a similar forum for medical governance leads to meet.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Staff identified controls to mitigate the level of risk and progress notes were recorded. Directorate risk registers identified areas such as staffing in urology, the demand on the urology assessment unit, and patients with challenging behaviour in neurosurgery.
- Most of the management team and senior staff were aware of the issues on the risk register and agreed they were representative of the risks they identified in their clinical directorate.

Leadership of service

- Staff told us they felt senior staff and managers were visible, approachable and supportive and that they received appropriate support to allow them to complete their jobs effectively.
- All staff explained that they would be happy to approach senior staff to raise concerns and that the issues would be dealt with in a timely manner.
- We met with clinical directorate managers who felt supported and engaged with the executive team.
- The matrons met monthly with senior ward staff.
- Senior staff told us they could access support and leadership courses to help them in delivering services.
- Staff on wards knew the Chief Executive and members of the executive team. They had attended team meetings in some areas.
- Ward managers had dedicated management time when they were not expected to be providing clinical care. This allowed them to focus on management and administrative issues.
- The management team were aware of the impact on morale of staff moves to different wards

Culture within the service

- All members of staff we spoke to were proud to work in the trust and they spoke positively about team work and the care they provided to patients.
- Staff conveyed a strong open and honest culture in all areas that we visited during our inspection.
- The operating services, critical care and anaesthesia care group developed a behaviours framework to support staff deliver a high quality service to patients. We saw staff in theatre displaying these behavioural standards during our inspection.
- Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers.

- Staff felt supported to develop their skills and progress their careers. Many staff we spoke to had worked at the trust for a number of years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.
- Nursing staff morale was low due to frequent relocations to cover vacancies on other wards. Staff had left the trust because of the frequency of ward moves.

Public engagement

- During our visit we saw wards displayed FFT results and cards sent by patients and relatives in 2015. Theatre admissions unit displayed evidence of good practice and suggestion sheets from patients.
- We saw evidence of public engagement at ward level. Ward F1 displayed a board showing "What I had wished I'd known before my op" and "Things I think could be improved". There were five comments on the board at the time of our inspection; two mentioned improving the speed of discharge medications.
- The trust sought feedback from patients using the frequent feedback inpatient survey.
- Patient governors were involved in staff recruitment interviews.

Staff engagement

- As part of listening into action the trust completed a pulse check asking staff 15 questions, for example, managers and leaders seek my views about how we can improve our services and communications between senior managers and staff is effective. The 2015 results were better than the trust's 2014 results and better than the average of healthcare organisations.
- All staff we spoke to felt that communication within the trust was good.
- We saw evidence that areas were involved in the trust's listening in action scheme. Ward F1 displayed a "no skeleton's in our closet", a directorate senior management listening event for staff. Leaders in theatre introduced a weekly half hour huddle after staff said teams did not meet regularly.
- Staff meetings took place on most of the wards we visited. We reviewed minutes of these meetings.
- Staff and ward managers told us there was an open door policy for staff to discuss issues.
- Staff were engaged in quality and service improvement. We observed a fitness for anaesthesia microsystems academy meeting where staff were valued and new ideas were tested. Staff told us of a "perfect day" held in theatre, where staff suggested service improvement ideas. The trust ran initiatives such as "give it a go week" and "a right good week" where staff suggested and tried out ideas to improve services and patient experience.

Innovation, improvement and sustainability

- Staff told us the Microsystems Coaching Academy worked well to support small scale service improvements.
- The trust was committed to the development of advanced nurse practitioners to ensure patient care was maintained and the potential recruitment difficulties to junior doctor posts mitigated. This also allowed good advancement opportunities for nurses.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The operating services, critical care and anaesthesia care group developed "The Magnificent 7" a document outlining seven areas for achievement in the department. The seven areas included zero harm, making every operating minute count and transformation through technology. Each area had a lead, an executive sponsor, an action plan and a review date.
- One of the urology consultants held the most senior position at the European Association of Urology, the international authority on urological research.
- A robot used in urology surgery had given superior outcomes compared to traditional surgical techniques.
- The robot was used by surgeons across the specialities of urology, ENT and gynaecology.
- The neurosciences directorate introduced an electronic referral tool "Refer a patient." This shared referral information between the referrer and neurosurgeon who could give an immediate decision and feedback to the referrer.
- The podiatry service had been awarded Customer Service Excellent Award for the 15 consecutive years.

Critical care

Safe	Good
Effective	Outstanding
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	Outstanding

Information about the service

Sheffield Teaching Hospitals NHS Foundation trust provided critical care services at the Royal Hallamshire Hospital (RHH). There were two purpose built units adjacent to each other; the General Critical Care unit (GCC) which had eight beds and the Neuro Critical Care (NCC) that had 20 beds.

The GCC and NCC provided critical care at level two and three as defined by the Intensive Care Society. Level two patients are those requiring more detailed observation and intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multi-organ failure.

In the reporting period December 2014 to November 2015, there were 703 admissions to GCC and 1064 admissions to NCC.

A critical care outreach team provided a supportive role to the wards medical and nursing staff when caring for deteriorating patients and support those patients discharged from GCC. The team was managed from the GCC and was available Monday to Friday 8.00am to 4.00pm. In the reporting period December 2014 to November 2015, the critical care outreach team responded to around 195 ward referrals and followed up 147 patients who were discharged from GCC.

The critical care services at RHH are part of the North Trent Critical care Network.

We visited the GCC and NCC. We spoke with four patients, two relatives and 34 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, administrative and housekeeping staff. As part of our inspection, we used the Short Observational framework for Inspection (SOFI). This was used to observe care and help us understand the experience of people who could not speak with us. We observed interactions between patients, their relatives and staff. We also considered the environment.

We accessed the clinical patient information system to review eight medical, nursing and allied health professional care records and eight medication prescription charts.

Before our inspection, we reviewed performance information from and about the hospital.

Critical care

Summary of findings

We rated the safety of this service as good. Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Performance showed a good track record and steady improvements in safety. Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Systems, processes and standard operating procedures in infection control, medicines management, patient records and assessing and responding to risk were reliable and appropriate to keep patients safe. There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. Staff were aware of the signs of abuse and had access to appropriate resources. However, the system for maintaining medical equipment was not always reliable.

We rated the effectiveness of this service as outstanding. There was a truly holistic approach to assessing, planning and delivering care and treatment to patients. Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver care to patients. The systems to manage and share the information (needed to deliver effective care) was fully integrated and provided real-time information across teams and services. An electronic care management system provided real time information across teams and services. For example, there was prompting of basic tasks before moving onto another task this ensured care elements were not missed. Other examples included being able to review microbiology results and trend in a real live system and joined up working with other members of the multi-disciplinary team for a real time view of the care and progress of the patient. Treatment plans could be adapted quicker as a full at a glance status was seen.

Staff were qualified and had the skills they needed to carry out their roles effectively. Staff had access to the information they needed to assess, plan and deliver care to patients in a timely way. Care and consent to treatment was obtained in line with legislation and guidance. Where patients lacked mental capacity to make a decision, 'best interest' decisions were made in accordance with legislation. Deprivation of Liberty Safeguards were used appropriately.

The care provided to patients in critical care was good. Patients were treated with kindness, dignity and respect. Patients and relatives were positive about how they were cared for and supported. Staff spent time with patients and relatives to ensure they understood the care and treatment and were involved in making decisions about their care and treatment. Staff responded compassionately when patients needed help and support to meet their basic personal needs. Staff helped patients and those close to them cope emotionally with their care and treatment.

We rated the responsiveness of critical care services as good. People's needs were met through the way services were organised and delivered. The needs of different people were taken into account when planning and delivering services. Access to care was managed to take account of peoples need, including those with urgent needs. There was openness and transparency on how complaints and concerns were dealt with. Facilities and premises were appropriate for the services being delivered.

We rated the service as outstanding for well led. Governance and performance management arrangement were proactively reviewed and reflected best practice. There was collaboration and support across all areas with a common focus on improving quality of care and patient experience. Leadership strategies were in place to ensure good care delivery within a supportive and open environment. There were high levels of staff satisfaction. Staff were proud of their units and spoke highly of the culture. The services proactively engaged and involved staff and ensured that the voices of all staff were heard and acted on. Staff innovation was supported.

Critical care

Are critical care services safe?

Good

The safety of this service was good. We found;

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Performance showed a good track record and steady improvements in safety. for example there were a low number of infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.difficile)
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and the monitoring and assessing and responding to risk were reliable and appropriate to keep patients safe.
- There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. Staff were aware of the signs of abuse and had access to appropriate resources.

However we found;

- The system for maintaining medical equipment was not always reliable.

Incidents

- Staff were aware of, and appeared knowledgeable and confident about reporting incidents. All staff had access to the online reporting system; staff gave us examples of when they might report incidents such as a pressure ulcer. Staff said there was a non-blame culture in the service and they felt empowered to report incidents without fear of reprisal. Links to the electronic reporting system were also embedded into certain care pathways, for example a link to report a pressure ulcer from the skin bundle tab, this meant there would be timely reporting of incidents.
- Staff told us they received individual feedback for incidents they reported.
- Incidents giving cause for concern or following a specific trend were discussed in the ward meetings, handover or through the ward newsletter. We saw evidence of this in the ward meeting minutes and during the main ward handovers, we attended.
- There were 227 incidents reported between December 2014 and August 2015. Drug related incidents made up the largest group of incidents; these were for a variety of reasons, for example, a drug not being available. Other incidents included pressure ulcers and general care. We reviewed the records for the incidents. These were reviewed and appropriately investigated by staff.
- Following a serious incident at a nearby district general hospital, the critical care pharmacists had developed a safer alternative to replacing potassium in infusions, which had reduced the risk of inadvertent overdose.
- The new regulation, Duty of Candour states providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. Most staff we spoke with were aware of duty of candour.
- There were regular mortality and morbidity meetings to share learning from the deaths of patients in critical care. The meetings were open for all staff groups to attend however, nursing staff on general intensive care (GCC) told us it was often difficult to attend these meetings as they were held on the Northern General Hospital site. The ward sister attended these meetings and shared the information with the team via the communication folder

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism.
- There were three pressure ulcers, three falls and three CUTIs recorded between July 2014 and July 2015.
- The safety thermometer information was displayed in most clinical areas for staff, patients and visitors to see. Only data for November 2015 was visible therefore trends could not be seen.

Cleanliness, infection control and hygiene

Critical care

- Data from October 2014 to March 2015 submitted and verified by the Intensive Care National Audit and Research Centre (ICNARC) showed both GCC and NCC performed in line with similar units for unit acquired Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.difficile) infection rates. MRSA and C.difficile infections have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. C.difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics
- In the reporting period April 2014 to April 2015, there were a low number of infections reported on the GCC (two) and NCC (nine).
- Critical care had received accreditation from the hospital through the trust infection control accreditation programme. This programme sets standards for infection prevention and control practice. The aim was to optimise and assess infection prevention and control practices in clinical teams throughout the hospital in order to reduce infection rates.
- We spoke with domestic staff who were proud to be part of the critical care team. All areas of the units were well presented, visibly clean and tidy, not just the clinical areas but also the corridor, bathrooms, offices and storage rooms.Cleansing gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively.
- Staff were 'bare below the elbow' to allow effective hand washing.
- Protective equipment, such as gloves and aprons, were available and we observed staff using this appropriately. We also observed staff washing their hands between patients.
- During the reporting period December 2014 to September 2015, hand hygiene compliance by staff was 100 %.
- We saw movement in and out of side rooms of patients who were suffering from infections. Movement in and out of the side room was restricted and the side room doors remained closed. This minimised the infection risk.
- GCC had three side rooms with differential pressure ventilation. Differential room pressure is an isolation technique used to prevent cross-contamination from room to room. It includes a ventilation system generating negative or positive pressure to allow air to flow into the isolation room but not escape from the room, this prevents contaminated air escaping from the room and helps to minimise the risk of spreading infections.
- We observed staff following local policy and procedures when scrubbing, gowning and gloving prior to procedures, for example, insertion of a central venous catheter (CVC). This minimised the infection risk. A CVC is a device inserted into a large vein usually in the neck for the administration of medication.
- There was an effective system for the cleaning and decontamination of equipment for example 'I am clean' stickers. These were clearly visible, dated and signed appropriately. Audits demonstrated 100% compliance for every audit between December 2014 and September 2015.
- We observed patient-care equipment to be clean and ready for use.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste.

Environment and equipment

- The GCC and NCC were located side by side and shared some facilities for example a pharmacy room. The areas were spacious with sufficient room for the equipment required in each bed space. The areas utilised natural light to assist patients' sensory awareness.
- Each bed space was suitably equipped and able to manage the care and treatment of a level three patient. There was sufficient equipment for all patient bays to be utilised.
- Resuscitation and emergency/difficult intubation equipment was available in both patient areas and staff were aware of its location in the event of an emergency.
- The resuscitation equipment, emergency / difficult intubation equipment and emergency transfer bags on the ward had been checked daily by staff and were safe and ready for use in an emergency. Single-use items were sealed and in date, and emergency equipment had been serviced. Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway.
- The units employed critical care technicians (CCT'S). Some of the many roles of the CCTs were to make sure

equipment used in the care of critically ill patients was safe and effective. CCT'S were responsible for training staff to use machines correctly; they were also responsible for equipment management for example reporting maintenance and repairs.

- Data provided by the hospital showed on 1 October 2015 92% of devices had been serviced within one month of their due date against a target of 90%. Staff told us equipment in the unit was treated as a priority for repairs and maintenance, however we found one infusion pump on GCC that was four months late with electrical testing. The pump was not in use at the time; however, a discontinued infusion was still in the pump. It was removed immediately following escalation to the ward sister. A further four pieces of equipment we looked at on the NCC were between two and six months past their medical engineering service date; we escalated this to the nurse in charge. None of the equipment was in use at the time. When we returned two days later, all of the out dated equipment had been removed. We noted the risk of out date equipment was on the local risk register.
- Fire-fighting equipment had been maintained and tested.
- Equipment was available for overweight patients, for example larger commodes, hoists and chairs.
- The trust was reaching the end of a tendering process for the replacement of the ventilators used by all critical care departments, and a decision was expected to be made by the end of December 2015 as to which product would replace the current ventilators.

Medicines

- There was a centrally located pharmacy on the ward and pharmacy technicians worked as part of the team to ensure there was sufficient stocks and supply of medications.
- We looked at the electronic prescription and medicine administration records for eight patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them. This meant people were receiving their medicines as prescribed. Records of patients' allergies were recorded on the prescription chart.
- Nurses were responsible for administering medication, including patients' own medicines brought in from home. We observed nurses following the hospital policy when administering medicines to ensure the safety of patients. This included checking the patient's identity.
- An advanced clinical pharmacy service had been developed to improve the safety and efficacy of medicines used in GCC and NCC. A consultant pharmacist led the clinical pharmacy service. The critical care pharmacy service provided specialist pharmacy cover for the critical care areas, ensuring medications were prescribed and used in a cost, clinically effective and safe manner. The clinical pharmacy service had a number of prescribers, enabling them to immediately prescribe or correct prescription errors. This supported timely administration of the correct medications and allowed medical staff to undertake other roles.
- Allocated to critical care was a senior clinical pharmacist and a pharmacist consultant, both with expertise in critical care. The pharmacist attended the daily multidisciplinary ward round and handovers.
- There were pharmacist prescribers working on the units. Pharmacist prescribers assist in allowing clinical staff to deliver more direct clinical care and contribute to improvements in safe prescribing for patients.
- The medicines storage room and fridges were required to have their temperatures monitored and recorded daily on an electronic database. On three occasions in November 2015, the temperature had not been recorded. Recording of fridge temperature is important to ensure the integrity of medicines is maintained.
- Medicines stored in the fridge where necessary were labelled with the date they had been opened.
- There was electronic prescribing on the units. A new hand written drug prescription chart was provided when patients were discharged or stepped down to the wards.
- There was standardised medication across the whole of the critical care departments. This ensured consistency of best practice throughout the trust and patients received the best possible care.
- Antibiotics had start, stop and review dates on the patient's medicines administration record. There were local microbiology protocols in use for the administration of antibiotics. A consultant microbiologist was part of the daily ward round to promote and ensure good antibiotic use.

- Intravenous fluids were stored in an unlocked cupboard. This did not meet current guidance; intravenous fluids should be stored in a locked room with restricted access. A risk assessment was in place.
- We checked the stock levels of controlled drugs in the main pharmacy with the controlled drugs register and they tallied correctly. Controlled drugs are prescription medicines which are controlled under the misuse of drugs legislation e.g. morphine and pethidine.
- There was inconsistency in the daily checking of the satellite controlled drug cupboard on the NCC. Although the amount of stock tallied with the drug book, the cupboard had not been checked for 20 out of the 30 days in November 2015; this was not in line with the hospital's policy. We escalated this to the senior team at the time of our inspection. We noted the use of multiple controlled drug cupboards was on the department risk register.

Records

- We looked at eight patient records across the GCC and NCC. Records were electronic and accessed via a bedside computer. This allowed for easy access for all staff caring for the patient.
- We saw computers were locked when not in use to avoid any unauthorised access to the records.
- An electronic clinical information system automatically recorded physiological observations. Though observations were recorded automatically, they had to be validated by the nurse at the bedside, this included ventilator settings.
- All of the electronic patient records we looked at included a range of clinical entries, assessments and plans for example, nutritional risk, falls assessments, physiotherapy treatment plans and skin bundles.
- Patient records were multidisciplinary and we saw where nurses, doctors and allied health professionals had made entries.
- All entries were legible, up to date and accurately reflected the outcome of assessments for example where a skin assessment had shown a risk to the patient of developing a pressure ulcer, additional plans of care were in place.
- All of the eight records we reviewed had the time and decision to admit to Intensive Care recorded, this was in line with best practice.
- Audit data for the Intensive Care National Audit and Research Centre (ICNARC) was recorded using the electronic system.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- A direct link was available from the electronic clinical information management system so staff had easy access to make safeguarding referrals should they be required. Nursing staff told us about a recent safeguarding referral they made when a full time carer was admitted to the unit leaving a vulnerable adult at home.
- On NCC, the neurosurgical flow manager led and supported staff on safeguarding, including deprivation of liberty (DOLS).
- Staff received safeguarding of vulnerable adults training (level two) and safeguarding of children, and young people (level one) as part of their mandatory training. Completion rates for nursing staff were between 94%-100%; this was above the trust target of 90%. Completion rate for medical staff was between 68%-80%; this did not meet the trust target of 90%. We discussed this with the senior management team and this was due to a recent change in the way the training was recorded for new doctors in the trust. There was a plan in place to address this issue.

Mandatory training

- Mandatory training for all groups of staff was comprehensive; modules included moving and handling, infection control, fire safety and resuscitation.
- Mandatory training data for nursing staff showed a varied completion rate of between 81% and 90% against the trust target of 90%. Completion rate for medical staff was lower between 70%- 83% and did not meet the trust target of 90%, however this was this was due to a recent change in the way the training was recorded for new doctors in the trust. There was a plan in place to address this issue.

Assessing and responding to patient risk

- We saw nurses carrying out a safety check of the bed area at the start of each shift. Checks included the oxygen and suction supplies. The safety check was recorded on the clinical patient information system.

Critical care

- The Sheffield Hospitals Early Warning Score (SHEWS) was used throughout the trust to monitor patients and identify when their condition may be deteriorating. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- All clinical employees were encouraged to complete the early warning score e-learning package; this was role specific and therefore mandated for relevant staff and completed every 3 years.
- There were standard operating procedures covering in and out of hours escalation of the deteriorating patient, these were available on the wards.
- A critical care outreach team consisted of four whole time equivalent nurses and was available Monday to Friday between 8.00am to 4.00pm. Out of hours, cover consisted of a hospital at night team. There was a designated anaesthetic registrar to support the Neuro and General critical care areas as well as all urgent referrals and acutely deteriorating patients across the hospital. There was access to a consultant 24/7.
- The outreach team provided a supportive and educational role for medical and nursing staff when dealing with a deteriorating patient and with implementation of the Sheffield Hospitals Early Warning Score (SHEWS).
- The outreach team also provided support and training to staff in developing the skill and confidence in managing complex patients.
- In conjunction with the local university, a course the Sheffield Management of Acutely Ill patient, Recognition and Treatment (SMART), had been designed which all new doctors were expected to attend when they started at the trust.
- The critical care outreach team followed up all level three patients and level two patients who had been in GCC for three days or more; outreach for NCC patients was provided by an neuroanaesthetic Specialist Registrar 24/7. NCC.
- Risk assessments were carried out including pressure ulcer risk and the risks associated with moving and handling. Individual patient risk assessments were reviewed daily so they were kept up to date.
- Patient observations were taken and recorded at the required frequency including ventilator observations. Appropriate action was taken in response to changes in observations.
- A neuro simulation team-training programme for anaesthetists was being piloted on NCC. This was training for the whole MDT and aimed to prepare staff for the challenges of managing acutely unwell patients.
- We saw a multi-disciplinary handover document in use, which promoted safe practice, and consistent use of local guidelines.

Nursing staffing

- The Intensive Care Society and British Association of Critical Care Nurses (BACCN) standards were used for assessing patient acuity and determining the number of staff required on each shift. The staffing allowed for one to one nursing of level three patients and one nurse for every two level two patients. This met the 'Core Standards for Intensive Care Units' published by the Intensive Care Society (ICS). The staffing was adjusted according to demand as the numbers of level two and three patients could change.
- Nursing staffing levels were monitored against the planned levels. We found adequate staffing to meet peoples care needs and which were in line with national guidance.
- Shortfalls in staffing levels were met by using in-house bank staff or external agency staff. In-house staff were always contacted first for any cover required and agency staff were used as a last resort.
- The use of agency nurses was low, ranging between 0.8% and 3.6% over the period April 2014 to March 2015.
- The Core Standards for Intensive Care Units state there should be a supernumerary clinical co-ordinator per shift to provide clinical nursing leadership, supervision and support when there are more than six patients. GCC did not always have a supernumerary clinical co-ordinator on shift due to three nurse vacancies. We did note a supernumerary clinical co-ordinator would not be required at the weekends as the number of beds was reduced to six.
- The units had in its nurse-staffing establishment a number of specialist nurses at band 6 and above including a rehabilitation nurse lead, an audit and quality nurse lead and full time practice educators. NCC also had a dedicated neurosurgical flow manager.

- Clinical educators worked clinically if required to support the service.
- NCC had Advanced Nurse Practitioners (ANP) supporting the delivery of care to patients. GCC had recently introduced a training programme for advanced nurse practitioners (ANP) and we spoke with some nurses who were being supported through this training.
- There was a standardised approach to handover; this was communicated as a large team and a specific handover at the patient's bedside. Handovers were recorded on the electronic records system.

Medical staffing

- NCC General Critical Care and Neuro Critical Care had designated clinical leads who worked with their respective Clinical Directors in Operating Services, Critical Care and Anaesthesia (OSCCA) and Head and Neck care groups.
- The units operated a closed unit model with critical care doctors responsible for planning the care of patients.
- On GCC, there were 15 whole time equivalent consultants. All consultants were Faculty of Intensive Care Medicine accredited (FICM). This met the Core Standards for Intensive Care Units.
- On GCC the consultant to patient ratio during the daytime did not exceed the range of 1:8 to 1:15 and so met with the Intensive Care Society standard..
- The Intensive Care Society standards recommend that consultant work patterns should deliver continuity of care and suggest a five-day block. GCC / GHDU consultants covered a one or two-day block on the unit therefore we could not be assured that patients always received full continuity of care.
- The GCC had 24 hour seven days a week cover by an anaesthetic registrar.
- GCC consultants were able to attend the unit within 30 minutes if required. We were not assured this would be the case as the consultant covered two sites. However, there was also a consultant on call for NCC and there were no reported incidents of a consultant not being available. One consultant told us there was an informal agreement with each other for additional support from another consultant if required.
- On NCC, there were 11 whole time equivalent neuro intensivist / neuro anaesthetic consultants. All consultants were Faculty of Intensive Care Medicine accredited (FICM).
- On NCC, the consultant to patient ratio did not meet with the ICS standard of 1:8 to 1:15.
- Out of hours consultant cover was shared with neuro theatres. This falls short of the Core Standards for Intensive Care Units as consultants, participating in the on call rota must not be responsible for delivering other services such anaesthesia whilst covering the critical care unit.
- Medical notes and staff confirmed twice-daily bedside ward rounds did not take place. However, there was a consultant led daily review, a remote microbiology ward round and a formal sit down ward round with the MDT. The electronic patient record was used so clinical observations were reviewed remotely. Core Standards for Intensive Care Units state the consultant must see all patients at least twice daily (including weekends and National holidays) and set a management plan, in the form of a structured bedside ward round.
- There was a structured clinical standardised approach to handover. Handovers were recorded on an electronic records system.
- In the reporting period, April 14 to March 15 there was a low locum usage of 2.8%.
- Nurses and junior doctors in the units told us advice and support from consultants was readily available, including out of hours.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available. A 'Battle Bag' stored under the nurses station contained all the necessary information / resources staff may need. All staff we spoke with were aware of the 'Battle Bag' and knew their roles in the event of a major incident.
- Bedside boxes were also available to support the nurse in the event of a power failure the boxes included a torch and some basic airway support equipment.
- The departments had clear guidelines and action cards for a MAJAX (major incident) and copies of these were displayed by the nurse's stations within the units.
- Staff were familiar with how the chain of command worked in the trust for major incidents.

Critical care

Are critical care services effective?

Outstanding ☆

We judged the effectiveness of this service to be outstanding because there was a truly holistic approach to assessing, planning and delivering care and treatment to patients. We found:

- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver joined up care to patients. For example, the use of the electronic patient information system.
- The systems to manage and share the information needed to deliver effective care were fully integrated and provided real-time information across teams and services. For example, there was prompting of basic tasks before moving onto another task which ensured care elements were not missed. Other examples included being able to review microbiology results and trend in a real live system which enabled joined up working with other members of the multi-disciplinary team for a real time view of the care and progress of the patient. Treatment plans could be adapted quicker as a full at a glance status was seen.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff had access to the information they needed to assess, plan and deliver care to patients in a timely way.
- Care and consent to treatment was obtained in line with legislation and guidance.
- Where patients lacked mental capacity to make a decision, 'best interest' decisions were made in accordance with legislation.
- Deprivation of Liberty Safeguards were used appropriately.

Evidence-based care and treatment

- The units used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society, National Institute for Health and Care Excellence (NICE) and National Confidential Enquiry into Patient Outcomes and Death (NCEPOD).
- We saw the units were adhering to NICE Guidelines, for example NICE CG50 Acutely ill patients in hospital and NICE CG83 Rehabilitation after critical care illness. This was because there was a sufficient system in place for managing the deteriorating patient and we saw rehabilitation needs assessed within 24 hours of admission to critical care.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care were based on the use of care bundles for example, ventilator care bundles. Such bundles were evidence based and aligned to best practice guidance.
- An electronic care management system to manage and share information needed to deliver fully integrated effective care was in use. The system provided real time information across teams and services. For example, there was prompting of basic tasks before moving onto another task this ensured care elements were not missed. Other examples included being able to review microbiology results and trend in a real live system and joined up working with other members of the multi-disciplinary team for a real time view of the care and progress of the patient. Treatment plans could be adapted quicker as a full at a glance status was seen.
- Compliance with key trust policies, such as, central venous catheter care and ventilator associated pneumonia were monitored through quarterly audits. In the reporting period December 2014 to September 2015, there was a 100% compliance with all care bundles such as Ventilator Associated Pneumonia (VAP), Central Venous Catheter (CVC) insertion and ongoing care.
- There was designated quality and audit nurses in post who managed the wide ranging unit audit program.
- We saw a local audit calendar. Audits scheduled to be carried out included inpatient rehabilitation outcomes in hypoxic (lack of oxygen) brain injury, admission of neurology patients to critical care and the management of hypoglycaemia in critical care. Audits were discussed at clinical governance meetings.
- Treatment guidelines for patients with Traumatic Brain Injury (TBI) were in place. This ensured standardisation of care in GCC and NCC.
- There was a standardised handover procedure for patients discharged from the unit to the wards. A unit nurse accompanied the patient to the ward and gave a formal written and verbal handover. This included information such as a summary of the patient's care and treatment in the unit, a plan for on-going treatment, and any follow up requirements. This met the Core Standards for Intensive Care Units.

Critical care

- We saw patients with a tracheostomy tube had appropriate weaning plans in place; however, they were consultant led.. NCC had a multidisciplinary tracheostomy weaning ward round twice a week. On GCC allied health professionals (AHP's) did not have any input into weaning plans; this is not in line with the recommendations made in the provision of intensive care services guidance. Multi-professional teams consisting of senior medical, nursing, physiotherapy and dietitian members should be involved in the management of these patients. A tracheostomy is an artificial opening into the windpipe (trachea) and is held open by a tracheostomy tube should manage these patients. This helps people to breathe more easily. Weaning is gradually reducing the amount of support the ventilator gives a patient to help them breathe until they are able to breathe on their own. A ventilator is a machine to assist breathing.
- All patients were screened for delirium at least daily. Delirium is an acute medical condition and a common occurrence in critical care units. Patients with delirium are likely to spend longer in hospital and have an increased risk of long-term cognitive impairment or death.
- There was a range of local policies, procedures and standard operating protocols in place, which were easily accessible via the trust wide intranet and directly available through the electronic records system.
- A specific critical care pharmacist was available and was instrumental in the education of staff in new drug protocols. This meant patients received the most up to date evidence based medicines care available.
- A consultant pharmacist working on GCC had developed a guideline for management of delirium. We saw that this was available on the electronic patient information system and staff were following this guidance
- Nursing staff had access to the critical care-learning zone accessed through the trust intranet this provided updates on policies, procedures and new evidence based guidance / protocols pertinent to the critical care area.
- Sedation breaks were implemented where appropriate. A sedation break involves stopping the patient's sedative infusion and allowing them to wake up. Sedation breaks have been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress).

Pain relief

- As part of their individual care plan, all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain-scoring tool for patients who were awake and for those patients who were ventilated (receiving breathing support via a tube).
- Pain relief and sedation for patients was recorded on the clinical patient information systems at the same time as observation. The patient's response was monitored and changes were made to medicines as necessary.
- Patients and relatives told us staff responded quickly if a patient appeared to be in pain or distress.
- There was access to the pain management team for support and guidance.

Nutrition and hydration

- We saw patients screened for malnutrition and the risk of malnutrition on admission to critical care using an adapted Malnutrition Universal Screening Tool (MUST).
- Patients who were able to eat and drink were highlighted on the ward board so they received appropriate access to food and drink.
- We saw the use of the hydration and nutrition assurance toolkit (HANAT) on critical care; this supported staff to meet the hydration and nutritional needs of patients.
- We saw there was a standardised feeding plan for patients who were being fed by Nasogastric tube (NG) or Percutaneous Endoscopic Gastrostomy tube (PEG). This meant there would be no delay in the feeding of patients if a dietician was not available. A NG tube is a narrow bore tube passed into the stomach via the nose. It is used for short- or medium-term nutritional support. A PEG tube is a flexible feeding tube, which is placed through the tummy wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output, this was recorded on the clinical patient information system.

- There was access to a Speech and Language Therapist (SALT), dietetic service and a dietician attended the unit when required.
- Some nursing staff had been trained to carry out swallow assessments; this ensured that there would be no delay in meeting the nutrition needs of patients if a SALT was not available.

Patient outcomes

- The units engaged, participated and contributed in the North Trent Critical Care Network. This included audit activity and regular benchmarking against other Critical care services in the region.
- The units participated in the national annual audit of Critical care services by the Intensive Care National Audit and Research Centre (ICNARC). This meant the outcomes for patients using the Critical care service could be measured against outcomes achieved by similar services.
- The results from the latest ICNARC data available to us at the time of our inspection were for October 2014 to March 2015. This showed patient mortality rates for GCC were lower (better) and for NCC within the expected ranges when compared with similar units nationally.
- Unit acquired MRSA and C.difficile infections were similar to other units.
- At the time of our inspection, NCC did not audit catheter related blood stream infections (CRBSI) or Ventilator Acquired Pneumonia (VAP). The data provided to us for GCC showed that in the reporting period January 2014 to December 2014 there were zero CRBSI and in the reporting period January 2014 to September 2015 the VAP rate was 1.4 per 1000 ventilated days.

Competent staff

- There were dedicated clinical nurse educators responsible for coordinating the education, training and continuing professional development framework for critical care nursing staff. This met the ICS standards, however senior nurses on GCC told us there was often a lack of access to the clinical educators who were based on another campus.
- Newly appointed nurses had an induction to their role in the unit and had a supernumerary period. They had identified mentors on all shifts and worked through a competency framework.
- Nursing staff received an annual appraisal. The latest figures showed 82 % of nursing staff on NCC and 93 % on GCC had received an appraisal in the last 12 months against a trust target of 90%.
- Appraisal figures for the medical staff were 75% for NCC and 80% for GCC.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- The percentage of nurses with a post registration award in critical care nursing was 64% for GCC with a further 7% currently undertaking the course. Fifty percent of nurses on NCC had the qualification. This met the Core Standards for Intensive Care Units.
- In addition to the critical care course, NCC nurses undertook an advanced training course in neurological care. Completion rates for this course at the time of our inspection were 90%.
- All of the newly appointed consultants working in the units had the correct competencies as defined by the Intensive Care Society.
- A revalidation process was in place with good opportunities for training for medical staff.
- The critical care outreach team provided education and training in acute and Critical care skills to staff across the trust.
- The critical care education team produced a quarterly educational update to support ongoing learning and development of nursing staff.

Multidisciplinary working

- The multidisciplinary team (MDT) included nursing and medical staff, physiotherapists, dietician and speech and language therapists, microbiologist, and pharmacist. On NCC, the pharmacist did not always attend the daily ward rounds. The ward round did not meet the Core Standards for Intensive Care Units asclinical ward rounds must happen every day in the unit with input from nursing, microbiology, pharmacy and physiotherapy.
- There was an MDT approach which enabled care to be delivered in a coordinated way. Allied health professionals such as pharmacists worked well with the nursing and medical teams. We attended the daily team handover, which included the nurse in charge, consultant, pharmacist and a physiotherapist. During

the handover patient care and progress was discussed, the electronic recording system was used to enable current patient records to be used as part of the handover process.
- There was the use of an electronic referral system on NCC. This ensured a consistent and reliable service to patients requiring neurosciences input and was utilised within the hospital and other neighbouring hospitals.
- On NCC, we observed a morning MDT meeting. This included a neuro surgeon, radiologist and nursing staff. Regional patients who had been referred to the service were discussed and scans reviewed. This meant there was good MDT working with other services and patients received appropriate and timely treatment.
- The critical care outreach team followed up patients discharged from GCC with a stay greater than three days.
- Consultant led MDT clinical wards round did take place every day as required by Core Standards for Intensive Care Units.
- We saw that weekly rehabilitation meetings had taken place between consultants, nurses, physios and occupational therapists.
- We also saw twice weekly MDT ward rounds took place on NCC for all patients with a tracheostomy; this included the Speech and Language Therapist (SALT), physiotherapist and neurosciences consultant.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours.
- The physiotherapy and pharmacy team also provided seven days a week service to the units during the day with an on call service out of hours.
- Diagnostic imaging was available on call outside normal working hours. Consultant staff described during interviews how there were never any problems obtaining diagnostics or laboratory support out of hours.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There was an electronic record for each patient, which included medical, nursing and allied health professional's notes. Observation charts were accessible via the same system. This enabled consistency and continuity of record keeping whilst the patient was on the unit, supporting staff to deliver effective care.
- There were computers available by each patient bedside and on the unit; these gave staff access to patient and trust information for example policies and procedures. Direct links to the intranet pages were embedded in the electronic system for example links to the safeguarding policy if required, this saved staff time and meant they had the most up to date information at all times and could make timely referrals if required. Other examples include links to refer a patient to the tissue viability nurse.
- There was a formal handover for patients transferred from the units to the wards. This included information such as a summary of the patient's care and treatment in the unit, a plan for on-going treatment, and any follow up requirements. This met the Core Standards for Intensive Care Units.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- The staff we spoke with demonstrated understanding of the issues around consent and capacity for patients in critical care. Staff told us if they were unsure in any circumstances they would seek guidance from senior staff or from the safeguarding lead.
- On the NCC, the neurosurgical flow manager led and supported staff on issues around deprivation of liberty (DOLS).
- We saw two patients receiving care on NCC whilst being deprived of their liberty. We saw the deprivation of liberty safeguards and orders by the court of protection authorising deprivation of a person's liberty were used appropriately.
- There was a policy for the management of patients whose behaviour challenges the service (adults) in place should this be required .No one was being restrained during our inspection, therefore we were unable to comment on its use.

Critical care

Are critical care services caring?

Good

The care provided to patients in critical care was good because patients were treated with kindness, dignity and respect. We found;

- Patients and relatives were positive about how they were cared for and supported.
- Staff spent time with patients and relatives to ensure they understood the care and treatment and were involved in making decision.
- Staff responded compassionately when patients needed help and support to meet their basic personal needs.
- Staff helped patients and those close to them cope emotionally with their care and treatment.

Compassionate care

- We spoke with four patients and two relatives. They were all positive regarding the care provided they told us they or their relative were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate manner.
- We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed.
- When patients were being cared for in closed side rooms, we observed all staff knocking on doors and waiting for a response from staff, patients and or relative before entering and referring to patients by their name of choice.
- We saw patients' bed curtains were drawn and doors closed when staff cared for patients. A sign was clipped to the outside of each curtain reminding staff to seek permission before entering. This was a further measure used to maintain patient's privacy and dignity and to inform other staff care was in progress and they should not be disturbed.
- Staff throughout the units had joined the 'Hello my name is' campaign, aimed at improving communication with patients and each other. This is recognised as a key part of building trust and supports providing compassionate care. During our inspection we heard staff introducing themselves to patients and relatives using 'hello my name is'.
- We observed patients remaining covered at all times; this maintained their dignity.
- We saw most of the patient name boards positioned where those patients who were awake could see them. Most of them had been completed to include the patients preferred name and the name of the nurse and consultant looking after them.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were involved and kept up to date with the care and treatment of the patient. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- We saw in patient records where doctors had noted their discussions with relatives. The notes showed the questions asked by relatives and the answers given.

Emotional support

- The hospital chaplain was available to visit the units regularly and on request to provide support.
- Patients discharged from the GCC were followed up on the ward by staff from the critical care outreach team. This was to support the patient with their recovery and to support the ward staff to meet the patient's needs.
- The critical care outreach team assessed patients discharged from GCC using cognitive and trauma screening questions. This meant any additional emotional support could be offered, if required.
- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients told us the staff were understanding, calm, reassuring and supportive and this helped them to relax.
- The units were not currently routinely using patient diaries for those patients in critical care. Patient diaries are a simple but valuable tool in helping people come to terms with their critical care experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown patient diaries may help

the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress. There were firm plans in place to roll this out across all critical care areas in January 2016.

Are critical care services responsive?

Good

We found the responsiveness of this service to be good because people's needs were met through the way services were organised and delivered. We found;

- The needs of different people were taken into account when planning and delivering services.
- Access to care was managed to take account of peoples need, including those with urgent needs.
- There was openness and transparency on how complaints and concerns were dealt with.
- Facilities and premises were appropriate for the services being delivered.

Service planning and delivery to meet the needs of local people

- The NCC was a regional neurosciences unit and received referrals from a number of neighbouring hospitals.
- The GCC had provision for up to eight patients and NCC had 20 beds.
- Follow up clinics were not provided for patients discharged from critical care. This does not meet the Core Standards for Intensive Care Units. Critically ill patients have been shown to have complex physical and psychological problems that can last for a long time following discharge from critical care. These patients benefit from the support offered by a specialised critical care follow up service once discharged. Although not a follow up clinic, patients were invited to attend the Sheffield Critical Care support group, which was led by the critical care outreach nurses. Nursing staff told us if a patient raised any concerns at these meetings, they would advise them to see their General Practitioner (GP).

Meeting people's individual needs

- Patients were being reviewed in person by a consultant within 12 hours of their admission.
- Care plans demonstrated peoples' individual needs were taken into consideration before delivering care.
- Language interpreting services were available within the hospital if required.
- There were facilities for relatives to use such as a designated room. Relatives could stay overnight using recliner chairs in the patient's rooms if required.
- The units did not manage a significant number of patients living with dementia or learning disabilities but the nurses described how they would care for and manage such patients, they told us it was important to involve family members and / carers in providing aspects of the care and support required.
- Nursing staff told us about the learning disability passport and the unit had a dementia link nurse who attended regular meetings and updated the team on any pertinent issues. Nursing staff were also encouraged to complete the e-learning module 'care of patients living with dementia'.
- There was a specially adapted side room on NCC for use by patients who were experiencing challenging behaviour; this included a low rise bed and wall padding. This meant patients could be safely accommodated without the risk of self-harm ordestruction to their surroundings and avoided the potential risk of injury to staff. It also ensured the patient's dignity was maintained.
- The unit had a chaperone policy in place. A chaperone is a person who accompanies a patient during an examination for example a female would be accompanied by a female member of staff when being examined by a male member of staff .Staff we spoke with told us every time a chaperone was required they assisted.
- NCC patients had access to a Neuro Psychotherapist if required.
- GCC patients had access to psychologist if required; they could be accessed via the critical care outreach team

Access and flow

- In the reporting period December 2014 to November 2015, there were 703 admissions to GCC and 1064 to NCC.
- Most admissions to the GCC (60%) and NCC (69%) were planned.
- Decisions to admit to the units were made by an Intensive Care consultant together with the consultant or doctors already caring for the patient.

Critical care

- A daily board round took place at the start of each day with the matron, flow manager and senior nurse in charge of NCC to troubleshoot and reduce unnecessary delays which included initiating reviews assessment of capacity.
- On GCC, there was a daily liaison meeting with the trust bed manager to facilitate discharges. A morning meeting was also held with theatres flow manager, GCC nurse in charge and bed managers to discuss elective surgical activity and the requirements for GCC beds.
- Critical care bed occupancy was in line with or below the England average for the period November 2014 to July 2015.
- Patients should be admitted to critical care within four hours of when the decision to admit is made. In the reporting period December 2014 to November 2015 98% of NCC and 95% of GCC admissions were meeting this target.
- Patients should not be discharged from critical care between 10pm and 7am if possible. Discharges during the night have been associated with an excess mortality and patients find it unpleasant to be moved from Critical care to a ward outside of normal working hours. Staff told us they avoided out of hours discharges whenever possible. ICNARC data from October 2014 to March 2015 showed both GCC and NCC had a lower rate of out of hour's discharges when compared to other similar units nationally.
- Patients should be discharged from the critical care within four hours of the decision to discharge. In the North Trent Critical care, network annual report 2014/2015 30% of discharges from NCC and 27% from GCC were longer than four hours due to bed pressures within the hospital.
- There was noted to be a falling rate in the number of non-clinical transfers out of GCC which meant the numbers were now lower than those of similar units. The number of non-clinical transfers out of NCC was in line with similar units. Non- clinical transfers are patients moved to a Critical care unit in another hospital due to lack of beds. Clinical reasons would be for different specialist care, such as treatment for patients with severe burns. Current evidence and guidance indicates patients transferred to other Critical care units for the same type and level of care spend longer in hospital overall and have poorer outcomes.
- There was a low rate of patients readmitted to NCC and GCC. A low rate of readmissions indicates patients were discharged at an appropriate point in their treatment and with suitable support.
- The time of the decision to admit patients to the critical care was noted in all of the patients' records this met the Core Standards for Intensive Care Units.
- In the period January 2015 to September 2015 four patients were ventilated outside the Intensive Care Unit owing to bed pressures; this meant there was not always suitable bed capacity.
- In the North Trent Critical care, network annual report 2014/2015 it was noted the NCC had a high number of patients requiring level one care remaining on the unit. This reflected difficulties in discharging patients to a more appropriate environment; this could lead to beds not being available for urgent admissions. During our inspection, we noted one patient was ventilated in the recovery department whilst waiting for a bed on NCC.
- Nursing and medical staff told us patients were only discharged to a suitable ward. For example, there were specific wards with staff who had the skills to care for a patient with a tracheostomy, (an opening created in the patient's windpipe to help them to breathe). Staff told us patients were kept on the unit rather than discharged to an unsuitable ward, even if this meant a delay.
- The average median length of stay in the reporting period 2014/2015 for GCC was approximately one day with a maximum stay of approximately 15 days. For NCC the median length of stay was approximately two days and maximum median stay of 91 days this is in keeping with other neurosciences units. The median is the "middle" of a sorted list of numbers.
- North Trent Critical care network annual report 2014/2015 reported the number of planned operations cancelled due to a lack of GCC beds was 20; this was an improvement on previous years. NCC data was excluded from the report as the department were not confident the data submitted fully reflected the definition of operations cancelled due to lack of critical care beds.
- We saw there was a specific critical care bed escalation policy which would be used if capacity was limited or in the event of a major incident.

Learning from complaints and concerns

- There was a formal policy for managing concerns and complaints. Staff were aware of the policy and how to access it.

- Information on how to raise a concern or make a complaint was readily available to patients and relatives.
- There were low numbers of complaints about the critical care service. Complaints and concerns were discussed at monthly clinical governance meetings. Actions to address concerns and make improvements were noted. Most complaints related to communication between staff and relatives and lessons were learned and disseminated. For example, the need for staff to keep family members appraised of all aspects of care and all reviews that had taken place.
- Senior nurses told us they openly addressed any concerns or complaints raised in the unit and instantly entered into open discussions with patients and relatives in order to come to a prompt resolution. Relatives we spoke to told us if they had a complaint, they felt confident they would be listened to and treated with dignity and respect during the process

Are critical care services well-led?

Outstanding ☆

The leadership of critical care services was outstanding because governance and performance management arrangement were proactively reviewed and reflected best practice. We found;

- There was a collaboration and support across all functions and a common focus on improving quality of care and patient experiences.
- Leadership strategies were in place to ensure delivery and desired culture.
- There were high levels of staff satisfaction.
- Staff were proud of their units and spoke highly of the culture.
- The services proactively engaged and involved staff and ensured that the voices of all staff were heard and acted on.
- Staff innovation was supported.

Vision and strategy for this service

- We saw copies of the care groups five-year strategy, the strategy for the Operating Services Critical care and Neurosciences directorates were similar in they were striving for the best clinical outcomes for patients and delivering patient centred care; these were in line with the overall hospitals aims.
- Staff were able to articulate the trust's vision and the values, which were Patient first, Respectful, Ownership, Unity and Deliver (PROUD).
- We observed staff delivering care and demonstrating behaviours in line with the hospital values.
- We saw there were specific departmental visions for GCC and NCC.

Governance, risk management and quality measurement

- There was a strong culture of clinical governance supported by multiple audits. There was a clear management structure, with teams working together effectively to provide an excellent service.
- There was a good feedback loop from governance meetings, which included monthly governance newsletters highlighting learning from incidents; these were seen in staff areas. Staff told us they also received this electronically.
- There was an open invite to all MDT members at the monthly governance and mortality and morbidity meetings. Staff were encouraged to present any updates at these meetings. Nursing and physiotherapy staff on GCC told us these meetings were difficult to attend as they took place on another campus.
- Significant incidents and action points from clinical governance meetings and mortality and morbidity meeting were included as action points, which were read out during a daily five-five brief, where five issues were briefly discussed in five minutes.
- This five to five brief was written by nursing and medical team members across all units and had been set up so the leadership team could inform as many people as possible useful and important information in a consistent manner.
- Nursing staff told us the brief altered each week to provide the latest relevant information and updates. Staff had the opportunity to contribute to the five to five briefing as and when they had information, which would be useful to share across the whole team.

- The briefing supported effective and consistent communication across the team. In all of the meetings we attended during our inspection, for example daily handovers and ward rounds we saw the five to five brief was read out aloud to all of the team members present.
- There were monthly and bi monthly work streams for catheter related blood stream infections (CRBSI) and Ventilator Acquired Pneumonia (VAP) to review compliance with the associated care bundles**.**
- Appropriate risk registers were maintained, reviewed and acted upon; risks with a significant rating were escalated to the executive team for oversight and consideration.
- Unit leaders were aware of the current risks affecting the units and the delivery of safe care.
- The services measured themselves against both the Intensive Care Society Core standards and the North Trent Critical care Network service specifications. Peer reviews were carried out, however in 2014 and 2015 a peer review was not carried out instead a critical care network audit was carried out. We reviewed minutes from the North Trent Critical Care Operational Delivery Network meeting and noted that there were plans in place to facilitate peer reviews going forward.

Leadership of service

- The senior leadership team consisted of a Clinical Director, Nurse and Deputy Nurse Director, Operations and Deputy Operations Director. The units have designated Clinical Leads who report to their respective Clinical Director.
- There was clear nursing and medical leadership with the skills, integrity, capacity and capability to lead the service effectively.
- We saw senior medical and nurse leaders were committed to providing a safe service for their patients.
- Staff organisation within critical care showed nurses were in specific lead roles such as quality and audit, practice education and rehabilitation.
- NCC nurses were able to access an in house leadership course, staff were very positive about this course.
- Ward managers were supported by the trust to complete a nationally recognised leadership programme.
- Nurse leaders within critical care had achieved several external awards for leadership in recognition of the leadership they provided.
- Staff told us the nurse director would often work clinically in the area..

Culture within the service

- Staff skills and strengths were recognised. We were given examples of where staff had been given development opportunities and one health care assistant we spoke to told us she was being encouraged to undertake her nurse training.
- Staff were positive about working at the hospital; they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.
- Many staff had worked in the service for a considerable amount of time; some staff we spoke to had been there for over 10 years.
- We found a supportive and open culture, with nursing, multi-disciplinary and medical staff able to raise concerns about incidents poor care and safeguarding.
- Staff told us senior nurses, matrons, consultants were visible, supportive, and staff felt happy to discuss any issues.
- Staff told us they were most proud of the teamwork and said staff were always willing to help and support their colleagues.

Public engagement

- Thank you cards from patients and relatives were displayed.
- The Sheffield critical care support group helped support patients and their relatives who had been discharged from hospital following a stay on GCC. Patients and relatives were invited to attend a monthly 'drop in' session at a local venue to chat about their experiences and share their thoughts and feelings.
- Patients who had been discharged from GCC were invited back at a later date to share their experiences of intensive care. We saw a video had been recorded recently (August 2015) of patients sharing their experiences, this was used as part of ongoing development of the service.

Staff engagement

- Using a hospital initiative 'Listening into Action', staff within Critical care were actively encouraged to explore the experiences of patients and carers and work together as team to look at ways of improving patient care and experiences. This was then presented to the

executive team to progress to the next stage. The initiative was still in its infancy and staff were unable to give us any examples of implemented change at the time of our inspection.
- We saw there was a suggestion box located in the staff room. Staff suggestions were reviewed at operational meetings.

Innovation, improvement and sustainability

- On GCC and NCC there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines.
- An advanced clinical pharmacy service had been developed to improve the safety and efficacy of medicines used in critical care.
- A neuro simulation team-training programme for anaesthetists was being piloted on neuro critical care. This was training for the whole MDT and aimed to prepare staff for the challenges of managing acutely unwell patients. It introduced staff to crisis resource management non-technical skills.
- Electronic online referral system on NCC care ensured a consistent and reliable service to patients while freeing up doctors to maximise direct patient contact on NCC.
- An innovative clinic providing medico-legal expertise was available to patients and their families. The service gave access to experienced legal professionals able to give advice across a breadth of areas including managing the personal affairs of a patient.

Maternity and gynaecology

Safe	Good
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Outstanding
Overall	**Outstanding**

Information about the service

Maternity and outpatient Gynaecology services at Sheffield Teaching Hospital are located at the Royal Hallamshire Hospital, Jessop Wing. The wing has an independent access within walking distance of the Royal Hallamshire Hospital.

Gynaecology inpatient services are provided on a day case ward and inpatient ward. The day case and early pregnancy unit (G1) comprises of four ultrasound scan rooms, three clinical rooms, a hyperemesis rehydration bay with four chairs, and 12 further beds, including side rooms. A minor procedure room is also available on the gynaecology unit.

G2 is the 26-bedded inpatient ward, which specialises in gynaecology oncology and urology cases.

Maternity care at Jessop wing includes the antenatal clinic, a fetal maternal medicine unit, the antenatal day unit, pregnancy triage area, labour ward, one antenatal ward and two post-natal wards. There are also neonatal intensive care, special care and transitional care (for babies requiring extra care) facilities at the hospital.

There are 129 beds dedicated to women's and maternity services and during January to December 2014, the hospital had 6703 deliveries.

During the inspection, we visited all areas and departments relevant to the service. We spoke with 24 women, 5 relatives and 48 members of staff including senior managers, and service leads, managers, midwives, consultants, doctors, nurses, anaesthetists, sonographers, support workers, administrators and domestics. A further 27 members of staff attended focus groups held during our visit. We reviewed 30 sets of women's records.

Maternity and gynaecology

Summary of findings

Overall we rated maternity and gynaecology services as outstanding. Patients were protected from the risk of avoidable harm and when concerns were identified staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary actions were taken to prevent reoccurrence.

Staff delivered evidence based care and treatment and followed NHS England and National Institute for Health and Care Excellence (NICE) national guidelines. Staffing levels were monitored and reviewed to keep women safe at all times.

There was excellent multidisciplinary working that promoted integral care. Staff worked together to make changes to improve the outcomes for women and babies.

Staff were thoughtful and responded compassionately to women, treating them with kindness dignity and respect. Partner and relatives felt included in the care given.

The variety of specialist services in maternity and gynaecology met the needs of women both locally and nationally.

People's individual needs and preferences were central to the planning and delivery of tailored services. The importance of flexibility, choice and continuity of care was reflected in the services.

Leaders and senior managers had an inspiring shared purpose, they strove to deliver and motivate staff to succeed. They were motivated, visible and accessible and participated in the day-to-day running of the service.

Are maternity and gynaecology services safe?

Good

We rated safety of this service as good. We found;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and the monitoring and maintenance of equipment were reliable and appropriate to keep patients safe. The trust devised and implemented modified WHO checklists for emergency caesarean sections.
- There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. Staff were aware of the signs of abuse and had access to appropriate resources.
- The midwife to birth ratio was 1:28 in line with national recommendations. Staffing levels and skill mix were planned and reviewed to keep patients safe.
- At the time of our inspection, dedicated consultant presence on labour ward did not meet the national recommendations of 168 hours. A plan was in place for this to be increased to 111.5 hours per week from February 2016.

However, we also found that:

- Babies were removed from the obstetric operating theatre without an identification label, although they were accompanied by a midwife at all times.
- Documentation on the cardiotocographs (CTGs) did not always match the recommended minimum data.
- Documentation of the checking of neonatal resuscitaires (a warming platform used for clinical emergencies and resuscitation) had missing signatures.
- Mandatory training rates for infection prevention and control were not meeting trust targets.

Incidents

- The trust had a clear incident reporting policy in place. All staff understood their responsibilities to raise concerns, and report safety incidents and near misses on the electronic incident reporting system. Nominated

members of the staff reviewed the incidents each weekday morning. Staff in each ward area reviewed and processed incidents. In 2014-2015, approximately 800 incidents had been reported.

- Staff told us they all knew how to report incidents and described the feedback they had received. They were able to tell us of changes made as a result of clinical incidents.
- At the time of our visit, the trust had 53 open incidents; the majority were no harm incidents. Closure of no harm incidents was delayed due to investigating staff prioritising serious or moderately serious incidents. We saw action plans and changes in practice as a result of the investigation of major incidents, such as the review of antibiotic prescription for babies at risk of infections. Staff in antenatal clinic described a change in practice as a result of a serious incident involving confidentiality.
- Staff discussed incidents and root cause analysis at the monthly obstetric risk management meeting, and perinatal mortality and morbidity meetings.
- Between March 2014 and March 2015, gynaecology services reported two serious incidents to the NHS strategic executive information system (STEIS). These were incidents described as most serious and staff were aware of what would constitute a serious incident. We saw evidence of changes to the way results were reported because of one of the incidents. We saw evidence of a change in the triage procedures as a result of an incident.
- There were monthly multidisciplinary perinatal mortality and morbidity meetings. Staff discussed babies that had difficult births, became ill after the birth, or had a poor outcome. Improvements to care and treatment were shared and actions agreed.
- Information from incidents, including trends were displayed in ward areas and staff were notified via ward specific newsletters to each ward area. Each ward handover included current important information.
- There was evidence of an understanding and application of the duty of candour regulation in all minutes to meetings. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. The change in the triage procedure had been developed in consultation with the client affected by an incident.
- Members of the risk management team agreed and rated identified risks within the service. The directorate clinical governance meeting then addressed the risks formulating action plans. We saw maternity risks identified and actions taken on the electronic reporting system.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. The safety thermometer captures information on the number of pressure ulcers, venous-thromboembolisms (blood clots), falls and catheter urinary tract infections. The maternity and gynaecology service participated in the NHS safety thermometer and collected the data. Ward managers displayed outcomes in the majority of ward areas. Between January and March 2015 there had not been any reported episodes in relation to the safety thermometer, achieving 100% harm free care.
- The service also collected data and contributed to the NHS maternity safety thermometer. These statistics are available nationally for members of the public to view.

Cleanliness, infection control and hygiene

- All areas appeared visibly clean, staff cleaned equipment after use. Rooms had 'I am clean' stickers on the doors, dated, timed and signed to indicate that the room was clean and ready for use.
- There were hand gel dispensers on entry to all ward areas and at point of care. We saw members of staff carrying out hand hygiene measures such as hand washing.
- Staff followed best practice with infection control and prevention principles in relation to management of waste, including sharp items, and clinical waste.
- Staff received mandatory training on infection prevention and control, 88% of nurses in gynaecology and 67% of midwifery staff had completed the training. This was worse than the trust target of 90%.
- An infection control accreditation programme was in use. It was a package of practices considered likely to reduce infection rates when carried out consistently by clinical teams. Staff had to achieve set standards for a

minimum of three months prior to re-accreditation. Between June and August, maternity and gynaecology areas achieved 95% in the infection control audits, achieving re-accreditation.

- The hospital's bare below the elbow' policy for best hygiene practice was adhered to. Staff had access to, and were seen to use personal protective equipment, such as gloves and aprons.
- All areas had designated housekeepers and cleaners who took pride in their ward areas. In addition, domestic staff were present on labour ward to assist in the cleaning of delivery beds and rooms to improve turn-around time and patient flow.

Environment and equipment

- In maternity, doors to gain entry to all the ward areas were locked and staff gained entry via a swipe card system. CCTV cameras were in use in all areas. Receptionists were employed to assist in answering the doors. These receptionists were part-time and covering several areas so their assistance was limited. During the visit, we witnessed waiting times of up to 16 minutes to gain entry to one ward.
- Babies were tagged with a security tag that alarmed on their removal from the ward. We saw the alarm activated and a quick response by staff.
- During elective caesarean sections, the baby was taken to the resuscitaire (a warming platform used for clinical emergencies and resuscitation) in an adjoining room without applying an identification label. The room was used by more than one theatre. There was the potential for more than one baby to be present at any time. There was a risk of mixing babies up, although staff did not leave a baby unattended, and the baby was returned to the parents after the necessary care had been performed. In gynaecology wards G1 and G2 the doors were open and reception staff were able to direct women and visitors to the correct wards during clinic and visiting times.
- Patient led assessments of the care environment (PLACE) audits demonstrated that all areas met the hospital standards.
- Resuscitation equipment was readily available in all clinical areas. Adult and neonatal resuscitation trollies were locked and checked monthly, with items appropriately packaged, stored and fit for use.
- On labour ward the documentation for checking of the neonatal resuscitaires in the rooms had signatures missing. Three of the resuscitaires that we checked had signatures missing between five and eight times a month. White board information highlighted that all rooms and equipment had been checked daily. A process of covering clean equipment was in place. All equipment was appropriately packed, stored, and fit for purpose. The lack of signatures could mean that reviewing data retrospectively would be difficult.
- All patient equipment we looked at had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff were aware of the process for reporting faulty equipment.
- A medical physics department was located on labour ward, which assisted in the checking and repairs of all equipment within the maternity department. The close proximity of the department was thought to make the process more efficient. Results for October 2015 demonstrated that 89% to 93% of equipment was maintained within the recommended time-frame. This was in line with trust targets.
- Cardiotocography (CTG) equipment was available in all labour rooms to enable staff to monitor the fetal heart rate in labour. This included adhesive telemetry fetal heart monitors for monitoring mothers with a raised body mass index.
- There were three obstetric theatres with a dedicated neonatal resuscitation area and a dedicated recovery room. The recovery room was set up for two patients at a time.
- Equipment was available within the gynaecology day unit and treatment unit. This enabled outpatient procedures to take place within these areas such as Colposcopy and hysteroscopy procedures.

Medicines

- In most areas, there were effective arrangements in place for storing medicines, including controlled drugs and refrigerated items. During the visit, some medications and intravenous fluids were stored in unlocked clinical areas. Inspectors escalated this to management staff, new arrangements were made, and key pads placed on doors.

- The emergency drugs on labour ward were stored at the correct temperature within a room with a keypad on the door.
- On labour ward the checking of temperatures on drug fridges was inconsistent, with data missing on 17 occasions in the last two months. This could mean that drugs were not stored at the right temperature and their efficiency affected.
- Nitrous oxide (Entonox) for pain relief was piped into the birthing rooms.
- Staff were observed undertaking a medicine round wearing a do not disturb tabard. This could reduce the incidence of drug errors or disturbances.
- We looked at the prescription and medicine administration records for 24 patients in gynaecology and maternity. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.
- On the postnatal wards staff used two medication trollies to reduce the time women waited for their medication. We spoke with 18 women in both gynaecology and maternity. Out of the women we asked, only one said that staff did not bring her pain relief often enough.
- Medication incidents were reported and all were investigated. On the wards, members of staff were identified to perform any investigations with the support of Supervisors of Midwives.
- Staff had reported a delay in discharge of women due to the processing of take home medication (TTO's). This included waiting time for doctors to prescribe the TTO, sending the script to pharmacy, and collection of the drugs when ready. A pharmacist visited the ward daily Monday to Friday, to prevent the drug charts having to leave the ward. This meant that patient's medication delays was reduced. Staff planned to make changes to improve the provision of TTO's. The antenatal ward securely stored a limited stock of common medicines to dispense on discharge. The postnatal wards were changing to an electronic medication ordering process to expedite the discharge.
- The gynaecology ward did not report problems with TTO's or delayed discharges.

Records

- Medical records for gynaecological patients were stored in the trust's medical records store. During the pregnancy, maternity hospital records were stored in a records room within the department to allow 24-hour access.
- Women carried a set of pregnancy related care notes in the form of hand held records. The community midwife completed these at booking. All information documented by the labour ward and community midwives was stored electronically using digital pens. The hospital and community staff could all access and review this information. At present, the hospital retained the paper original copy of all records.
- The bereavement services and chaplaincy teams used electronic safeguarding systems to record pregnancy loss and neonatal death. This improved information sharing and reporting facilities.
- Notes were stored in unlocked, closed trollies in office areas on the wards. This was not in patient access areas.
- All women were given child health record books (red books) which included body mapping of the baby. Hospital and community staff used the red book to record the child's health and development.
- We reviewed 30 sets of records; the named midwife leading the women's care was documented. Records were legible, dated and signed, although the designation of the carer was not always documented. In both gynaecology and maternity risk assessments were completed and notes contained clear plans of care.
- Cardiotocographs (CTGs- fetal monitoring printouts) were stored in envelopes within the hospital notes. We examined eight sets of notes that included CTGs. In five sets of notes the number of CTGs stored did not match the documentation on the storage envelope and printouts from previous pregnancies and current were stored together.
- Documentation on the CTGs did not always match the recommended minimum data. We reviewed 39 fetal heart rate monitoring records (CTGs). In 86% of record's monitoring did not contain clear accurate data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not

always documented on the monitoring, in accordance with trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6) . This made reviewing labour events complicated and did not meet trust guidelines.

Safeguarding

- All staff were required to undertake safeguarding training to an appropriate level. In maternity 93% of staff, and in gynaecology 100% of staff had received level 3 adult and children safeguarding training. This was better than the trust target of 90%.
- All staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. Staff followed safeguarding legislation and local policy for reporting concerns to safeguard adults and babies from abuse.
- A specialist team of ten whole time equivalent midwives worked to provide care and support for women with more complex social needs. The team performed daily maternity ward rounds and discussed new cases, ensuring all women within their caseload had a named midwife from the vulnerability team.
- There were trust wide guidelines for the care of women with female genital mutilation (FGM) and mental health problems. All staff we spoke to in both gynaecology and maternity were aware of their responsibilities concerning the referral of women and babies.
- A recent audit had confirmed that not all pregnant women were seen alone and the routine enquiry for domestic abuse was not always asked in accordance with trust policy. A new pathway had been developed and was about to be introduced for booking and the first ultrasound scan to ensure that all women were seen alone.
- Midwives were identified by a recent CQC review for looked after children, as high referrers for the Family Common Assessment Framework (FCAF) and to the local Multi Agency Support Teams (MAST) to elicit early support. Expectant women could access support from the local voluntary Doula service.
- Staff were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. Babies had electronic tags that set off alarms if the baby was removed from the ward.
- Midwives attend child protection conferences and as a minimum submitted reports. Figures seen confirmed that 100% of case conferences, where midwifery were involved, were informed by a conference report completed by their service. We saw evidence of detailed plans of care in notes and electronic records for women with complex social and safeguarding needs.

Mandatory training

- Newly appointed staff completed the trust induction programme. Newly qualified staff completed a competency pack in all areas of work. Staff told us that this took approximately 18 months to complete. New staff also worked under close supervision from named mentors.
- Medical staff had a comprehensive induction and were supervised until deemed competent. Staff described a supportive environment during training.
- Trust mandatory training demonstrated an overall compliance of 71%. Most subjects ranged between 71 and 93% with moving and handling training at 55%. This was worse than the trust target of 90%.
- Staff and managers reported that previously, attending the maternity multidisciplinary emergency skills training (Yorkshire and Humber Obstetric Training Study Day; YMET) had been difficult due to cancellation. This cancellation was due to staff shortage caused by sickness. Data demonstrated that 65% of midwives and doctors had attended the YMET day. Staff identified that this had improved and they had training dates booked. Ad hoc emergency skills training was performed on labour suite led by the clinical educators.
- Staff reported that dedicated staff notified them of training that was due to be renewed.
- Nurses who worked in the obstetric recovery area received appropriate recovery training. Staff working in the Advanced Obstetric Care Unit (AOCU) received training in caring for critically ill patients either in house training or combined with Huddersfield University.

Assessing and responding to patient risk

- Risk assessment booklets were completed in gynaecology for all patients. Where there was a need, we saw evidence of escalation to a senior member of staff. We reviewed five copies and they were all complete including a signature sheet.
- There was a dedicated 24-hour triage telephone Contact Centre for pregnant women in the maternity department. Triage was staffed by two midwives and a support worker during the day and one midwife and one support worker at night. We observed calls being

taken and detailed use of the electronic records and flow charts to assess women's needs. Within the clinical Maternity Assessment Area (clinical triage), maternity staff assessed women who attended the labour ward for midwife led or consultant led care in one of the four assessment centre beds. Staff reported good medical support from the labour ward medical staff.

- Women who required follow up care or who attended for induction of labour were seen in the antenatal clinic in the antenatal day unit. Day unit staff reported that medical review of women was often delayed due to the unavailability of doctors. No doctors were rostered to work on the day unit, as not all women who attended needed their care reviewing by medical staff.
- All women were assessed at the beginning of pregnancy and assigned midwife led care or consultant care for the higher risk complex cases.
- In maternity and gynaecology services, the Maternal Early Obstetric Warning Score (MEOWS) and Sheffield Early Warning Score (SHEWS) were used respectively to assess the health and wellbeing of women. Early warning scores enabled early recognition of a patient's condition by grading the severity of their condition and prompting staff to get a medical review at specific trigger points if a woman's condition deteriorated. We saw the results of two MEOWS audits with an action plan implemented in between. The second audit showed an improved completion rate from 50% to 83%. We checked 30 sets of notes and found MEOWS had been completed and scores were calculated accurately.
- We observed good communication and teamwork in theatre during surgery. The theatre staff followed the World Health Organisation (WHO) surgical safety checklist pathway (designed to reduce the number of surgical errors) appropriately to ensure patient safety. Following an audit by the Royal College of Anaesthetists (RCoA) in May 2015, the trust devised and introduced modified WHO checklists for emergency caesarean sections called MAMMA (maternal identity, anaesthetic, mode of delivery allergies, anaesthetic) and HAPPE (History, help, airway assessment, position and cricoid, pre-oxygenation). An audit in September 2015 showed 100% compliance with completion of WHO checklist for emergency caesarean sections. These checklists were used by the Obstetric Anaesthetists Association, as an example of good practice.
- During handover staff on the postnatal and antenatal wards highlighted, the current MEOWS score and the highest score during admission. This allowed the midwife in charge to be informed of the women who were potentially at greatest risk.
- A neonatal early warning scoring (NEWS) system was not in use at the time of our visit. The service had reviewed charts and had modified a NEWTT (track and trigger) to implement in the future. We saw evidence of discussion of this at governance meetings. Newborn early warning scores enabled early recognition of a baby whose health had deteriorated. At present observations were documented on observation charts.
- Patients identified as high risk post-delivery were cared for in the AOCU. High dependency charts were in use, with peripartum (post birth) criteria for escalation if the women's condition deteriorated. Nursing staff received high dependency care training in order to provide Level two high dependency care if required.
- All notes we reviewed contained completed venous thromboembolism (a blood clot in the deep veins of the leg) risk assessments. Each assessment sheet was attached to the drug prescription chart.

Midwifery staffing

- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. The maternity service had achieved this ratio since March 2014. This was despite the higher than national average sickness rate of 7%. Women received one to one care when in established labour.
- Expected levels and actual levels of staffing were displayed on notice boards for the general public to see in all ward and clinic areas. During our visit, the maternity and gynaecology wards mostly reached these levels, although labour ward rarely met their planned staffing figures for whole shifts. During periods of high activity, we saw measures taken to divert staff from administrative work, management time and the community in order to maintain a safe environment. From May 2015 to August 2015 staffing for midwives, nurses and healthcare assistants met planned levels between 86% and 90% of the time.

Maternity and gynaecology

- The Maternity unit comprised of Labour ward, Whirlow, Rivelin and Norfolk wards. We saw evidence of staff deployed between these areas to best meet the needs of women and babies.
- The service did not use a staffing acuity tool, but monitored staffing using the midwife to birth ratio. There were currently adequate levels of staffing and levels were regularly being reviewed. Although they currently had no vacancies the trust stated that recruitment was an ongoing process.
- The antenatal day unit was staffed with two midwives and a healthcare support worker from 8am to 6pm.
- Staffing in all areas consisted of a variety of grades and specialities to ensure safer staffing. Maternity support workers, nursery nurses, registered nurses and midwives were employed in all areas of maternity. Nurses and support workers worked within the gynaecology department.
- Community midwives carried a caseload of one midwife to approximately 80 women and provided a homebirth service. Four midwives supported the home-birth service 24 hours a day. The home birth service was not affected by the use of community staff to support labour ward.
- Staff sickness within the maternity unit was high. At the time of our inspection, sickness rates within the maternity and gynaecology department were between 5-7% against a trust target of 4%. Managers held monthly sickness strategy meetings to address the sickness rates. We saw evidence of return to work meetings and staff self-referral to physiotherapy for musculoskeletal complaints whilst working. It was hoped that early self-referral would reduce the likelihood of sickness occurring.
- Supervisors of midwives (SoMs) help midwives provide safe care and are accountable to the Local Supervising Authority Midwifery Officer (LSAMO). The national recommendation for a SoM is to have a caseload of 15 midwives. There were less SoMs than the national recommendation with 19 midwives each to supervisor. This and other issues were addressed in the 2015 LSAMO audit; we saw action plans and activities that addressed issues raised in the audit, such as reducing the SoM to midwife ratio. A full time SoM had been appointed to deal with the deficit and issues highlighted. The audit identified a need to increase the visibility of the SoM; this had been addressed with drop in sessions and use of Local Supervising Authority postcards for all women with contact details.

Nursing staff

- A safer nursing care tool was in use and staffing levels were set to meet patients' needs. Flexible working and the use of an evening 'twilight' shift had improved staffing levels.
- Staffing on the gynaecology day surgery and early pregnancy unit had altered to accommodate the ward attender patients. Staff worked a 10am to 6 pm shift to staff these busier periods. Training and role development was introduced to gynaecology outpatient department for support workers to extend their roles such as with phlebotomy and patient chaperoning.

Medical staffing

- Quality clinical outcome data indicated there was an average of 87.5 weekly hours of dedicated cover from consultants' presence on the labour ward. This was not in line with national recommendations, for the number of babies born on the unit each year; there should be 168 hours a week. There was a plan to increase the dedicated cover on the labour suite to 111.5 hours per week from the February 2016.
- There had been a regional reduction in the number of shifts worked by the second senior registrar level doctor (ST3) on duty. This reduction of 104 shifts a year had caused concern for the senior obstetric team due to increased pressure for the service. A plan was in place that consultants would cover the unfilled registrar shifts two nights a week with a 'stay in' on call. This would also increase the consultant presence to 109 hours a week.
- Junior medical staff described the unit as happy and a supportive environment. Due to the recent change in foundation year doctors (junior doctors), staff told us and we saw close supervision/ support by the registrar and consultant on duty. Medical staff reviewed all antenatal inpatients daily.
- Doctors described a difficulty in reviewing patients on the maternity wards due to work pressures throughout the unit. This delayed discharges of women from the wards.

Maternity and gynaecology

- Staff on gynaecology wards described good access to medical staff. Women we spoke with did not describe a delay in being reviewed by the doctors.
- It was rare to have medical locums at short notice. If used an induction process was in place.
- On labour ward anaesthetists provided a 24 hour service. Three anaesthetists were available during the day and one at night. Extra staff were available on call in the hospital if necessary.

Handovers

- Medical staff held multidisciplinary handovers three times a day, which included discussion of inpatients, births and admissions. We observed two handovers, which were structured and flowed well. All the information needed was handed over but they did not completely follow the 'situation, background, assessment, recommendation' (SBAR) format.
- We observed four nursing/midwifery handovers of care. On labour ward, the midwife in charge allocated patients to the oncoming staff. A handover of the five 'hot topics' and 'safety topics', such as pressure area care and ensuring that two signatures were documented when dispensing take home medication were highlighted. As soon as this information was communicated, midwives dispersed and received one to one handover from the outgoing midwife.
- Staff on the antenatal, postnatal and gynaecology wards used printed sheets in an SBAR format. Handover of patients and care was clear and concise including the 'five hot topics in five minutes'. It was noted the handovers were often interrupted by staff due to questions or requiring access to the office space.

Major incident awareness and training

- The hospital had a major incident plan on the intranet. Staff were aware of the policy and prompts were available for staff to remember the 'red battle bag'. This contained necessary emergency equipment in the event of a major incident.
- An obstetrics multi-professional skills drill training was developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the new-born.

Are maternity and gynaecology services effective?

Good

We judged the effectiveness of this service to be good because people using the service were receiving effective care and treatment, which met their needs. We found;

- Staff planned and delivered patient's care in line with current evidence based guidance, standards and best practice legislation. Patient needs were assessed throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal Colleges' guidelines.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Staff worked collaboratively to understand and meet the range of people's needs.
- Consent to care and treatment was obtained in line with legislation and guidance. People were supported to make decisions.
- Women had access to appropriate pain relief throughout maternity and gynaecology services.

However;

- The normal birth rate was 54.9%, less than the national average of 60.4% and the caesarean section rate was 29%, higher than the national average of 26%. This was thought to be due to the complexity of the patient groups.

Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, Termination of pregnancy for fetal abnormality guidance were also followed.
- We reviewed ten guidelines; they were all easily accessible, in date and version controlled.
- The Early Pregnancy Assessment Clinic closely followed NICE guideline CG154: Ectopic pregnancy and

miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage. Women using the maternity services were receiving care in line with NICE quality standards 22 (which related to routine antenatal care) and 37 (for postnatal care).
- Policies were subject to audit; the results were presented to staff. For example, we saw a re-audit of completion of Modified Early Obstetric Warning Score Charts and theatre swab counts that demonstrated improvement. Actions were planned and the need for further auditing identified.

Pain relief

- The midwife led unit had a birthing pool. The unit had funding for two further pools. The midwife led unit also offered Entonox gas (a pain relieving gas) and stronger pain relief by injection.
- Within labour ward, Entonox, epidurals and patient controlled analgesia (PCA) were available for women in labour 24 hours a day, seven days a week.
- Women were able to access pain relief during birth and post operatively in a timely way. Analgesia was offered regularly, and most of the women we spoke with felt their pain was managed well. Only two women commented that they had to wait for pain relief. In the gynaecology ward patients told us they were offered pain relief regularly and were not left in pain. Information was given to take home concerning managing pain effectively.
- Entonox gas was also available within on gynaecology for use in invasive procedures and painful dressing changes.

Nutrition and hydration

- Women we spoke with told us that the meals were of an acceptable standard and that snacks were available in a patient fridge. Women could choose whether to eat in the dining area or by their bed.
- The enhanced recovery programme for gynaecology patients included the use of glucose drinks prior to surgery (unless the patient could not have them for medical reasons) and high protein supplements post-surgery. These were used to improve women's wellbeing and aid recovery.
- Women were encouraged to make an informed choice on the best method to feed their baby. The service was awarded UNICEF level three Baby Friendly Initiative in July 2015. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding.
- Breast-feeding statistics for initiation within 48 hours of birth were 79% for 2015. This was better than the UK average of 76% and regional target of 74%.
- A citywide team worked together to support women with infant feeding concerns. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers. The continuing support meant that the figure for the number of women who discontinued breast-feeding after the first week fell from 13% in 2008/9 to 7% in 20014/15. This was similar to the national target of 7.6%.
- In response to an audit, the trust implemented a colostrum pack project. This supplied the equipment and information necessary to support mothers in expressing colostrum (mother's first milk) as soon as possible after birth. The colostrum was given straight to their baby, particularly if the baby was in the neonatal unit. If the baby was not tolerating feeds then the colostrum was used for mouth care.

Patient outcomes

- Patient outcomes were monitored and recorded on a performance dashboard. All staff were actively encouraged to gather data and monitor outcomes. The trust was part of a dashboard redesign, with agreed performance parameters that would include the Yorkshire and the Humber region. This was not yet operational, but the first quarter's information had been submitted for comparison. This would help identify trends and patient safety issues that could be compared to other hospitals within the Yorkshire and Humber region. This was in accordance with The Royal College of Obstetricians and Gynaecology 2008 guidelines.
- The number of women who had a normal birth between 2014 and 2015 was 54.9%. This was less than the England average of 60.4%. The homebirth rate was between 2-3%, similar to the England average, and the caesarean section rate was 29%, which was higher than the England average of 26%. This was due to a higher than average emergency section rate of 19.1% (England average 15.1%). Staff were examining methods of addressing this. The high rate of complicated pregnancies was thought to compound the outcomes. Senior staff had implemented a change in the induction

of labour criteria and process in order to improve the process and potentially reduce the emergency caesarean section rates. A vaginal birth after caesarean and a birthing without fear clinic were also provided to target the high caesarean rates. Data from July 2015 to October 2015 indicated the current caesarean section rate was 26.2% of deliveries, which is equal to the England average.

- Between July 2015 and September 2015, 13% of babies were delivered by medically assisted instrumental delivery (forceps and ventouse extraction). This was close to the trust target of 12%. All cases were reviewed by a midwife and medical lead to identify trends or practice issues.
- Between July 2015 and September 2015, 1.2% of women had a third or fourth degree perineal tear following a spontaneous normal birth. This was below (better than) the expected threshold of 2.6%. During this same period 0.8% of women suffered a third or fourth degree tear following an assisted instrumental delivery which was better than the trust target of 4.7%..
- Within the time frame, 1.7% of deliveries resulted in a blood loss of greater than 1500mls. The national dashboard did not define a target for this.
- National antenatal key performance indicators were reported electronically for screening in pregnancy data. The database identified actions for any data that did not meet national standards.
- The enhanced recovery programme was in place in both maternity and gynaecology to improve outcomes for women and reduce their recovery time. This included detailed information on what to expect and a structured pre and post-operative process.
- Following the inspection, the hospital was identified as an outlier for the incidence of puerperal sepsis. The trust reviewed case notes and responded appropriately: an action plan was put in place.

Competent staff

- Yorkshire maternity emergency training was developed regionally for the maternity services. This was an accepted format by which multidisciplinary healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the new-born.
- Staff received updates in caring for women whose condition was deteriorating. Those responsible for post anaesthetic care had received anaesthetic recovery training and competency assessment. This complied with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia.
- Staff caring for the women within the Advanced Obstetric Care Unit had received additional training in the care of the critically ill women. This followed the best practice guidance, 'Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman.' (The Royal College of Anaesthetists 2011).
- Records confirmed that 100% of gynaecology and 75% of maternity staff had completed an appraisal in the last 12 months. The appraisal process was linked to the trust values of patients first, respect, ownership, unity, and delivery. Staff told us that this made appraisals much more meaningful.
- Newly qualified midwives completed a comprehensive competency (preceptorship) pack prior to progressing to the next grade. All staff in clinical areas and the trust clinical educators supported this process. Newly qualified staff wore red lanyards on their identification badges so that other staff could easily identify and support them. This also restricted the duties asked of these staff.
- Maternity support workers were trained to work in all areas, working closely with nurses and midwives to provide care. Staffing was comprised of nurses, midwives, nursery nurses and support workers all carrying out specific roles in the ward areas.
- Medical staff attended weekly training opportunities, and described a supportive department for training.
- Midwives throughout the hospital were trained in performing the newborn baby checks. We saw daily clinics held by midwives who had received the additional training, to perform the checks. Staff attended yearly updates for the examination of the newborn.
- Midwives' maintained competencies by working for three to six months at a time in each area of the service. In each area, a core of midwives did not do this, which enabled stability and expertise in all area.
- Nursing and midwifery revalidation drop in sessions and promotions were held to prepare nursing and midwifery staff for the revalidation process.

- Trained advanced nurse practitioners and nurses worked in the gynaecology ward in an extended role, providing ultrasound scans and minor procedures on the day case ward.

Multidisciplinary working

- Staff reported that the multidisciplinary working within the department was efficient and effective. During our visit we saw evidence of all staff working together to maintain the flow of patients throughout the gynaecology and maternity service. We also saw minutes of weekly meetings that reinforced this. Staff described multidisciplinary meetings to provide women centred care, such as consultant input in plans for complex deliveries in the home environment.
- Hospital and community staff reported a good working relationship between the teams.
- Physiotherapists and uro-gynaecologists supported women with third and fourth degree tears and after caesarean section.
- The physiotherapists, uro-gynaecologists and occupational therapists supported patients after surgery on the gynaecology ward and for assessments prior to discharge home.
- Counsellors were available in the gynaecology day unit for women making difficult decisions.
- There was joint working with the mental health teams, who held clinics alongside the antenatal clinics.
- The neonatal intensive care staff worked closely with the maternity staff in provision of care in the transitional care department.
- Midwives and care support workers on the postnatal ward worked in pairs whilst caring for women. This allowed for appropriate delegation of work.
- The Consultant Nurse for the Early Pregnancy Assessment Centre worked with the emergency department, community midwives and the fertility unit to ensure appropriate referral criteria were in place.
- Many midwives attended monthly meetings with GP practices and health visitors to discuss families of concern and share information. This helped to provide a co-ordinated approach to their care.

Seven-day services

- Maternity and emergency gynaecology services were available 24 hours a day, seven days a week. This included the termination of pregnancy treatment service. The early pregnancy unit was open between 8.30am to 9pm Monday to Friday, and 8.30am -12.30pm on Saturday. An ultra sound scanning service was provided in the clinic throughout these times.
- The antenatal day assessment service was open 8am to 6pm seven days a week.
- A Supervisor of Midwives (SOM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided midwives with access and support at all times.
- A consultant on call and anaesthetist was available 24 hours a day, seven days a week.

Access to information

- Patient white boards were available in the office area on all wards. Information was displayed in the Situation, Background, Assessment and Recommendation (SBAR) format. These boards were not visible to members of the public.
- In gynaecology the electronic patient board had the patient details minimised for patient confidentiality. Icons were in use to inform staff of details and actions required, such as ordering take home medications.
- Medical records were accessible and available for both gynaecology and maternity clinics.
- The electronic records system provided and sent summaries to the GP and community midwives on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave verbal consent for their care and treatment and this was clearly documented in the women's records. The records we reviewed contained written consent for surgical procedures.
- Training on consent, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLs) and learning disability was part of mandatory training for all staff.
- Staff we spoke with had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. During the inspection, there were no patients subject to a Deprivation of Liberty application.
- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed and submitted to the Department of Health. Checklists were available to ensure that this occurred.
- While signed consent was not required for the disposal of fetal remains, guidance states women should be

offered a choice of how to manage the remains, and as such, the conversation should be recorded. Notes reviewed showed clear written consent was obtained indicating the woman's choice of disposal.

Are maternity and gynaecology services caring?

Good

The care provided to patients in maternity and gynaecology services was good. Patients were supported, treated with dignity and respect and were involved as partners in their care. We found;

- Feedback from patients was predominantly positive about the way staff treated them. We heard examples of staff going that extra mile during difficult situations.
- Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- Staff in the gynaecology day unit demonstrated compassion and a great understanding of the emotional and physical needs of their women.
- Specialist clinics were available for emotional support of women.
- Maternity surveys highlighted that the trust performed similar to other trusts in the 2015 maternity survey.

Compassionate care

- We observed ward areas, listened to focus groups and spoke with individual staff who were involved in patient care. We saw good interactions during some particularly challenging events, and found that staff responded compassionately, treating people with kindness, dignity and respect. Within the gynaecology day unit care was taken to treat women with great dignity and respect privacy during potentially upsetting times.
- The women and their partners we spoke with felt that they had been treated with respect and compassion. They felt confident to ask questions and said all staff had been caring and hardworking. A partner described the staff as 'amazing' and a woman explained that they 'couldn't fault the care'.
- Friends and Family Test (FTT) results were generally above the England average for antenatal care, birth, postnatal ward and postnatal community care between March 2014 and February 2015. Ninety eight percent of responses stated women would be 'likely' or 'extremely likely' to recommend the unit. The local inpatient survey dashboard asked women about their care at the hospital. The trust scored above the expected average in most areas.
- In the CQC maternity care survey 2015, the hospital performed the same as other trusts around the kindness and understanding by staff after the birth of their baby.
- We observed staff respecting the women's dignity by knocking and waiting to be invited in to rooms, or behind the curtains around the woman's bed space.
- During our visit, women described staff as caring throughout the hospital. We spoke to two women who chose to come to Jessop wing to have their baby after having previous children there. We were made aware of some occasions where women were not satisfied with their care. We saw evidence of the trust complaints process being followed.
- In gynaecology we saw evidence of staff providing emotional support for women who had previously suffered pregnancy loss. The staff considered a holistic approach to care.

Understanding and involvement of patients and those close to them

- Women attending the Early Pregnancy Assessment Centre had their choices explained fully to them. We saw how staff ensured women had a good understanding of their options.
- Women for whom antenatal screening had raised significant concerns were given time and space to consider their decisions. Partners were involved in these processes in accordance with the women's wishes.
- We also saw evidence of patient involvement in both gynaecology and the fetal medicine unit. This was in the form of information booklets for the enhanced recovery programme, and questionnaires on using the service.
- The CQC maternity survey 2015 demonstrated that the trust scored similar to other trusts in women and partner involvement in care.

Emotional support

- Specialist midwives were available to provide additional support for women in the form of a Birth Options clinic. This gave women the opportunity to discuss their fears and concerns and plan their care. The Next Birth after Caesarean Section clinics demonstrated a need for

women to be given time to talk and discuss their care, and has led to a birth after caesarean section pathway to be developed. This had not been launched at the time of the visit.
- Mental health guidelines and a care pathway existed for the care of women who had mental health disorders, including previous puerperal psychosis. Mental health screening was undertaken during pregnancy.
- Confidential professional counselling from a qualified therapist registered with the British Association of Counselling and Psychotherapy was available for women using the termination of pregnancy services. Consultations were available before and after procedures.
- A specialist midwife ran an 'extra input' antenatal clinic to support women with psychological or significant anxiety issues around childbirth. Midwives in a focus group were able to give examples of providing women centred care during complex situations.
- Bereavement support was provided by teams of nurses, midwives and dedicated bereavement officer.

Are maternity and gynaecology services responsive?

Outstanding ☆

We rated the responsiveness of maternity and gynaecology services as outstanding. Services were organised and delivered to meet the diverse groups requiring care and treatment.

- People's individual needs and preferences were central to the planning and delivery of tailored services. The importance of flexibility, choice and continuity of care was reflected in the services.
- We saw evidence of integrated person-centred pathways of care. These often involved people with complex needs.
- There was an active review of complaints. Improvements were made to services as a result of complaints.
- Access to care was person centred. Changes had been made to increase the flexibility for women to access care.

Service planning and delivery to meet the needs of local people

- Routine antenatal care was carried out by community midwives based in health centres and children's centres. Maternity services held hospital antenatal clinics at the Jessop wing from Monday to Friday.
- Multidisciplinary clinics ran for many specialities, such as, cardiology, renal services, endocrinology, epilepsy, rheumatology, haematology, maternal mental health services and diabetes. These clinics were in addition to specialist midwife clinics supporting women suffering with gestational diabetes or more who were more vulnerable.
- Midwives and doctors discussed the preferred place of birth with all women on booking of the pregnancy. This was reviewed periodically throughout the pregnancy. Staff explained the women's choices and gave information leaflets.
- The one to one midwifery team cared for women with more complex needs or wishes, for example women wanting to give birth to twins at home or have a home birth after a caesarean section. In order to support the complex care plans, the team cared for the women throughout pregnancy, delivery and during the postnatal period. We saw evidence of cases where the team had provided one to one care and supported women's decisions.
- Women who were low risk but did not want a home birth, were given the option of a consultant-led area of the labour ward. This was part of the labour ward and promoted normal vaginal births in or out of water. Staff could easily transfer women to the labour ward in an emergency. Guidelines for midwife led care incorporated both labour ward and the midwife led unit. If women with more complex medical needs wanted to have a home birth, birthing on the midwife led unit was offered as a safer alternative with less intervention. However, there were examples of women with more complex medical or obstetric needs being given the support they needed for a safe birth of choice, including home birth.
- Early booking ensured women had access to antenatal screening. The trust target was to book 90% of women for antenatal care by the time they were 12 weeks and six days pregnant. Data for 2014/15 showed 90.75% of

women were booked by this stage. Within the antenatal clinic there was a quiet sitting room used by staff to provide counselling to women and their partners following antenatal screening.
- Clinics were held for women who had undergone female genital mutilation, supported by the safeguarding midwife.
- Consultant gynaecologists with specialist interest had specialist roles such as urology investigations and robotic surgery. We saw that staff took the lead on different conditions to provide a comprehensive gynaecological service to women.
- The gynaecology ward occasionally had women from other medical and surgical specialities present due to bed capacity issues within the hospital. Policy and processes were available for caring for these patients on a gynaecology ward, including a named consultant responsible for their care.
- Babies who required extra monitoring and treatment were cared for on the transitional care ward on the maternity ward. This enabled mothers and babies to stay together during their stay. Advanced nurse practitioners supported the staff to care for these babies.
- The advanced obstetric care unit was renamed as a result of patient discussion. Women highlighted that care in a high dependency unit can be more distressing for women and families. The area had facilities for caring for women who needed isolation or privacy in a high dependency setting.

Access and flow

- Maternity services did not report any unit closures between January 2014 and June 2015. There was a process in place during times of significant operational pressures to give assurance that a safe maternity service could be provided. This was known as the Bronze Command. In the event of pressures increasing then the process was for further escalation to Silver and Gold Command.
- We saw evidence of senior management support and guidance during busy times prior to the activation of bronze command.
- The service implemented the enhanced recovery after surgery programme (ERAS). This promoted early mobilisation and early discharge for women following an elective caesarean section or certain elective gynaecology procedures. Audit of the process had highlighted that there had not been an increase in women or baby readmissions.
- The hyperemesis (severe sickness in pregnancy) suite offered a rehydration service for women with severe hyperemesis. Women were treated on G1 as day cases if appropriate. If readmission was required women were able to refer themselves to the unit.
- Terminations of pregnancy were performed in conjunction with the British Pregnancy Advisory Service and carried out during dedicated times.
- The hospital provided colposcopy as a 'one-stop shop'. This was subject to regular audit and complied with national targets. This process meant women were able to attend, have treatment and be discharged from the service in one appointment.
- There was a delay in women's discharge home; this was considered to be due to waiting for medicines from the pharmacy to arrive. Plans were in place to supply training and medicines to the ward staff for dispensing take home medication. A ward pharmacist visited the wards daily to speed the process up.
- The elective caesarean section (CS) theatre list ran daily Monday to Friday. A dedicated theatre team including one of the consultant obstetricians was present for the surgery.
- There were routine ultrasound scanning clinics for dating and growth scans. Midwife sonographers mainly staffed the clinics. Staff felt that this made the appointments more timely and meaningful for the women.
- The trust had developed new reduced fetal movements' guidelines. This gave staff greater guidance in the management of reduced fetal movements throughout pregnancy.
- Between June 2015 and December 2015, the maternity unit bed occupancy was 52%. This was better than the national average of 55-60%, although we saw evidence of women staying on Labour ward due to the postnatal wards being full. We did not see significant delays in women's admission to labour ward.
- Pregnant women who had any concerns could call the triage call centre. Staff monitored and documented calls in the electronic records. We saw evidence of staff

making follow up calls and enquiries on behalf of a woman, whose pregnancy was at the end of her second trimester (mid pregnancy) but booking had not been completed.
- Changes to the induction of labour process included a live database that allowed staff in all areas to liaise and plan patient flow. Women's needs were prioritised with the ability to look at the service as a whole. The criteria for induction of labour had been improved with flow charts for staff to follow. Staff reviewed the women who could wait at home for treatment to start, and encouraged them to go home rather than wait unnecessarily in hospital.
- General practitioners and patients could refer themselves straight to the services on G1 to prevent gynaecological patients attending the emergency department at Northern General Hospital.
- Ward staff were not aware of gynaecology patients being refused beds due to other non-gynaecology patients filling beds.
- A rapid access clinic was available for community midwives to refer babies to during the first two weeks after delivery. Babies who had lost a significant amount of weight, had poor feeding patterns or were jaundiced, were seen by an advanced neonatal nurse practitioner and members of the feeding support team. Detailed plans for care were made and the baby followed up. This reduced the admissions for feeding assessments and observations.

Meeting people's individual needs

- Women were given a choice of place of birth in line with national guidance, which recommended both a choice in place of birth and lead carer. This included choice to have a home birth, birth under the care of a midwife in a midwife led unit (MLU), or birth in a hospital supported by midwives, anaesthetists and consultant obstetricians.
- The Diabetes Specialist Midwife streamlined the care of the pregnant woman with gestational diabetes. This meant that the women received specialist appointments designed to cater for their individual needs and were supported with telephone contacts.
- The trust had access to 24-hour interpreting services via a national database. Staff described the service as efficient and easy to use.
- Termination of pregnancy clinics on G1 occurred at both evenings and weekends to ensure access for more people.
- Leaflets were available for women in several different languages. Staff used interpretation services as either face to face or a telephone contact.
- The bereavement room on labour ward enabled families who had suffered a loss in pregnancy to stay together in a sound proofed room unaware of the activity around them. Families could return to see their child in the Jessop Wing mortuary. This had a separate entrance and sensitive viewing area.
- The public health midwife supported the influenza vaccine clinic. In accordance with government recommendations, vaccines were offered to all pregnant women.
- The smoking cessation support midwives visited women in whichever setting was more convenient to the women and families. This included home visits and local children centres if required. This had reduced the smoking at delivery from 23% in 2014 to 12.4% in 2015.
- Due to an increase in the need for third trimester (late pregnancy) ultrasound scans, the trust had trained midwives to perform third trimester scans. This increased the availability of appointments for women.
- After feedback from families' two single rooms with en-suite facilities were available on the post-natal ward. These private amenity rooms were often unoccupied, as the length of stay was so short for women. During our visit, the rooms were offered to women with greater needs, such as after the loss of a baby.
- The service ran community clinics for glucose tolerance tests (GTT). A GTT is a blood test that measures how the body regulates sugar. This test takes over two hours to perform. The use of community clinics improved attendance rates. Children's centre locations also made it more convenient for women with children to attend.
- The 24-hour vulnerability team held daily discussions to update the team on the higher risk cases that those on call may be contacted about.
- The BLISS Nurse (for babies born too soon, too small or too sick) visited those women on the antenatal ward if it was identified their babies may be admitted to the neonatal unit. This gave the families a chance to discuss concerns and ask questions.

- Services for women requiring bladder surgery included Percutaneous tibial nerve stimulation (PTNS), an alternative to Botox injections for an over active bladder.

Learning from complaints and concerns

- Patients and their partners were encouraged to provide feedback on their experiences. Complaints and concerns raised were addressed, when possible, at the time they were raised.
- The highest number of complaints had been due to delays in the induction of labour process. We saw actions taken to alter and monitor the process closely. These had just been implemented and an audit was planned in six months' time.
- All complaints were dealt with and actioned within the recommended timeframe. We saw evidence of service user involvement and changes as a result of a complaint. Meetings held with the complainant were recorded and a copy given to all parties. This allowed greater transparency and gave the complainant extra time to review the information that they had been given. We also saw evidence of client contact as a result of a discussion that had not become a formal complaint.
- Patient Advice and Liaison Service (PALS) information leaflets were displayed in some areas. The leaflets informed patients how to raise concerns or make a complaint. Patient's we spoke with did not all know how to complain, but the two patients who were unaware would have spoken to their midwife.

Are maternity and gynaecology services well-led?

Outstanding ☆

The leadership of gynaecology and maternity services was outstanding. The leadership, governance and culture were used to drive and improve the delivery of high quality and person-centred care. We found;

- Leaders and senior managers had an inspiring shared purpose, they strove to deliver and motivate staff to succeed.
- The senior management team and other levels of governance within the organisation functioned effectively. There were clear links from ward to board and staff were encouraged to attend governance meetings.
- There was a strong focus on continuous learning and improvement and staff innovation was supported.
- Leaders were visible and accessible and participated in the day-to-day running of the service.
- The dedication of staff and excellent teamwork was apparent throughout the unit.

Vision and strategy for this service

- The hospital strategy of PROUD values (patients first, respect, ownership, unity, and delivery) underpinned the vision for maternity care. The values were displayed throughout the unit and mentioned by staff during their daily activities. This hospital wide inclusion was supported by the recommendations for addressing maternal obesity, smoking in pregnancy and teenage pregnancy highlighted in the Sheffield Teaching Hospital Strategic plan document 2014-2019.
- Managers displayed a desire to provide women centred care and a 'first class' service for women in both maternity and gynaecology. They wished to keep Jessop wing maternity unit as one of the 'best hospitals in the country. Staff were aware of the vision and displayed it in their care.
- Strategies were in place for economical solutions to improve services for women. For example the use of current available space in hospital for women to wait prior to caesarean section.
- There was a five year strategy in place for Obstetrics, Gynaecology & Neonatology.

Governance, risk management and quality measurement

- A governance framework was in place for maternity and gynaecology services. Meetings were monthly and multidisciplinary; all grades of staff were welcome to attend. The meetings covered topics including serious incidents, safety thermometer, the risk register, staffing levels, and patient experience. Previous actions were reviewed and monitored. We reviewed minutes of three meetings which demonstrated this.
- Two dedicated clinical governance and risk management midwives held regular clinical incident panel meetings and reviewed all adverse outcome

incidents. These midwives worked proactively with wards, audit leads and supervisors of midwives and fed into the governance process to recognise and raise concerns and ensure safe practice.

- We saw that the maternity and gynaecology risk register was reviewed and updated regularly. Actions taken were visible and the process completed for removing risks from the register. Staff sickness was a concern and had been addressed with a new sickness strategy and regular trust wide meetings.
- The government had commissioned an independent investigation into maternity and neonatal services nationally (the Kirkup report), to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The maternity, neonatal and paediatrics senior team had benchmarked the report to their services in June 2015. We saw a plan produced in response which had a number of actions allocated to staff for completion in set timeframes.
- Sheffield Teaching Hospital used an electronic clinical assurance toolkit to monitor patient outcomes and user feedback. Clinical governance staff were able to demonstrate the use and told us information was related to the staff via a newsletter.
- Governance documents clearly identified the roles of the supervisor of midwives and the local supervising authority. Supervisors of midwives told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.

Leadership of service

- The directorate of maternity and gynaecology possessed a clear managerial structure, which included strong clinical engagement. We found the consultant body to be cohesive and proactive in decision-making, with innovative approaches to areas such as sub-specialisms and job planning.
- Matrons, the head of nursing and head of midwifery were all highly visible and described as supportive and approachable. They undertook clinical shifts and attended ward handovers and safety briefings as well as antenatal clinics. The Head of Midwifery managed to care for a small caseload of women during their pregnancy. Throughout the inspection, we saw that they had a good knowledge of activity and clinical issues within the unit.
- Following an incident on one of the wards during the inspection, senior staff were present to provide support to staff at the same time as managing the rest of the unit.
- The Head of Midwifery explained a strategy to work with sonographers to improve the scanning facilities for the maternity department.
- All staff described that senior managers could be contacted out of hours. There was not a manager on call system in place, however staff told us and we saw evidence that managers were contacted out of hours. A plan was in place to review the process to give greater assurance of a sustainable service.
- It was clear that where audits, incidents and complaints demonstrated room for improvements, action plans were developed, implemented and monitored to ensure performance was improved.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff were able to report when errors or omissions of care had occurred and use these to learn and improve practice. For example, patient stories and postnatal debriefs were actively used for learning.
- Staff we met were welcoming, friendly and helpful. They were passionate about their role and said they were happy working for the service.
- Universally throughout the unit staff described the teamwork as exceptional. We saw evidence of this during some very busy periods where staff working together ensured the service continued in a safe manner.
- Many of the staff described a family environment. Local walking groups for staff were advertised throughout the unit.
- We saw evidence of senior staff supporting colleagues experiencing difficult times due to illness.

- Staff did explain that the high workload and rapid throughput of women put constant pressures on the staff. They explained that working together allowed them to manage the workload. The opinion of many was that more beds and staff would ease pressures.
- Gynaecology staff said that they enjoyed their job and were very proud of their department. The staff we spoke with thought highly of their ward manager, they felt supported, and said the manager was visible on the ward area.
- Staff in both gynaecology and maternity described a culture of opportunities to develop roles, such as the support workers in gynaecology outpatients and nurses working in the advanced obstetric care unit.

Public engagement

- We saw minutes from the local Maternity Services Liaison Committee meetings. These demonstrated an active, inclusive committee. The working relationship between the Clinical Commissioning group, the public and the maternity department was one of inclusion. We saw evidence of surveys seeking women's opinions around a birth centre, changes in the child health record and projects for supporting partners.
- Patient satisfaction surveys and action plans were visible throughout gynaecology inpatient and outpatient departments.
- Volunteer peer support staff were trained to support breast feeding mothers as inpatients and outpatients.
- We saw evidence of 'Tell us what you think' notices in ward areas.
- A Sheffield Maternity Matters Facebook group sought opinions and engagement of the service users. MSLC members created a film advertising the thank you messages from women. This was shared on the Maternity matters site and the staff involved were asked to create a national version by the Association for Improvements in the Maternity Services.
- Women and families were encouraged to voice their opinions on changes in services such as gaining public opinion around the development of a stand-alone birth centre and the support dads felt they required.

Staff engagement

- Staff felt the trust listened to them. We saw evidence of changes on the ward as a result of staff engagement. For example, the introduction of extra trollies and drug boxes to speed up the drug rounds was due to staff request.
- Staff spoke of good psychological support when required.
- Bi monthly staff forums were advertised in staff areas.
- Staff opportunities for inclusion in research projects and other secondments was apparent throughout the unit.
- Staff were supported to develop their careers. Support was given to gain entry level qualifications and acquire the necessary skills to enrol in nurse training. This was described by staff as the hospital "Prepare to care" initiative.
- A staff sitting room had been created away from the ward area. This encouraged staff to leave the ward and take their breaks in privacy. An 'honesty pig' was in place for staff to pay for the fruit and snacks that were available. These were bought by the ward matrons.

Innovation, improvement and sustainability

- The nurse led early pregnancy unit had improved the services for women attending the gynaecology ward. Plans were in place to extend the nurse led ultrasound scanning services on the ward to 24 hours a day.
- The hyperemesis (severe sickness in pregnancy) area on G1, with reclining seats was under development to make the area more conducive to patient recovery.
- The use of the less invasive surgical robot used within gynaecology reduced the length of stay for certain patients.
- The adhesive telemetry fetal monitors enhanced the labour experience for mothers with a raised body mass index. The non-invasive electrocardiogram (ECG) monitoring of the fetal heart gave a clearer monitoring and allowed free movement by the labouring woman.
- The uro-gynaecology unit accreditation was one of only 13 in the country. This accreditation defined and monitored standards of care, organisation and quality within uro-gynaecology units. It identified units that deliver best practice.
- The GRIP project (getting research into practice) had been implemented to introduce procedures that research had found to be affective, such as the routine use of skin to skin contact for the mother and baby at caesarean section.

Maternity and gynaecology

- Blood salvage was widely in use in the maternity and gynaecology unit in routine surgery. Research was extending this use to emergency caesarean sections. Research described a faster recovery for patients with this procedure

Services for children and young people

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Sheffield Teaching Hospitals NHS Foundation Trust provided services for children and young people in their neonatal unit, at the Jessop Wing of Royal Hallamshire Hospital. This unit comprised of 18 intensive care cots, eight high dependency cots and 18 special care cots. There were also six transitional care cots, based on the postnatal ward of the Jessop Wing. The unit provided a neonatal outpatients department for follow up appointments for babies discharged from the neonatal unit or transitional care.

The cots on the unit were separated into nine rooms. The rooms contained between four and six cots, depending on size. There was one room used for isolation purposes and was also used to facilitate simulation training, .

There was a rapid access clinic held seven days per week in the neonatal outpatients department, where babies who had been discharged early could be followed up and monitored. Babies who were discharged early were also given support at home by the neonatal outreach team.

During the inspection, we visited all the areas where babies were seen. We spoke with 28 staff, which included nursing staff, doctors, the clinical lead, managers and allied healthcare professionals. We went on three home visits with the neonatal outreach team. We looked at 20 records and we spoke with 11 families.

Summary of findings

Overall, we rated the service as good.

The service had a good culture of incident reporting, and there was evidence of lessons learnt from incidents. The neonatal unit had implemented a programme of simulation training to apply changes in practice following learning from incidents.

The service promoted a culture of improvement. There were competency frameworks for nursing staff and medical staff received good clinical support and training.

The neonatal unit worked in a family centred way, to promote the confidence of parents in caring for their baby. This helped facilitate the unit's strategy of early discharge, with the support of the neonatal outreach team and the rapid access clinic.

Staff working at the trust were aware of the trust's values and there was a strategy to promote staff engagement. There was a supportive culture, with open door access to senior management. Staff participated in the research activity of the service.

The neonatal unit had gaps in medical staffing; however these gaps were being covered by advanced neonatal nurse practitioners. Nurse staffing was not at current recommended staffing levels.

Services for children and young people

Nurse staffing levels did not meet the current national guidelines and were not achieving national recommendations for staff having a qualification in speciality.

The environment of the unit was not ideal and was not compliant with current Government best practice guidelines. However, work was underway to commence reconfiguration of the unit to address the constrictions on space.

Are services for children and young people safe?

Good

We rated safe as good. We found:

- The service had a well-established culture of incident reporting, and there was evidence of lessons learnt from incidents. The unit had implemented a programme of simulation training to apply changes in practice following learning from incidents.
- Staff were compliant with safeguarding training and had access to safeguarding supervision. We saw good documentation of safeguarding issues. Records were good.
- The unit had gaps in medical staffing, but these gaps in medical staffing were being covered by advanced neonatal nurse practitioners, to ensure adequate medical cover was provided.

However:

- Nurse staffing was not at current recommended staffing levels.
- There was no patient centred care planning evident in the care records.
- Not all medicines were reconstituted in an aseptic environment. This was not best practice in reducing the risk of medicine errors.
- Mandatory training rates were not meeting the trust target.
- The environment of the unit was not compliant with Government best practice guidelines. However, work was underway to commence reconfiguration of the unit to address the constrictions on space.

Incidents

- Neonatal services had not reported any never events between September 2014 and August 2015. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented.
- The neonatal unit reported incidents using an electronic reporting system. Between September 2014 and August

2015, 157 incidents had been reported. All of the incidents were classified as insignificant or no harm. The main themes of incidents were general care, drug incidents and diagnostics.
- The unit had a band 7 nurse who worked as a clinical governance coordinator for 50% of the time. They were responsible for reviewing and investigating all the incidents reported by the unit.
- All of the staff we spoke with could tell us about the electronic reporting system and how to use it. There was a well-established culture of reporting incidents.
- The unit held weekly morbidity and mortality meetings. The team also contributed to the monthly perinatal morbidity and mortality meetings in the trust. The unit was a member of the Yorkshire and Humber neonatal operational delivery network and contributed to the neonatal mortality peer review meetings. This represented shared learning across the region.
- Duty of Candour was introduced as a statutory requirement for NHS trusts in November 2014. Staff we spoke with told us they understood the need to be open and honest with families when things went wrong.
- The unit undertook simulation training with staff in response to learning from incidents. Examples of these were reviewing aseptic techniques, insertion of chest drains and transportation of a deteriorating baby to another hospital.

Cleanliness, infection control and hygiene

- There were policies and procedures for infection prevention and control, which were easily accessible on the trust's intranet site.
- Staff received mandatory training on infection prevention and control, 67% of nursing staff and 60% of medical staff on the unit were up to date with this training at the time of inspection. The trust target was 90%.
- The environment of both the neonatal unit and neonatal outpatients was visibly clean.
- The unit took weekly swabs from the babies to test for Methicillin-resistant Staphylococcus aureus (MRSA). There had been no reported cases of MRSA bacteraemia or Clostridium-difficile (C Diff) within the service between February 2015 and July 2015.
- Wall mounted alcohol gel was available at all entrances and exits to the departments, personal protection equipment (PPE) and alcohol gel was available at all sink areas. We observed staff to be compliant with the bare below the elbow (BBE) policy.
- We observed staff using the hand gel when entering the ward and washing their hands before attending to patients. Staff used universal precautions. This meant they always used aprons and gloves when delivering care to babies, to reduce the risk of infection.
- Hand hygiene audits between February and August between 2015 reported between 86% and 100% hand washing compliance on the neonatal unit. In the same period, the unit scored 100% for aseptic techniques.
- There was an isolation room on the unit for babies known to have an infection.

Environment and equipment

- The neonatal unit was locked to prevent unauthorised access. There was a buzzer, which incorporated a camera, outside the unit. Parents and visitors gained access via the buzzer; however, they could leave the unit without staff unlocking the door.
- Space in the neonatal bays was limited. There was not the space for two chairs and capacity for five people at each cot, which was described as best practice by Department of Health standards for neonatal units (Health Building Note 09-03, 2013). We recognised the relevant design guidance was followed at the time of construction of Jessop Wing. The trust had plans for reconfiguration of the unit to improve space between cots. We were told this work would begin in February 2016.
- We also saw, on the neonatal unit, the corridors lined with cots, incubators and other equipment due to the lack of storage space.
- The equipment we saw was physically clean. There were stickers on all equipment seen to show it had been serviced and when the next service was due, and we were told equipment safety was managed by the medical engineer team.
- Staff knew how to report faulty equipment to medical engineers. Staff told us there was always adequate equipment for care. We saw evidence of a learning log used by staff to ensure they knew how to correctly use equipment in the unit.

- We observed an up to date cleaning checklist for equipment, which was completed by the housekeeping staff. Up to date cleaning stickers were seen on all equipment not in use.
- Each room contained resuscitation boxes, which were secured, fit for purpose and checked.

Medicines

- The temperature of the medicines fridges was recorded once per day and was within range, however minimum and maximum temperatures were not recorded. This meant staff would only be able to see the current temperature of the fridge and would not be aware if the temperature had been outside of the 2-8 degree range.
- The fridge in the transitional unit office, which stored medicines, was not consistently checked. At the time of inspection, on eight out of 22 days, the fridge temperature had not been recorded. This was brought to the attention of a senior member of staff at the time of inspection.
- The pharmacy department, where medicines were made in an aseptic environment, was not working at the time of inspection. This meant that some medicines which would normally come to the ward in pre measured doses were being made by the nursing staff, using pharmacy guidelines. We saw this being done in the rooms at the end of babies' cots, rather than in a treatment room. This was not best practice in reducing the risk of medicine errors.
- Controlled drugs were handled, stored and recorded correctly.
- We saw on drug charts that medicines had been administered at appropriate times. Medicines were reviewed during the doctors ward rounds.
- There were 53 of incidents reported as drug related between September 2014 and August 2015. These were classified mainly as delayed treatment, or near miss due to action. We saw evidence of how staff competency in drug calculation and administration was measured following drug related incidents. There was a process for support to improve medicines competency for staff.
- We were told that staff were tested on drug calculation competency on their first day of work on the unit. This allowed the clinical educator to provide support during the preceptorship period if necessary.

Records

- Records were paper based. Each baby had a folder containing the daily record of care delivered by the nurse. This was, kept at the nurse's station in the room, and the observation record chart was by the baby's cot. Medical records were stored securely in locked trolleys.
- We looked at 20 nursing and medical records. All records were written in a timely manner, were legible and signed.
- Nursing records did not contain evidence of a care plan individual to each baby. The record was a documentation of the care provided during the shift. We did not see how individual assessment and planning was made from the nursing records we saw.
- We did not see risk assessments documented in the records.

Safeguarding

- The trust had a lead nurse for safeguarding and also a named nurse for children's safeguarding.
- There was a vulnerabilities team located at Jessop Wing. The team consisted of named midwives for safeguarding and specialist midwives for families with social issues, such as homelessness and substance misuse. The team supported staff on the neonatal unit when they had safeguarding concerns about babies and their families.
- The team also provided safeguarding level 3 training, This training is required by nursing and medical staff working with children and babies. The training included learning about female genital mutilation and child sexual exploitation.
- The trust target for safeguarding level three training was 90% and 94% of nursing staff had completed the training, according to data received.
- Staff we spoke with demonstrated safeguarding knowledge and were aware of the obligations to report cases of female genital mutilation. They told us they worked closely with the vulnerability team when there were safeguarding concerns and they had access to safeguarding supervision.
- We were told senior staff on the ward received extra training in safeguarding, such as writing a safeguarding report and attending safeguarding meetings, for effective working in child protection proceedings.
- Safeguarding information about babies on the unit was kept securely in medical records. We looked at three

records which included safeguarding notes. We saw documented that the team had shared their concerns with parents, and parents were aware of the referrals to safeguarding services. This was good practice.
- There was an up to date safeguarding policy in place, and trust had an action plan in place in response to the Savile investigation to ensure that volunteers were appropriately selected.

Mandatory training

- There was a programme of mandatory and statutory training available for all staff, which covered areas such as moving and handling, safeguarding, information governance and infection control.
- The trust target for mandatory training was 90%. The training target had not been met in any of the mandatory training areas, other than safeguarding, but this was only by the nursing staff. Medical staff did not meet the trust target in any areas of training. For example, information governance training had been completed by 68% of nursing staff and 69% of medical staff. Equality and diversity training was completed by 72% of nursing staff and 71% of medical staff.

Assessing and responding to patient risk

- The unit did not use an early warning system to identify deteriorating babies; however, there were medical staff at the unit 24 hours per day to respond to concerns.
- We saw from the governance meeting minutes, that there were plans to implement NEWTT, new-born early warning trigger and track system. This is a way to identify early, babies whose health is deteriorating.
- The unit worked with MBRRACE-UK, a paediatric medical transfer service, to safely transfer babies who needed specialised care. Guidance on how to access MBRRACE-UKwas seen on the wards and it was also available to staff on the intranet.
- The MBRRACE-UKservice would locate a bed in a specialist paediatric service if necessary and transfer the patient.
- Medical and nursing staff on the unit had received simulation training in the transfer of a deteriorating baby, to ensure they had the skills to undertake this when Embrace were not available.

Nursing staffing

- According to the Royal College of Nursing, 2013, neonatal services should provide a staff to patient ratio of the following:

Intensive care cots – 1 registered nurse: 1 patient

High dependency cots – 1 registered nurse: 2 patients

Special care cots – 1 registered nurse: 4 patients

- The Royal college of Nursing recommended these levels of staff for day and night shifts.
- We saw that the staffing establishment and actual staffing levels were displayed on noticeboards in the corridor of each ward. We were told that the staffing establishment for the ward was based on 2010 recommendations due to funding. The unit had a full establishment of nursing staff at the time of inspection.
- During our inspection, we observed the number of cots and the staffing levels. We found that staffing levels were consistently at 85% of the current recommendations.
- The transitional unit was staffed on a rotational basis from the neonatal unit. They provided a neonatal nurse and advanced neonatal nurse practitioner on each shift, to provide nursing and medical cover.
- Staff we spoke with told us the unit was very busy and extra staff would make things better. We were told that often the co-ordinator would take a clinical role, rather than being supernumerary, if there were staff shortages.
- The unit had a pathway for capacity management; this detailed how to escalate concerns if the minimum number of staff were not available for a shift.
- Nurse handovers occurred twice a day at each shift change over. Handovers occurred at the bedside between the nurses caring for the baby and parents were allowed to remain during handover. The information was clear and concise identifying the care given to the baby, what care was required, and the involvement of parents. If there was information that needed to be shared that needed to remain confidential, for example safeguarding concerns, then the staff would share this information outside of the room.

Medical staffing

- The unit had 24-hour medical cover, seven days a week.
- There were eight whole time equivalent neonatal consultants at the time of inspection, and there had been recruitment of a further consultant, to meet consultant cover requirements.

Services for children and young people

- There was consultant cover on the unit seven days per week during the day. The consultant covering the night shift would attend the medical handover at 8.30pm, and the following ward round. They would be available until late night then accessible via on call.
- The unit had eight paediatric registrars. Four registrars covered the unit 8.30am-5pm. Two registrars were on duty between 5pm-9pm and one registrar overnight.
- There were also junior doctors on the unit to support the registrars over the 24 hour period.
- We were told by the junior doctor that they often covered the locum shifts as overtime. Data provided showed that locum use on the unit was 0.4% between April 2014 and March 2015.
- Medical staffing of middle grade doctors (registrars) in neonatology/paediatrics was on the trust wide risk register. This risk was mitigated by including the five advanced neonatal nurse practitioners on the medical rota to ensure there was sufficient medical cover.
- We observed a medical handover. The staff used an electronically produced handover sheet generated from information entered onto the BadgerNet system. BadgerNet is an national electronic reporting system where perinatal patient data is collected and reported on in national audits.

Major incident awareness and training

- Major incident and business continuity planning was in place as part of the wider trust's continuity planning.
- There was an adverse weather plan for the service.

Are services for children and young people effective?

Good

We rated effective as good. We found:

- Staff on the unit had easy access to up to date policies and links to NICE guidelines on the trust intranet. There was also access to Neonatal Network Guidelines. The unit provided data to national databases which measured outcomes. We saw evidence that the unit responded to data by changing practice to improve outcomes.
- The unit had embedded kangaroo care, a way of caring for low birth weight and premature babies outside of an incubator, into their practice to promote outcomes for premature babies and their families.
- The unit had two clinical educators. They supported a programme of simulation training to improve practice and also developed competency frameworks for staff. There was evidence of good multi-disciplinary working.

However:

- Some patient outcome measures in National Neonatal Audit Programme (NNAP) were below national standards.
- Nursing staff on the unit who had a qualification in speciality (QIS) in neonatal care, was below the recommended standard.

Evidence-based care and treatment

- Neonatal policies were accessible on the intranet. The policies we saw were up to date, the information was accessible to staff and there were links to NICE guidelines. However, the unit also had hard copies of the policies and these were not the most up to date versions. This meant there was a risk that procedures may not be carried out in line with current practice.
- Staff had access to Embrace procedures and Neonatal Network Guidelines on the trust intranet.
- We did not see care bundles in use. These are pathways of nursing care, that are evidenced based, and provide staff with guidance. Care bundles ensure care delivered is best practice and consistent.
- The unit was working towards accreditation with UNICEF Baby Friendly Initiative, and we saw a culture of promoting breast-feeding in the care families received. UNICEF Baby Friendly Initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast-feeding and promote parent/infant relationships.
- The unit actively promoted kangaroo care, which is a way of caring for low birth weight and premature babies outside of an incubator. The parents have skin to skin contact with their baby to help maintain the babies' temperature and it also promotes bonding between babies and parents.
- The unit was undertaking a research project to promote family centred care, some of the nursing staff had contributed to the project.

Services for children and young people

Pain relief

- We observed pain scores were being monitored and recorded on observation charts. A pain assessment tool was used.
- The unit had implemented developmental care. This was a way of providing care in a way that promoted a baby's comfort.

Nutrition and hydration

- The unit had a full time dietician. They assessed babies' nutritional needs and provided plans for feeding regimes to promote babies' growth.
- Fluid balance records were completed accurately for babies who required monitoring.
- Breast-feeding was encouraged on the unit and breast pumps were available. There was a facility for the storage of breast milk. The bottles containing breast milk were clearly labelled and dated.
- The unit was part of the regional bank for donor breast milk distribution.

Patient outcomes

- Senior staff told us that actions had been taken to improve the standards following data from the National Neonatal Audit Programme (NNAP) in 2013. At that time the unit to be meeting only one out of the four standards for neonatal care.
- NNAP data for 2014, showed the unit achieved 96% against the standard for babies requiring screening for retinopathy of prematurity (ROP). This was not meeting the national target (100%) and was below the England average (97%).
- According to NNAP (2014) data, documented consultation within 24 hours of admission for the unit was 90%. This did not meet the national standard of 100%, but was above the England average of 89%
- The trust had a Neonatal Intensive Care Unit (NCC) service speciality dashboard. The unit performed worse than the England average in its rates of blood stream infections. We were provided with evidence that the unit had implemented simulation training to reduce infection rates from long line catheters. We had no further data or audit information as to the impact of this on infection rates.
- The unit performed above the England average for babies receiving neonatal care with a low temperature.

Competent staff

- The unit had two clinical educators. Their role was to manage preceptorship and support staff to complete competency frameworks. The competency frameworks helped staff develop the skills needed to care for babies on a neonatal unit.
- The clinical educators also developed and ran simulation teaching sessions, which took place weekly on the unit. These sessions helped staff to update their skills and knowledge.
- Staff we spoke with said they were supported to develop their skills and knowledge and had access to appropriate training. We were told 60% of nursing staff on the unit had a qualification in speciality (QIS) in neonatal care. Department of Health (2009) recommend a minimum of 70% of staff are speciality trained.
- There were five members of staff who had advanced their skills in neonatal care to the level of advanced neonatal nurse practitioner (ANNP) and they were able to support medical staff.
- All of the nursing staff we spoke with told us they had received an appraisal within the last year and all of the medical staff were undertaking revalidation processes.
- The medical staff provided positive feedback about clinical support and training on the unit.

Multidisciplinary working

- Staff we spoke with gave positive examples of multidisciplinary working. We saw paediatricians and nursing teams, along with other allied healthcare professionals (dieticians, physiotherapists and speech and language therapists) working together.
- We attended a multi-disciplinary meeting during our inspection. The meeting was well attended by a range of professionals, including the neonatal outreach team and link staff to community services.
- The meeting was focussed on discharge planning and there were also discussions around safeguarding issues for babies. A member of the safeguarding team was present to support and share information.

Seven-day services

- Consultants provided 24 hour on call service seven days a week and staff reported they were available for ward rounds at the weekend.
- There was 24-hour support from pharmacy service and a 24-hour seven day service from diagnostics.

Access to information

Services for children and young people

- Staff told us they had access to information for each patient, which included medical and nursing records and results from any investigations.
- There was a process for informing GPs and health visitors of discharges. The unit had a link health visitor who attended the multi-disciplinary team meetings.

Consent

- We saw evidence of consent being asked from parents, for example, when giving blood transfusions.
- Families told us that they were informed of the risks of any planned procedures, as staff had explained these fully to them, before consent was given.

Are services for children and young people caring?

Good

We rated the caring as good. We found:

- All the staff we spoke with were passionate about their roles and dedicated to making sure babies had the best care possible.
- We observed staff explaining to families the care their child was receiving and the purpose of the equipment helping them to do this. This was done in a compassionate way allowing the families to ask questions to understand what was happening.
- Families we spoke with felt involved and well informed about the care of their child, and they had been involved in the decisions about care.

Compassionate care

- All the staff we spoke with were passionate about their roles and were dedicated to making sure babies had the best care possible.
- We observed staff providing care to babies in a sensitive way, talking to the babies in an appropriate way when delivering care. The nurses responded to crying babies, if parents were absent, quickly to comfort them.
- We observed staff to talk with families, who were visiting their babies on a regular basis to ensure their needs were met and to provide reassurance. We saw an example of a nurse helping a parent give their baby kangaroo care. The nurse was reassuring the parent and being positive to help them gain confidence in handling their premature baby.
- We saw friends and family test comment cards at the nurses desk on the unit, however there was no data provided about any feedback received.

Understanding and involvement of patients and those close to them

- We observed staff explaining to families the care their child was receiving and the purpose of the equipment helping them to do this. This was done in a compassionate way allowing the families to ask questions to understand what was happening.
- Families we spoke with felt involved and well informed about the care of their child, and they had been involved in the decisions about care. Parents were supported by staff in the initial days on the unit as to how to handle their babies confidently, when the babies were supported by medical equipment.
- The unit promoted family-centred care by involving families in care and providing to facilities to allow families to spend as much time as possible at the unit with their babies.

Emotional support

- The NNU was supported by a BLISS volunteer. BLISS was a UK charity of peer support workers who supported parents of premature babies.
- We were told that the unit were hoping to re-establish funding for a psychologist, as this was a valued support for both parents and staff.
- The unit had links to the local children's hospice and could make quick referrals to the service as necessary, depending on families' wishes.
- The BLISS volunteer also provided bereavement support. The unit had a family room to support parents with terminally ill babies. There was support from the chaplaincy team.
- We saw information leaflets and contact details for support organisations on the unit.

Are services for children and young people responsive?

Services for children and young people

Good

We rated responsive as good. We found:

- The unit worked in a family centred way, to promote confidence of parents in caring for their baby. This helped facilitate the unit's strategy of early discharge, with the support of the neonatal outreach team and the rapid access clinic.
- The unit had facilities for parents. This allowed families who travelled long distances to spend more time with their baby and be involved in their care.
- The unit had access to face to face translation services.
- The service had a good working relationship with Sheffield Children's Hospital to promote effective transition of care from children's services to the adult services at Sheffield Teaching Hospital.

Service planning and delivery to meet the needs of local people

- The unit worked towards a plan of early discharge for babies. The team was supported by a neonatal outreach team so that families could be discharged home whilst their baby was still naso-gastric tube fed. The neonatal team supported the family at home, following discharge, for up to six weeks.
- The advanced neonatal nurse practitioners ran a rapid access clinic seven days per week, 9am-7pm. The purpose of the clinic was to provide clinical assessment for babies discharged from either the neonatal unit or transitional care. Families could access the clinic if they had concerns about their baby, for example, feeding, weight or jaundice. This service prevented readmission to the unit.

Access and flow

- There were 50 beds across the service. The cots were used flexibly to meet the needs of babies admitted onto the unit, for example, on one occasion during inspection there were 30 babies receiving special care. At times, the neonatal unit had up to 48 babies on the unit. When twins were admitted they were cared for in one cot, so there were times when there was eight babies in one room receiving special care.
- The unit communicated well with the maternity unit and knew well in advance when a cot was required; allowing time to arrange discharges and transfers.
- We observed an admission of a premature baby to the unit; it was well-organised and professional.
- The unit held weekly multi-disciplinary team meetings to facilitate early discharge. However, median length of stay for babies under one year was higher than the national average.

Meeting people's individual needs

- We observed staff involved patients and relatives when delivering care and worked in a way which was family centred.
- The unit allowed 24 hour visiting to meet the needs of parents.
- The unit had six rooms which were specifically used for parents to stay overnight and care for their babies in preparation for their discharge home. This was to ensure parents had the confidence to care for their babies when at home. The unit had plans to develop off site accommodation for parents, to develop its family centred care approach.
- The trust had a policy to support the transition of care for children with long term conditions. The policy provided a plan of care to support the change from a child receiving care at Sheffield Children's Hospital, to receiving care from adult services at the trust.
- The staff had access to face to face translation services and they told us this service was easily accessible. Occasionally they used a telephone translation service, for example, if a parent needed urgent information about the care of their baby.
- We observed a range of information leaflets across the service.

Learning from complaints and concerns

- There had been no formal complaints about the service.
- We were told that there were informal complaints from families, and these were usually about basic care, such as feeding and nappy changing, when staff had done these before parents arrived.
- Staff told us they planned care around parents' visiting times, whenever possible.

Are services for children and young people well-led?

Services for children and young people

Good

We rated well-led as good. We found:

- Staff working at the trust were aware of the trust's values; there was a strategy to promote staff engagement.
- There was a supportive culture, with open door access to senior management.
- Staff participated in the research activity of the unit.
- A clinical governance coordinator dealt with incidents for the neonatal unit, and lessons learnt from incidents were cascaded to staff by email.

However:

- Audit outcomes demonstrated areas for quality improvement. Implemented action plans had not been fully effective.

Vision and strategy for this service

- The trust's children and young people's strategy was embedded in a policy related to supporting Sheffield Children's Hospital in the care of children and young people of Sheffield.
- The trust had 'PROUD' values: patients first, respectful, ownership, unity, deliver, which were embedded in staff appraisals, and all the staff we spoke with referred to them.
- The chief nurse was the representative for children services on the executive board. The role of this executive was to embed the voice of children in trust strategy and vision to ensure their rights and views were promoted.

Governance, risk management and quality measurement

- The unit had one risk recorded on the divisional risk register. It was related to the neonatal formulary update where errors had been highlighted. It reported a need for peer review and ratification of the document. A review date of August 2015 was documented, however it was not clear if this was completed and the mitigating actions in the interim.
- The divisional and trust-wide risk registers included issues raised during the inspection, for example, nurse staffing and medicines management. We were provided with data on the audit programme of the unit. The unit undertook a total of 21 audits. They contributed to national audit programmes, such as NNAP and NCEPOD, and there were also audits at unit level.
- Data from the national audits demonstrated that there were areas for quality improvement to meet national standards. For example, the number of babies with a ROP screening was still not meeting national standards despite the unit implementing an action plan for improvement.
- There was a clear management structure for the unit, which was overseen by a care group. This was the higher management structure responsible for the operation and governance of the unit.
- A clinical governance coordinator dealt with incidents for the neonatal unit, and lessons learnt from incidents were cascaded to staff by email.
- The neonatal unit reported to the obstetric, gynaecology and neonatology directorate governance group on risks, incidents, audits, complaints and strategy up dates.
- The unit provided data to BadgerNet, a neonatal network reporting system. This contributed to the North Trent Neonatal Network analysis of neonatal services across the region.
- The trust had a children and young people's services group who met on a quarterly basis. This group consisted of senior managers, who reported on the care and safeguarding of children who received care at the trust.

Leadership of service

- The neonatal unit was overseen by the nurse director /head of midwifery. It was managed by a clinical lead and a band 8 matron. The transitional unit and rapid access clinic was also supported by a nurse consultant.
- There were clear lines of leadership across the unit. Each shift had two band seven shift co-ordinators who managed the unit, and were supernumerary to the nursing staff numbers. This allowed them to provide clinical and leadership support to the nursing staff and they were the first line of contact when staff had concerns. However, when staffing numbers were low these staff took on a clinical role.

- Staff told us that there was good support from the co-ordinators, and that they felt the matron was visible. The matron told us there was an open door policy for staff to access support from higher management.
- All grades of nursing staff were encouraged to participate in the research projects on the unit.

Culture within the service

- Staff we spoke with told us they enjoyed working at the trust. Most of the senior staff had worked at the trust for several years. Staff told us there was a supportive team culture and they said they were happy to raise issues with management.

Public and staff engagement

- The unit has a plan to reconfigure the neonatal unit to provide more space for cots. We were told that the unit engaged BLISS in the planning of the unit. BLISS were used as a way to access public engagement. The BLISS worker presented ideas for the change to service users, through a parent group called Little Miracles. This was a group of parents and children who had experienced neonatal care in Sheffield.
- The trust had a staff engagement action plan. Staff told us they had been involved in the initial consultations about the reconfiguration of the neonatal unit. Staff were also encouraged to participate in the research activity on the unit.

Innovation, improvement and sustainability

- The neonatal unit was part of an action research project which was looking at ways to improve family centred care.
- The unit had embedded kangaroo care onto the unit to promote baby's development and attachment with parents.
- The unit ran a rapid access clinic seven days a week to facilitate safe early discharge of babies.

End of life care

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It is delivered by a multidisciplinary team and includes aspects of essential nursing care, medical and therapy interventions specialist palliative care, bereavement support and mortuary services. All these services were involved in end of life care at Royal Hallamshire Hospital.In 2014 to 2015 there were 317 end of life care patients who died at Royal Hallamshire hospital. The number of end of life care deaths in hospital increased during 2014- 2015 by 14% from the year before. At the same time there had been an increase in referrals to the specialist palliative care team. The increase in referrals could account for the increase in the number of deaths under the care of the end of life service.

The specialist palliative care team had both a clinical and educational role and worked seven days a week. It comprised 4.6 whole time equivalent (WTE) consultants and 6 WTE specialist registrars, 8.6 WTE Clinical Nurse Specialists (plus 1 WTE vacancy) and 1.6 WTE end of life care facilitators. The specialist palliative care team (SPCT) were based at Royal Hallamshire hospital and also the Northern General site. Specialist palliative care is the total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training.

There was a chaplaincy service, a chapel and a Muslim prayer room on site. There were a limited number of family rooms available on the hospital site, where overnight accommodation for relatives could be provided. There was a mortuary and viewing area. Porters took deceased patients from the hospital wards to the mortuary. Out of hours access to the mortuary was arranged by duty matrons. There was a bereavement office where relatives collected death certificates and were given information.

As part of our inspection, we specifically observed end of life care and treatment on wards and other clinical areas. We looked at 12 sets of patient care records, including medical notes, nursing notes and medicine charts. We visited the bereavement service, chapel and prayer room, mortuary, and general wards. We spoke with 22 staff including ward nurses, the patient's bereavement officer, the mortuary team, doctors, chaplains, the SPCT, pharmacists, transfer of care nurses, allied health professionals, resuscitation officers and senior managers.

End of life care

Summary of findings

We found do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always made in line with national guidance and legislation, for example the Human Rights Act (1998) and the Equality Act (2010).

The Deprivation of Liberty Safeguards (DoLS) policy expired in October 2013. The flowchart to guide staff in DoLS decisions was also out of date.

The trust did not monitor if patient choice around preferred place of care or death was met.

The chapel was noisy, however easily accessible and the Muslim prayer room was poorly signed.

There was no internal strategy in place for end of life care at the trust; We could not ascertain how progress towards achieving the five year plans leading up to 2017 was measured.

In response to the 2013 review of the Liverpool Care Pathway, the trust withdrew the pathway and trained staff in the 'five priorities of care' as described in national guidance. Local guidance was not introduced until October 2015.

However, we also found patients received safe care and treatment, which met their needs. The trust wide specialist palliative care team of nurses and doctors were skilled and knowledgeable. In the year from April 2014 – 2015, over 97% patients were seen within 24 hours of referral to the specialist palliative care team. There was seven day cover from the team. There was evidence of compassionate and understanding care on all the wards at the hospital.

Are end of life care services safe?

Good

We rated safe for end of life care as good. We found;

- Appropriate action was taken if an incident happened. Staff learned from previous incidents.
- Infection prevention and control measures were in place and audit results were good
- There was a well-staffed specialist palliative care team which provided seven-day cover.

However, we also found;

- Compliance with mandatory training for the specialist palliative care team was below the trust target.

Incidents

- Staff were aware of how to report incidents using the electronic incident reporting system and how to escalate incidents to senior staff.
- There had not been any serious incidents related to end of life care in the 12 months prior to our inspection.
- Incidents reported on the hospital IT system went automatically to senior leaders for attention and investigation.

Duty of Candour

- Duty of Candour is a legal duty on NHS trusts to inform and apologise to patients if there had been mistakes in their care which led to moderate or significant harm
- Staff spoke to us about their understanding of duty of candour and talking to patients if an incident or mistake had occurred. They were aware of the need to be open and honest. Staff told us duty of candour was dealt with at matron level or above.

Cleanliness, infection control and hygiene

- There was a trust wide infection prevention and control policy related to the care of deceased patients. This provided clear guidance for staff.
- We saw that staff used personal protective equipment and were bare below the elbows. There was access to hand-washing facilities.

End of life care

- It was trust policy that all deceased patients were placed in a sealed body bag before being taken to the mortuary. Mortuary staff told us this meant nurses did not have to risk assess infection risk on the ward after someone died.
- Areas inside the mortuary fridges were deep cleaned twice a year as recommended by the Human Tissue Authority.
- We were shown results of a mortuary cleaning audit from August and September 2015. In August 97.8% was achieved, in September this improved to 98.9%.

Environment and equipment

- McKinley syringe pumps were in use on the wards. Staff told us these were obtained for use from the medical device library and there were no delays in obtaining them when needed. The site manager would obtain them for ward staff outside of standard working hours. The syringe pumps were maintained by clinical engineering staff.
- We were shown trust-wide maintenance schedules which indicated 89% of pumps were maintained within one month of the due date. This was against a target of 90% for high priority equipment such as syringe pumps.
- There was a side room known as the 'dying with dignity' room on the haematology ward. This was a large room with ensuite facilities. There was a portable bed and kitchen facilities for families who wished to stay. The room had been funded by the family of a former patient and the hospital charity.
- There was a security system at entry to the mortuary and closed circuit television was in use in all areas. This meant video records could be used if there were any concerns in the mortuary areas.
- The fridge doors were linked to an alarm system. The temperature recording system was calibrated so in the event of a fault or temperature dropped an alarm sounded both in the mortuary and on the main switchboard; the estates team would then respond.
- Staff told us when the lift recently had been out of order for three weeks they used a lift designated for the medical school.
- The fridge doors were linked to an alarm system. The temperature recording system was calibrated so in the event of a fault or temperature dropped an alarm sounded both in the mortuary and on the main switchboard; the estates team would then respond.
- There was a bone bank where bone samples were kept in a separate refrigerated area.
- The mortuary had passed routine inspections carried out by the Health and Safety Executive and the Human Tissue Authority in 2014.
- There was capacity for 48 deceased patients in the mortuary fridges. There was room for four deceased bariatric patients.
- There was a trip hazard on the entry to the viewing gallery. A door opened directly onto some steps to the side, there was no warning sign to indicate this.

Medicines

- The specialist palliative care team gave advice on medication to ward doctors and nurses. There was 'Guidance for Medicines Management of Hospital Patients in the Last Few Days of Life'. This was part of the document 'Guidance for the care of the person who may be in the last hours to days of life'.
- Where appropriate, current medication was assessed and non-essential medication discontinued. Patients were prescribed anticipatory medications. The aim of anticipatory prescribing is to ensure in the last hours or days of life there was no delay in responding to a patient's symptoms.
- The trust had a multiagency palliative care formulary in place.
- On ward Q1, the stroke ward we saw medication for patients at end of life had been adjusted so they were only taking what was necessary.

Records

- An electronic records system had been recently introduced at the trust. Staff told us there had been some setbacks in its use which senior managers were aware of.
- There were both paper and electronic records in use across most areas of the hospital. We saw that paper records were stored securely, and the electronic boards on display were used in a way to maintain confidentiality.
- We saw notes for end of life care patients on the stroke ward. They gave detailed comprehensive information about the patient's condition and the medical plan of care.
- We saw in records on ward Q2, that the specialist palliative care nurses put a sticker in the patient records.

The sticker included the nurses telephone number, a record of what had been discussed with the patient and the plan. We found this would help communication with ward teams.
- A Sheffield palliative care coordinating system project (SPaCCS) had been developed and was being piloted.

Mandatory training

- An electronic system was in use to monitor and manage mandatory training. Information was transferred from electronic staff records into the Personal Achievement and Learning Management System (PALMS).
- There were training leads and administrators who kept records up to date.
- There was variability in trust wide compliance with aspects of mandatory training for porters, the overall compliance was over 93% which was above the trust target of 90%
- The specialist palliative care team had variable compliance with mandatory training. Of the 12 topics included in mandatory training, two had been achieved to be near or above the trust target. Overall compliance was 79%.

Assessing and responding to patient risk

- We saw risk assessments completed in medical and nursing records. These were commenced on admission and there was evidence that risk assessment continued throughout the patients stay in hospital. Examples of this included skin assessments for pressure ulcer risk.
- An early warning tool, SHEWS (Sheffield hospitals early warning score) was used to monitor for patient deterioration. This was a scoring system in which a score was allocated to physical measurements such as blood pressure and respiratory rate.
- We saw a large red sticker had been used in one patient's notes to indicate they were a deteriorating patient. This meant it was highlighted to staff looking in the records and acts as an aide memoire of what to do and document in such an eventuality.
- Clinical nursing guidelines had been developed for end of life patients. Once it was decided someone was nearing the end of life and had increased needs, nurses could refer to the guidelines on the intranet. This process however, was reliant on the individual nurses skills and experience; there were no 'triggers' or formal pathway to support the decision making.

Nursing staffing

- The specialist palliative care team had a clinical and educational role and the clinical nurse specialists worked seven days a week. There were 8.6 WTE (whole time equivalent) clinical nurse specialists (including one WTE vacancy). A new team member was due to start working with the team in January 2016.
- The team had moved to seven day working without an increase in staffing. This meant the number of staff on during the week was reduced in order to cover weekends.
- There were a minimum of two staff at Royal Hallamshire on weekdays and one on a weekend.
- They covered three hospitals at the trust. The teams were based on the Macmillan palliative care unit at the Northern general hospital site and at the Royal Hallamshire hospital.
- There was funding for 1.6 WTE end of life care facilitators who worked across the trust and also provided training support to community nurses and care home staff. One permanent staff member worked two days a week and another was seconded into a three day post. There were 73 end life care 'champions' or nominated link nurses across the trust. We could not decipher how many of these were at the Royal Hallamshire site. Their role was to raise awareness of good end of life care and to promote best practice on the wards.
- There were five mortuary staff who worked across the trust. They included a mortuary manager, a senior technician, two technicians and an assistant technician.
- There was a team of porters who worked across the trust. They were responsible for handling deceased patients and transferring them to the hospital mortuary via the ambulance or concealment trolley.

Medical staffing

- The palliative care doctors comprised of 4.6 WTE consultants and 6 WTE specialist registrars. They covered all areas of the trust. Information from the trust indicated there was a low vacancy rate of 0.2 WTE (less than 1%).
- The medical staffing levels were in line with the minimum requirement for the local population (Commissioning Guidance, National Council for Palliative Care 2012)

End of life care

- Junior doctors told us they felt supported and the consultants were very 'hands on'. The on call rota could be busy for junior doctors, however consultants filled the gaps. This meant there was less need for temporary doctors.
- There was low usage (2.2%) of locum or temporary doctors from April 2014 to January 2015. This means there was continuity of medical cover which helped to keep patients safe.
- The core working hours of the palliative care doctors was 9am- 5pm Monday to

Friday. Some consultants finished at 6 pm on certain week days.

- There was 24 hour cover from a palliative care consultant and registrar on an on –call basis. The on call duties included face to face medical care and telephone advice.
- The senior medical staff on call provided cover to wards in the trust, the local hospice and another hospice in Chesterfield.
- Senior doctors also supported some primary care (GP) and community services across Sheffield when specialist advice was needed.

Major incident awareness and training

- The mortuary staff were part of the South Yorkshire response plan for major incidents. There were detailed plans and partnership agreements with other hospital mortuaries in the event of a major incident with 100- 200 fatalities.
- In such an event the temperature in the general mortuary area could be altered to create further storage space for the deceased.

Are end of life care services effective?

Requires improvement

We rated effectiveness of end of life care services as requires improvement because:

- There was variable compliance with national standards for completion of DNACPR forms (do not attempt cardiopulmonary resuscitation).
- There was no individualised care plan to help staff identify and care for end of life patients. Standardised nursing care guidelines were available as a reference tool and staff could print these to use as a guide. However, there was no way to ensure all the relevant guidelines were followed and acted upon.
- The Deprivation of Liberty Safeguards (DoLS) policy was overdue a review from October 2013. The flowchart to guide staff in DoLS decisions was also out of date.
- The results from the National Care of the Dying Audit (2014) showed five out of seven organisational key performance indicators and six out of ten clinical key performance indicators were not achieved. The trust had taken action against the results of the audit and had participated in the 2015 audit.

However, we also found:

- Patients' care and treatment was planned in line with current evidence based guidance, standards and best practice legislation.
- The trust had taken action against the results of the National care of the dying audit for hospitals (2014) to improve the delivery of end of life care.
- The number of referrals to the specialist palliative care team increased from 2014 to 2015. The number of non-cancer patients seen by the team had also increased. This meant the team had worked with other services to reach patients with other conditions.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Pain relief for end of life patients was a priority and records demonstrated this.
- Staff worked well together to understand and meet the range of people's needs.

Evidence-based care and treatment

- In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance for staff. The pilot document 'Guidance for the care of the person who may be in the last hours to days of life' was based on up to date evidence and national guidelines. These included guidance from;
- the Leadership Alliance for the Care of Dying People (2014),
- More Care, Less Pathway: An Independent Review of the Liverpool Care Pathway (2013)

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- Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK, Public Health England (2013)
- The guidance was intended to ensure patients were appropriately assessed and supported with their end of life needs and included flowcharts and management plans. There was no tool or pathway for staff to complete.
- The guidance had recently been issued in (October 2015), so its effectiveness had not been measured. It was too early to say if this would impact on effective care and treatment.
- When it was decided a patient was for end of life care, nurses could refer to nursing care guidelines on the intranet. This meant they could follow procedures of what nursing action to take.

Nutrition and hydration

- We saw special diets and food supplements were noted on white boards in ward kitchens, so support staff could ensure patients had prescribed supplements.
- There were nursing care guidelines on the intranet related to nutrition and hydration so nurses could follow these. We saw three sets of notes included information about nutrition assessments.

Pain relief

- Symptom management guidance, including pain relief, had been produced by the specialist palliative care team. This was available on the trust intranet and within the 'guidance for the care of the person who may be in the last hours to days of life'.
- There were key prescribing points for staff to follow related to pain relief and to ensure medicines were available when the patient needed them.
- We saw records which showed severity of pain, site and type of pain were recorded, and that pain relief was offered.
- We checked pain charts on surgical wards; they were all appropriately completed.
- We did not see that the effectiveness of pain relief had been audited.

Patient outcomes

- The results from the National Care of the Dying Audit (2014) showed two out of seven organisational (KPIs) were achieved; these included access to specialist support for care in the last hours or days of life and clinical protocols for the prescription of medications at the end of life. Five out of seven were not achieved; these were access to information related to death or dying; care of the dying education, training and audit; trust board representation and planning; protocols to promote dignity and respect; formal feedback processes for bereaved relatives or friends.
- In the 2015 National Care of the Dying Audit, the categories changed however just three out of eight organisational quality indicators were achieved. This meant there had not been significant organisational improvement.
- For clinical KPIs, the hospital did not achieve six out of 10 indicators in the2014 audit. These included recognition the person was dying, communication regarding the plan of care, and a review of food and drink requirements. Four clinical indicators were better than the England average. These included medication prescribed for when it might be needed; a review of the number of necessary assessments in someone's last 24 hours of life; a review of care after death.
- In response to the performance results of the National Care of the Dying Audit, a project team developed an action plan with 10 recommendations. These included plans for a seven day face to face specialist palliative care service, an annual audit of care of the dying and the development of nursing guidance. These had all been completed by May 2015.
- The hospital results for multidisciplinary recognition that the patient was dying were much lower than national average of 59%, at 40%. In response to this, a communication framework was developed for initial and on-going discussion.
- There was one action which had not been achieved. This was education and training in care of the dying for all staff that care for those patients. A training needs analysis was undertaken and discussed with the strategy group. The trust action plan showed further funding was obtained and a training plan was in development.
- The more recent results in the 2015 national care of the dying audit were not directly comparable; however they showed the trust achieved just two out of five clinical outcomes. They were significantly worse (30% compared to 66% nationally) for the percentage of patients in the last 24 hours of life having an individual

plan of care and holistic assessment of the patient's needs. There were better than average results (74% compared to 56% nationally) for documented evidence for the needs of the person important to the patient being asked about.
- There was a plan for 2016 to collect and monitor information about patient outcomes. Topics included a service review of the use of ketamine in palliative medicine, a review of complaints and looking at why patients known to the palliative care service attend accident and emergency.
- The trust was developing an electronic system, a 'clinical information portal'. The aim was to link this to another electronic method, so that end of life patients could be identified if they were admitted to hospital. These meant the specialist palliative care team could be informed about their admission and see the patient quickly.

Competent staff

- We saw that the porters had the right skills and experience when dealing with end of life or deceased patients.
- A small number of porters had extra training to handle deceased patients and drive the ambulance used in their transfers to the mortuary.
- Mortuary staff were experienced in support of bereaved families.
- Mortuary staff had been trained to assist with post mortem examinations; however most post mortems now took place at other facilities, which were not part of the hospital.
- The end of life care facilitator was responsible for the training plan for different staff groups in the trust. They showed us the training schedule for 2016/ 2017. The programme included training for staff about care of the dying and the five priorities for care.
- There was a plan to teach staff on a diabetes ward about advanced care planning and asking patients about their preferred place of care.
- End of life care training was given to apprentice staff and support workers in order to develop their skills in giving essential care.
- 'SAGE & THYME' ® training was part of the 2016 plan. A number of STH staff including consultants had been involved in delivering this training to staff for the last two years.
- (The SAGE & THYME ® model was developed by South Manchester NHS Foundation Trust. Its purpose was an aide-mémoire to train all grades of staff on how to listen and respond to patients or carers who were distressed or concerned).
- The specialist palliative care team of nurses and doctors were skilled and knowledgeable. They were experienced in providing support and training to other staff. Most of the team had worked at the trust for several years and they were an established team who had a good reputation throughout the trust.
- All of the nurses were non-medical prescribers. This meant they were trained to prescribe certain medicines for end of life patients.
- They told us further education and degree courses they had undertaken was paid for by Macmillan.
- The specialist nurses started as a band 6 when they joined the team and progressed to a band 7 senior post once they had fulfilled competencies.
- The specialist palliative care nurses had group supervision with a psychologist. This meant they were able to reflect on and review their practice. They could identify training and development needs.
- The nurses had other roles which supported the learning in the team. For example, one specialist nurse was the 'link' for governance (the system in the NHS which looks at improving services).
- The specialist palliative care registrars met for half a day each week for education and training.
- There were 73 care champions across the trust. They had an interest in improving care and support for people at the end of their life. They attended 'champions days' each year in order to share idea and learn from each other.

Multidisciplinary working

- We saw positive internal multidisciplinary team (MDT) working between all staff we came across. This included including ward nurses and doctors, the specialist palliative care team, therapy staff, the bereavement officers, mortuary staff, pharmacists, porters and chaplains. Volunteer staff worked with professionals for the benefit of patients.
- The 'transfer of care' nurses worked with ward nurses when arranging discharge or transfer from hospital.
- Staff told us of external MDT working with the 'Intensive nursing at home' team and community staff who were involved in end of life care.

End of life care

- The palliative care consultants were part of the NHS Sheffield end of life care planning and commissioning network and worked together with hospice staff for the benefit of patients.
- There was no use of a standard EPaCCS (electronic palliative care co-ordination system). This is a tool to allow professionals to share information about a person's care preferences across different organisations. A Sheffield Palliative Care Coordination System (SPaCCS) which was in development and being led by the local hospice; when implemented, this would enable MDT working across organisations.
- This was developed as a result of an end of life communication audit (January to July 2014). The trust found a poor record of communication of relevant information to primary care (GPs) and a "Failure of patient care pathways to connect" to each other
- There are significantly higher cancer death rates in Sheffield than the England average. There are also significantly higher hospital death rates and lower care home and home death rate than England average (End of life care intelligence July 2015).
- . This meant more cancer patients died in hospital so it was very important for hospital teams to work together with community teams when passing on information about patients. This was being addressed by the Trust.

Seven-day services

- The clinical nurse specialists in the palliative care team worked across seven days a week from 9am – 5pm.
- One of the team preferred to work weekends and so worked alternate weekends in agreement with the team and their manager. The other nurses worked one weekend out of four.
- There was a consultant and specialist registrar available 24 hours a day. They were based on the Macmillan unit at the Northern General hospital. They worked from a rota to cover out of hours.
- Junior doctors worked from 9am – 3pm on weekends and 9am – 5pm on bank holidays.
- Mortuary staff provided 24 hour, year round cover. The manager told us they were on call on a year round basis. They had been contacted several times for advice while on holiday. Out of hours, the duty manager would meet bereaved families at hospital reception and accompany them to the mortuary.

Access to information

- There were different IT (Information technology) systems in use in different areas. Not all teams of staff could access information added by other teams. This meant that all the information needed for patient care could not always be shared in a timely way.
- Staff told us they copied information from SystmOne, (another electronic process) onto Info-flex. Info-flex could be viewed by hospice staff, community palliative care team, GPs, out of hours GPs and district nurses. However, they could not enter information onto the system.
- Complex case managers (who were involved with hospital discharge of patients with complex needs) used SystmOne, which could be viewed by GPs and community out of hour's teams.
- Information from a system known as ICE (Integrated clinical environment) was used to write discharge information onto an electronic letter in the 'e- discharge' system. This was sent to GPs and printed out to give to community nurses when patients were discharged. This meant information about end of life care needs was passed to community teams.
- Specialist palliative care consultants also used dictaphones in addition to writing in patient notes. This recorded information was typed by admin staff and sent to GPs.
- There was no use of a standard EPaCCS (electronic palliative care co-ordination system). This is a tool to allow professionals to share information about a person's care preferences across different organisations. A Sheffield Palliative Care Coordination System (SPaCCS) which was in development and being led by the local hospice; when implemented, this would enable MDT working across organisations.
- A further electronic system 'Lorenzo' had been implemented shortly before our inspection. There was a period of transition, so both paper and electronic records were in use. Four staff told us this meant it took them much longer to record patient information in two places.
- Information from the trust showed work was being done to resolve these problems.
- Wards used printed patient handover sheets as a reference tool to help them deliver care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

End of life care

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care.
- We saw good practice on ward Q2 that an IMCA (independent mental capacity advocate) had been consulted about the care of an end of life patient. The patient did not have capacity to participate in decisions about their treatment and they did not have family or friends.
- We looked at 15 DNACPR forms; nine of them (60%) were either incomplete or gave us concern.
- For example, on ward Q1, one DNACPR form had no patient address, only the relative's first name and no contact number for the family. On ward Q2, one form had no patient address, and no contact details for the family.
- On ward P3, two forms were filed near to the middle of the medical notes. These could be difficult to find in an emergency situation.
- One of the forms on P3 was for a patient with significant hearing loss. The resuscitation decision had not been discussed with them due to their deafness. We checked the notes but could not see that there had been a discussion with a family member. This meant there had been potential breaches of the Human Rights Act and discrimination under the Equality Act (2010).
- An audit of documentation and communication of DNACPR to GPs when the patient was discharged was carried out in 2014. This showed variable compliance with national standards. For example, there was 100% compliance for the initial decision of DNACPR being made by a doctor of F2 grade or above. However, only 68% of forms included the patient's full name, date of birth and address.
- We spoke with the Medical Director about DNACPR forms; they told us they were aware of issues related to a lack of countersignature by a consultant and a lack of documentation of capacity assessments. After our inspection, senior staff told us action was being taken to address this.
- The Deprivation of Liberty Safeguards (DoLS) policy had been due for review in October 2013. The flowchart to guide staff in DoLS decisions was also out of date. We checked the hospital intranet for 'pending' policies and the DoLS policy was not included.
- We spoke with senior nurses and the DoLS clinical lead about DoLS and capacity assessments. They told us a "pragmatic approach" was taken. They said in "high risk" cases, DoLS requests were sent to the local authority.

Are end of life care services caring?

Good

We found caring at end of life to be good. We saw;

- Evidence of compassionate and understanding care on all the wards at the hospital. Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- Patients were treated with kindness and respect.
- In 2014, the trust was in the top 20% of trusts in England for;
- Staff giving information about support groups and financial help
- Taking part in cancer research being discussed with the patient,
- Staff telling the patient who to contact if they were worried after discharge.
- When families went to the bereavement office they were met in a sympathetic and understating manner.

However, we also found;

- There was no set place to record the wishes and decisions of patients. The guidance contained a page which suggested an approach to spiritual care needs, such as asking about faith and the people who are important to the patient; however there was no set tool to record these.

Compassionate care

- We found evidence of compassionate, sensitive end of life care to patients at the hospital.
- We saw lot of thank you cards on several wards. There were messages from patients and family members which related to considerate respectful care.
- Porters told us they treated deceased patients as if they were a family member. They said this wasn't learned in training, it came out of respect for people.

- Bereavement office staff provided hot drinks for bereaved families while they were given the information they needed. The information included what official steps had to be taken after someone had died.
- Bereavement staff made appointments with the registrar so that families did not need to do this.
- Staff on wards told us how they ensured cultural and spiritual wishes of patients were met. Families were able to participate in preparing their loved one to go to the mortuary if they wished.

Understanding and involvement of patients and those close to them

- Two relatives told they had been kept up to date about their loved ones condition and given information in a way they could understand.
- One of the new nursing care guidelines for use at end of life was 'Care of the family and relevant others'.
- One of the new nursing care guidelines for use at end of life was 'Care of the family and relevant others'. There were guidelines within the 'guidance for the care of the person who may be in the last hours to days of life'. This included an overview of the conversation to have with the patient and relevant others when a patient was believed to be dying. The guidance suggested staff develop a care plan to include;
- What to expect as the patient neared the end of life
- What symptoms may occur
- The preferred place of death
- The needs of the family.
- There was no individualised or advanced care plan where the wishes and decisions of patients could be recorded. The SBAR draft guidance contained a page which suggested an approach to spiritual care needs such as asking about faith and the people who are important to the patient; however there was no set format or tool to record these.
- The specialist palliative care nurses told us they prompted patients and their families to think about advanced care planning. There was no tool to prompt ward nurses to do the same. This meant opportunities for patients to talk with staff about their wishes might be missed.
- The trust participated in the National Cancer Patient Experience Survey in 2014 (the 2015 results were not published at the time of our inspection). This was a national survey where the results are be used to make improvements in care.
- The trust was in the top 20% of trusts in England for;
  - Staff giving information about support groups and financial help
  - Taking part in cancer research being discussed with the patient,
  - Staff telling the patient who to contact if they were worried after discharge.
- The trust was in the bottom 20% of trusts in England for;
- Patients being given enough privacy when discussing their condition or treatment. (this result was the same as 2013)
- In Sheffield, 61% of families felt they were given enough information to provide care at home. This had fallen from 64% the year before. It was in line with the England average.
- We saw plans for 'Dying Matters' week 2016 where the public would be involved to participate as they had done in recent years. The National Council for Palliative Care set up the Dying Matters group to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.

Emotional support

- Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- Staff spoke of emotional support they would give to patients and those close to them.
- Spitiaual multi faith chaplaincy support was available 24 hours a day. In 2014, the chaplains carried out a patient satisfaction survey. 85% of the respondents said they had their spiritual needs met by the chaplains. The remainder said they did not have any spiritual needs or did not know about the service.
- A number of staff told us they could have counselling and debriefing if they wished.
- Bereavement office staff had carried out a survey to find out the views of families. The survey was carried out in March 2015. The results were variable; almost half of the respondents said they were given a choice of times to go to the bereavement office; that meant the other half

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were not. Results showed 99% of people were met in a sympathetic and understanding manner and 100% said they had just the right amount of time and were informed of what to do.

Are end of life care services responsive?

Good

We rated the responsiveness of end of life care services as good. We found;

- There was seven-day specialist palliative care clinical support to the hospital.
- During the twelve months from April 2014, 97.3% of patients were seen within 24 hours of referral to the specialist palliative care team.
- The number of referrals to the specialist palliative care team increased from 2014 to 2015.

However, we also found;

- The trust did not monitor whether patient choice around preferred place of care or death was met.
- Patients could wait up to a week to transfer to a bed on the palliative care unit at the Northern General hospital.
- There were delays in the fast track (rapid) discharge process.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team provided seven day clinical support to the hospital. All the clinical nurse specialists were non-medical prescribers. This meant they could prescribe medications for patients when they were needed.
- There was an 18 bed ward, the Macmillan palliative care unit (MCPU)) at the Northern General hospital site, specifically providing specialist level assessment, care and support for patients with unresolved complex needs and unstable symptoms designated for end of life care patients. Patients could be referred there for end on life care.
- If patients or families requested a side room, staff tried to accommodate their wishes. This was not always possible due to rooms being used for infection prevention and control.
- The chapel was located off a main corridor. It was accessible and well signed, however it was noisy as there were office doors which opened directly into the chapel environment.
- The Muslim prayer room was poorly signposted. It was located next to the theatre staff changing area. It was difficult to get in to the prayer room because of trolleys and laundry skips obstructing the area. It was a poor environment for prayer.
- The room next to the bereavement office where relatives were taken was very small and basic. It would have been difficult for someone in a wheel chair to use the room.
- The mortuary was for deceased patients from Royal Hallamshire hospital and Weston Park hospital. A dedicated ambulance was used to transfer deceased patients from Weston Park to Royal Hallamshire hospital.
- There was a team of eight chaplains who provided spiritual care for patients, relatives and staff. NHS Chaplaincy guidelines (2014) indicated there should be 13 chaplains for the size of the trust.
- There was a post mortem area and viewing gallery where students or other staff could observe post mortems, although most were now carried out off site.
- We visited the relatives viewing room in the mortuary. It was decorated to a basic standard.
- There was also a relative's waiting room with seating, tissues were provided and there was a nearby accessible toilet.
- There was free parking for families attending the bereavement office. (They were given a token from the ward).
- Services were commissioned (planned and bought) by Sheffield Clinical Commissioning Group (CCG). We saw the trust five year plans where it was noted that the introduction of a block contract for specialist palliative care ward visits since April 2012 had limited investment in the service.
- Since the withdrawal of the Liverpool Care Pathway (LCP), there was no way to measure if patient choice around preferred place of care or death was met. This meant because it was not identified, this information could not be used to improve or develop services.

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- Specialist palliative care nurses and doctors told us one reason for not recording preferred place of care was that patients changed their minds. We did not find this a strong enough reason not to ask or record those wishes.
- There was a development of a questionnaire which was planned to be sent to bereaved relatives or carers. The questionnaire was expected to contain a set of questions about the preferred place of care. The questionnaire was due to start being sent out to relatives in January 2016. It was not possible to ascertain how long it would take until patients would be routinely asked about preferred place of care or death.
- The trust was a pilot site for the Department of Health Medical Examiners scheme. The cause of all deaths that did not need to be investigated by a coroner were confirmed by a medical examiner before a medical certificate of cause of death was issued, or was established by a medical examiner. The medical examiner scrutinised the deceased person's medical records and could choose to carry out external examination of the body. The medical examiner (or an officer acting on his or her behalf) also speaks with a member of the bereaved family.

Meeting people's individual needs

- Standardised nursing care guidelines were available as a reference tool on the intranet; staff could print these to use as a guide. There was no individualised care pathway or care plan to help staff identify and care for end of life patients.
- We saw notes for end of life care patients on the stroke ward. They gave detailed comprehensive information about the patient's condition and the medical plan of care.

Access and flow

- From April 2014 to March 2015, there had been 2812 referrals to the specialist palliative care team. Of these 73% (2047) were cancer patients. The remaining 27% (765) were non-cancer patients.
- The number of referrals had increased from the year before; from April 2013 to March 2014 there had been 2524 referrals. Of these 78% were cancer referrals and 22% non-cancer referrals.
- This meant there had been an increase in the total number of referrals, there had also been an increase in the number of non-cancer patients seen by the team. They told us they had worked to address the imbalance by close liaison with other services to reach end stage heart and respiratory failure patients.
- A total of 97.3% of patients were within 24 hours of referral from April 2014 to March 2015. This decreased to 93.9 % during a six month period from 1 April 1 2015 to 30 September 2015.
- When the patients were not seen within 24 hours this was due either to a future time / date being requested; (often to coincide with the patient being given a diagnosis). A further reason for patients not being seen within 24 hours was when the request was non- urgent or the workload of the specialist palliative care team resulted in a delay.
- The specialist palliative care nurses had moved to seven day working without an increase in staffing. One nurse worked each weekend day at Royal Hallamshire hospital; on average they saw 10 new patients each day. On a weekday there was a minimum of two nurses, who saw an average of 15- 20 patients.
- They told us they were just able to keep up to date with referrals but it was difficult with their current numbers of staff. They described this as firefighting".
- The staff members who worked weekends worked on the Friday before the weekend so they were aware of the patients their colleagues had seen.
- Staff told us they referred patients to the MPCU. Referrals were discussed on the weekly MDT referrals meeting. Staff told us patients could wait up to a week for a bed after they had been referred. They told us some patients died at the Royal Hallamshire hospital before they could be transferred to the unit. Senior staff told us when there was a wait for beds, patients still received specialist input from specialist palliative care services .
- We saw there were delays in 'Fast Track' discharges. We saw from two patient records that there were delays of around two weeks. Staff told us this was not unusual. A fast track discharge is one where a patient has a rapidly deteriorating condition which may be entering a terminal phase, that is to say they may be dying.
- The national fast track process indicates completed documentation is sent to commissioners for "immediate action". When the commissioners receive the fast track

tool this should be accepted and actioned immediately. It is not appropriate for individuals to experience delay in the delivery of their care package. (Department of Heath 2012).

- After our inspection, the trust provided evidence that 46 % of fast track requests were approved by commissioners on the same day and a further (44%) the day after. It had been identified that some fast tracks had to be returned because the forms were completed incorrectly and work was being done to improve this.
- In February 2015, 66% of fast-tracked patients were discharged after three days; in March, this rose to 80%; in May 2015, 90% were discharged after three days.
- The delays experienced by patients meant that they could die in hospital while waiting for a decision about how their future care might be funded. The delays also meant other patients could not be admitted into those beds which were already occupied.

Learning from complaints and concerns

- We saw information leaflets and posters in relation to making a complaint were available.
- Complaints and concerns were monitored and followed up as appropriate.
- Staff told us they provided advice and support in making a complaint where appropriate. We were provided with an example of a serious complaint from several years ago. We found that staff had responded appropriately.
- Staff told us they would attempt to deal with complaints at the time, apologise and explain the reason for any failings. They would develop plans to rectify the problem. Staff said this level of complaint management minimised the number of complaints made formally, but that patients and their relatives were not discouraged or prevented from making formal complaints.
- Following a complaint or concern, information was shared with teams or if necessary, individual staff.

Are end of life care services well-led?

Requires improvement

We found end of life care services to require improvement for being well led. We found;

- There was no internal strategy in place for end of life care at the trust. We could not ascertain how progress towards achieving the five year plans leading up to 2017 was measured.
- In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance. However, this had not been made available until October 2015. Not all staff were aware of the guidance.

There was limited monitoring of quality of care for end of life care.

- The trust did not monitor if patients achieved their wish for preferred place of care or death. As this was not routinely identified, this information could not be used to improve or develop services.

However we also saw;

- Positive examples of local leadership in the palliative care team from both a nursing and medical perspective.
- Ward staff told us the specialist palliative care team were very supportive. Ward nurses knew the specialist team members by name and were able to give us examples of their involvement in patient care.

Vision and strategy for this service

- There was no internal strategy in place for end of life care at the trust. We spoke with senior leaders who acknowledged this. An end of life strategy group were responsible for providing provided the vision and strategy for end of life services in hospital and community services. The group were in the process of developing a strategy for the service provided by the trust. We did not know when this would be put in place.
- We found the absence of a strategy had resulted in staff not knowing the vision for end of life care. We found front line staff were committed to caring for those approaching the end of their lives; however, staff could not tell us their role in achieving the strategy.
- We saw a five year plan for specialist medicine from 2012- 2017. It included plans for end of life care as one of the six specialisms in the document. The document was written in 2012, and included an assessment of the trust position at the time, their aims over five years and how this was to be achieved. We understood this to be the 'vision' for the service. There was no detail or timescales to determine how different parts of the plan were to be achieved.

End of life care

- We saw that plans had changed since the five year plan was written. For example, one statement specified by 2017 the specialist palliative care team would have led the implementation of advanced care planning and AMBER bundle across the trust. This was no longer the plan in 2015 when we visited; the trust had stopped the implementation of the AMBER care bundle after four wards were using it. We did not see a framework or tool where these changes could be explained or evaluated.
- The goals of the medical director were to raise the profile of end of life care and to increase the number of non-cancer patients seen by the specialist palliative care team.

Governance, risk management and quality measurement

- There were quarterly governance committee meetings. We reviewed minutes from these meetings and found that serious incidents, complaints and the risk register were some of the agenda items discussed.
- The service participated in national audits, such as the care of the dying audit.
- There was limited monitoring of quality of care for end of life care. The medical director agreed there was a need for more robust, strong data to support the general 'feeling' in the trust that the service was doing well. However, there was a comprehensive audit programme for the specialist palliative care team for the coming year. This was to be used to monitor quality and plan where future action should be taken.
- We spoke with the medical examiner at the hospital. The trust was a pilot site for the Department of Health Medical Examiners scheme. The medical examiner scrutinised the deceased person's medical records and could choose to carry out external examination of the body. The medical examiner (or an officer acting on his or her behalf) also spoke with a member of the bereaved family.
- There were close links with the local hospice and the palliative care team were working with them to develop similar processes.
- The Deprivation of Liberty Safeguards (DoLS) policy expired in October 2013. The flowchart to guide staff in DoLS decisions was also out of date. This meant that staff may not be making decisions in line with national guidance and legislation, for example the Mental Capacity Act, Human Rights Act and Equality Act. After our inspection, senior staff told us out of date policies and guidelines remained valid until they were replaced.
- Trust audit had identified gaps in DNACPR forms; the issues remained at the time of inspection. We spoke with the Medical Director about DNACPR forms; they told us they were aware of issues related to a lack of countersignature by a consultant and a lack of documentation of capacity assessments. Action was being taken to address this.

Leadership of service

- The medical director was the executive lead for end of life care and a palliative care consultant was the clinical lead. We saw that staff were clear about their roles and responsibilities.
- In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance. However, this had not been made available until October 2015. Not all staff were aware of the guidance at the time of inspection.
- We spoke with the medical director about the lack of an end of life care strategy. They told us there were several reasons for this, including awaiting publication of NICE guidance and a replacement national care pathway. They also told us there were senior clinical leaders in each directorate, but they were not clear on how knowledge and skills were shared across the directorates.
- We saw positive examples of local leadership in the palliative care team from both a nursing and medical perspective.
- We saw that the palliative care consultants were visible and approachable. Junior doctors told us they received good direction and support from the consultants.
- Ward staff told us the specialist palliative care team were very supportive. Ward nurses knew them by name and were able to give us examples of their involvement in patient care.

Culture within the service

- We found an open and friendly staff culture at the hospital.
- Staff were open about reporting risks or incidents and there was a philosophy of learning from incidents and complaints.

End of life care

Public engagement

- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying Audit for Hospitals (2013-2014)
- They did not participate in the survey of bereaved relatives as this coincided with the Christmas period at the time. The trust felt this might be a difficult time for families so withdrew from participating in the bereaved relatives' survey with view to carrying out a relative's survey at a more appropriate time.
- We saw the bereavement office staff carried out a survey in March 2015.
- In 2014, the chaplains carried out a carer and relative satisfaction survey.

Staff engagement

- There was limited evidence of staff engagement. We asked staff what the trust vision and aims for end of life care was, but they were not able to tell us.
- Staff on the haematology ward told us they were thinking of starting 'Schwartz' rounds. Schwartz rounds are meetings which provide opportunities for staff to reflect on the emotional aspects of their work. Senior staff on the ward told us the aim was to let staff be open to expressing their thoughts and feelings, so they could become more confident in dealing with sensitive issues.

Innovation, improvement and sustainability

- We saw there had been use of grants from Health Education England. This had been used to fund palliative care fellowship posts. This meant that charitable funds paid for doctors to undertake research and projects.
- An example of these was the development of a bereavement survey and work with the Patient Partnership Team to develop a system for monitoring and responding to end of life care complaints.

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	**Outstanding**

Information about the service

Outpatient and diagnostic services operate as an integral part of most directorates at Sheffield Teaching Hospitals Foundation Trust (STHFT). There are outpatient facilities at each of the trust's five main sites. At this visit, we inspected outpatient and diagnostic services provided at the Royal Hallamshire Hospital (RHH), Northern General Hospital (NGH) and Weston Park Hospital (WPH).

The medical and surgical outpatient departments in the Royal Hallamshire Hospital hosted multiple specialties from across medicine and surgery. The RHH was the regional centre for the bone marrow transplant service. In addition, specialties such as ophthalmology, dermatology, ENT and urology had large outpatient departments within their own departments. There was an emergency eye clinic located next to which was open Monday to Friday, 8.30am to 4.30pm for referrals from GP's, the minor injuries unit, opticians, emergency department and self-referred patients. The trust also supported research and development and was nationally recognised for its expertise in a number of areas.

Between July 2014 and June 2015, there were 648,438 OP appointments at the Royal Hallamshire Hospital.

The majority of pathology services were located in the laboratory medicine centre at the NGH site. Histopathology, cytology and specialist haematology services were located at the RHH site.

Imaging services (radiology) were part of the medical imaging and medical physics (MIMP) directorate. This directorate was part of the Laboratory Medicine, Medical Imaging and Medical Physics, Obstetrics, Gynaecology and Neonatology (LEGION) Care Group. The MIMP directorate performed imaging investigations across all of the trust sites. There were approximately 500,000 attendances per year, and MIMP employed over 600 staff.

The MIMP services provided at RHH included Nuclear Medicine, MRI, CT, breast screening, ultrasound, fluoroscopy and angiography situated on floor 'C' and general x-ray plain film and dental x-ray services situated on floor 'B.'

During our inspection we visited the following OP areas:-

- Medical outpatients
- Ophthalmology, eye clinic and orthoptics
- Ear, nose and throat (ENT)
- Neurology
- Diabetes centre
- Endocrinology clinic
- Sexual health clinic
- Haematology clinic
- Histopathology
- Respiratory clinic
- Breast screening (mammography)
- Chest clinic booking office
- Ambulance waiting area

We spoke with 52 members of staff in radiology, 57 members of staff in OP and three members of staff in pathology. These included managers, nurses, medical staff, scientific/technical staff and administration staff. We also spoke with 46 patients and two care workers / supporters.

Outpatients and diagnostic imaging

In OP, we reviewed ten sets of patient records and we looked at 12 electronic patient records in radiology. We looked at a range of other records such as policies, procedures and audits.

Summary of findings

We rated the service as outstanding overall.

We rated safe and caring domains as good, with responsive and well led being rated as outstanding. The effective domain was inspected, but not rated. This was because we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic Imaging.

The services had a positive safety culture; there were clear management responsibilities and accountability for safety and governance. The services promoted continuous quality improvement.

There were enough qualified, skilled and experienced staff to meet people's needs. Staff received good support, staff appraisals and mandatory training was up to date.

Radiology services provided well-established, highly regarded training programmes for medical staff at every stage of their five-year programme and for student radiographers from local universities.

All of the staff were passionate about their work and staff teams worked well together to provide an excellent experience for their patients. All of the patients and relatives we spoke with gave positive feedback about the staff and the services.

Staff were aware of the trust values; there was good staff engagement and an open culture. Staff participated in research activities and there were numerous examples of innovation and improvement.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We safety of this service as good because staff planned and delivered care and treatment in a way that ensured people's health and safety, which protected them from harm. We found;

- Staff knew how to report incidents and could describe the requirements of the Duty of Candour. There was good evidence of learning from incidents.
- People were cared for in a clean, hygienic environment. There were effective systems in place to reduce the risk and spread of infection. There was enough well-maintained equipment to ensure people received safe treatment.
- Appropriate arrangements were in place for obtaining, recording and handling medicines and there were arrangements in place to deal with emergencies.
- Accurate and appropriate patient records were maintained, which were stored securely.
- The services had a positive safety culture and there were clear directorate management responsibilities and accountability for safety and governance.

However;

Safety checklists within imaging services were not always completed as required. Internal audits had identified this issue and the service was working towards improving the compliance rates.

Incidents

- There was evidence of learning from incidents; investigations took place and appropriate changes were implemented. Incident management and response was through the trusts online reporting system.
- Royal Hallamshire Hospital outpatients and diagnostic imaging had reported 1707 incidents from September 2014 to August 2015. Of these, 1677 (98%) had been categorised as either insignificant or minor, 24 (1.4%) had been categorised as moderate and six (0.35%) as major. Five of the six major incidents were in ophthalmology; three of these were described as 'impairment of sight and two as 'delayed treatment.' The sixth major incident was in MIMP, and was due to a delayed treatment in MRI.
- There had been no 'never events' reported in the past 12 months; never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff told us managers were trained to locally manage and investigate incidents within their own areas. The managers and section heads told us they encouraged staff to openly report incidents.
- Staff we spoke with across all of the areas visited confirmed that they were actively encouraged to report incidents. Staff all told us they knew how to report incidents and lessons learnt were shared. For example, we reviewed the minutes of the sexual health service's quality governance meeting for 10 December 2015. We saw all incidents reported between September and November 2015 were discussed. We saw incidents were a regular agenda item at this meeting.
- Senior nursing staff in the eye clinic in ophthalmology told us the main incidents reported in the department were ambulance delays and clinic cancellations.
- From reviewing minutes of meetings, we saw that learning from incidents/investigations took place and appropriate changes were implemented. During our inspection, we observed a serious incident meeting which involved a matron, senior doctor and junior doctor having a round table meeting to review an incident.
- Staff received induction and training on how to report incidents. Learning from incidents was communicated through team meetings and monthly incident bulletins circulated to all staff. Staff we spoke with confirmed incidents and any lessons learnt were discussed at staff meetings.
- In radiology, section heads had 'their own incident dashboards. These assisted them in monitoring incidents reported internally and externally. Incident dashboards also improved the timeliness of incident reviews and investigations. The directorate reported that monthly exceptions reports showed that 98% of incidents were closed within the trust's target of 35 days.
- The Radiation Safety Steering Group (RSSG) monitored the numbers of radiation incidents reported to the Care Quality Commission (CQC) under IR(ME)R regulations.

The number of IR(ME)R reported incidents (exposures 'much greater than intended' and unjustified exposures) had increased over the previous 12 months. The clinical directors and directorate manager told us there had been an increase in externally reportable IR(ME)R incidents mainly due to a change in the 'interpretation of the legislation and in response to actions as determined by CQC'.

- This was confirmed in the RSSG annual report for April 2013 to March 2014 presented to the trust's Healthcare Governance Committee. The report stated, 'clarification had been sought from the CQC IR(ME)R inspectorate and the trust's reporting criteria amended accordingly'. The report also stated that these changes 'will result in a higher number of incidents being reported externally, but it was stressed that this is not as a result of an increased number of incidents'.
- The ionising radiation sub group report to the RSSG July 2015 highlighted the on-going work to reduce the numbers of IR(ME)R incidents. This involved radiographers using the 'have you paused and checked' initiative. This initiative is a nationally recognised clinical imaging examination IR(ME)R operator safety checklist carried out before and after exposures.
- Pause and check operator checklists were displayed within the radiology treatment rooms. Staff confirmed they produced reflective statements from errors and these were reviewed with their line managers to identify learning outcomes. They also confirmed that a monthly bulletin detailing incidents was circulated to all staff to enable wider learning. The November and December 2015 bulletins highlighted safety concerns and point of good practice.
- In radiology, the clinical, scientific and nursing directors together with the matron, directorate and governance managers attended directorate monthly clinical governance committee meetings. The committee routinely reviewed all incidents in order to identify trends. We saw from the June, July and September 2015 meeting minutes that incidents were reviewed and action notes recorded. Actions were monitored, and followed up appropriately at subsequent meetings.
- Managers, section heads were aware of their responsibilities under the Duty of Candour legislation. Staff told us duty of candour was discussed and shared at meetings. We confirmed this when we reviewed the radiology minutes for the May 2015 meeting. The majority of staff we spoke with were aware of their responsibilities under the legislation. Duty of Candour was part of the trusts induction programme and was included as part of the electronic incident reporting system for completion by staff.

Cleanliness, infection control and hygiene

- The environment was visibly clean in all of the areas we visited. Hand sanitiser was readily available and we observed staff washing their hands and using hand wash gel appropriately. Staff practised good hand hygiene before and after contact with each patient. In ophthalmology we observed that hand gel was available on the reception desk. In OPD clinics, we observed hand-washing posters on display.
- Personal protective equipment (PPE) such as aprons and gloves was available and staff were observed using PPE correctly. Staff adhered to the 'bare below the elbow' policy.
- We saw the chairs in OPD waiting areas were covered in material which was washable.
- Clinical and domestic waste was disposed of correctly and sharps boxes were not overfilled. Appropriate containers for disposing of waste, including clinical waste, were available and in use across the imaging departments. Waste was safely managed and staff disposed of sharps items safely. In the eye clinic, we saw waste bins were segregated ready for recycling.
- The governance lead in ophthalmology told us infection control was a standing agenda item at the head and neck meetings.
- The OP and radiology departments carried out regular audits as part of the trust's infection prevention accreditation programme. This set the standards for infection prevention and control practice across all directorates. Compliance was assessed by monthly audits and quarterly compliance reports.
- These audits included aseptic technique, hand hygiene, cleaning and decontamination of equipment, care of central venous catheters and standard precautions. These audits monitored compliance with key trust policies. Between 1 October 2014 and 30 September 15 RHH scored between 98% and 100% in infection control audits, which monitored compliance with key trust policies.
- The diabetes and endocrine clinics were trust accredited and regular infection control audits were carried out using an electronic system (eCAT tool).

- The July 2015 MIMP clinical governance minutes recorded that infection control accreditations were up to date. Infection control results reported in the September 2015 minutes showed radiology achieved 99% compliance.
- The radiology waiting and recovery areas appeared clean, tidy and uncluttered. Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available and these areas appeared clean and tidy.
- Staff in radiology were responsible for maintaining the cleanliness of the radiology equipment in accordance with infection prevention and control (IPC) standards. Imaging and examination room cleaning schedules were available in all areas and were up to date.
- Staff in radiology could explain the procedures to follow for managing patients with suspected or confirmed infections.
- Patients in radiology and OPD commented on how clean all the clinics were.

Environment and equipment

- The maintenance and use of the premises, facilities, and equipment were designed to keep people safe.
- Security in the histopathology and cytology departments was good. Inspection team members were required to sign in and out and restricted areas had security devices in place to prevent unauthorised entry.
- The sexual health clinic was a separate unit over three floors, which provided a comprehensive genitourinary medicine and contraception service. We observed it was a clean, friendly and welcoming environment.
- When we visited the ear, nose and throat OPD, we saw the waiting room was full and the space available was limited. Within the emergency eye clinic, the treatment areas and waiting room was small for the number of patients and staff said the patients often would be queuing out of the department.
- The service manager in ophthalmology showed us the department's equipment log. We saw this included the dates of equipment checks. We confirmed all equipment in this area had been electrically tested. They told us the department was getting a new glaucoma scanner on the Monday following our visit. They said the wide field lens for oncology was 16mm (as opposed to 9mm). The service had been successful in obtaining funding for an upgrade to the imaging system.
- There were systems and processes in place to ensure the maintenance and servicing of radiology equipment. The directorate had an up to date inventory of all of the radiology equipment and the planned preventative maintenance (PPM) schedules.
- We were told by staff that a capital replacement scheme for equipment was developed and plans were in place for two additional MRI scanners and replacement of four CT scanners over the next two years. Staff told us one of the two new MRI scanners was for the RHH.
- During the course of our inspection, we observed specialised personal protective equipment was available for use within radiation areas. Staff wore personal radiation dosimeters (dose meters) and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionising radiation.
- We saw the majority of the equipment we looked at was routinely checked and labelled in date. However, in radiology we did see the routine checks for two items of equipment had expired one in July the other in October 2015. We brought this to the immediate attention of the senior staff; they removed these items from use and submitted maintenance requests.
- Emergency resuscitation equipment was readily available for use within the departments and checks of the equipment were up to date.
- Radiation warning signs were displayed along with the use of illuminated do not enter signs within all modalities.
- Radiation local rules were displayed and described the duties to be undertaken by staff in accordance with the local rules. Local rules are written to enable work with ionising radiation to be carried out in accordance with the Ionising Radiations Regulations (IRR99). It is the primary responsibility of the Radiation Protection Supervisor (RPS) to supervise work and observe practices in order to ensure compliance with these regulations. All modalities had appointed and trained RPSs.
- Radiation Protection Advisors (RPAs) were employed within the radiology service. They attended the RSSG meetings and undertook annual risk assessment inspections of the radiology services at each of the MIMP directorate locations. The RPAs produced an annual report.
- The purpose of the inspections and reports was to evaluate compliance with legislative requirements

associated with the radiation safety of patients, members of staff and the public. The findings from inspections were communicated to the trust Chief Executive and other responsible persons.
- We saw from the 2014 and 2015 inspection reports supplied by the trust that adequate standards of compliance were achieved. Where compliance fell short, requirements were issued and recommendations for action identified. The reports also contained follow up on previous requirements and recommendations.

Medicines

- Appropriate arrangements were in place in relation to obtaining, recording and handling of medicines. Medicines were prescribed and given to people appropriately and were stored securely in locked cupboards.
- Medicines including controlled drugs (CDs) were all stored correctly. The senior nurses were responsible for checking CDs and medicines. They were also responsible for the safe management and control of medicine keys.
- In radiology, the CD registers and order book were all checked and signed correctly. When we checked the expiry dates of other medicines stored, we found one medicine had passed the recommended expiry date. Staff replaced this immediately.
- Staff checked the drug fridge temperatures in the x-ray department; records of these checks were up to date. We saw medical gases and contrast media was stored safely.
- However, in ear, nose and throat OPD we observed that the medicine cupboard was not locked. When we asked staff about this, they confirmed that the cupboard should be kept locked. The member of staff turned the key in the lock but left it in the door. We were told that the nurse in charge should keep the keys. This meant medicine was not stored securely in that area.

Records

- People's care records were written and managed in a way that kept people safe.
- We reviewed five sets of electronic patient notes in the diabetes centre. We saw these were clear and comprehensive. All notes were signed, dated and times. Staff were confident in using the electronic patient health record system. Staff told us GPs could access this system.
- We reviewed five electronic patient records in the sexual health clinic; the service did not hold any written records. We saw that this system was secure for patient confidentiality; only sexual health clinic staff had access to patient details.
- Senior nursing staff in ophthalmology told us the service used paper records. They said the preparation of notes for clinics was good and a new system had helped with producing letters for patients and treatment plans.
- Reception staff in ophthalmology told us it was, "rare that notes were missing." They explained that there was a tracking system and notes were scanned so staff always knew where the notes were.
- We spoke with clinical support staff in a cancer OPD clinic. We saw notes were stored securely behind the reception desk until they were required. We observed staff moving and collecting notes face down. This ensured patients' names and other details were not visible. Staff told us they shredded the clinic list after the clinic finished.
- We observed inpatients attending the radiology department for treatment. We saw staff handed over their case notes safely to the department's recovery staff. However, there was no secure facility to store patient case notes within the recovery area. During our observations, we saw staff left case notes unattended on one occasion.
- In the other radiology departments, we found staff managed and handed over inpatient case notes safely. We reviewed 28 electronic patient records (across the three hospital sites) specifically to check whether radiology staff had completed the safety checks for MRI, pregnancy and interventional WHO safety surgical checks.

Safeguarding

- People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse or harm and prevent it from happening.
- Mandatory and statutory training courses included adult and children safeguarding. Safeguarding training for all staff was completed at level 2 and senior staff, such as OPD sisters, were trained to safeguarding level 3. We saw 84% of staff across the trust's outpatients departments had undertaken Level 1 safeguarding training for children and young people and Level 1 and

Level 2 vulnerable adults training; 81% had Level 2 training for children and young people. This was against a trust target of 90%. Hospital specific data was not available.

- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns whether for a child or adult. Staff were aware the trust had safeguarding policies and a directorate safeguarding lead they could contact for advice and support if they had any concerns.
- Staff in the eye clinic in ophthalmology told us that if patients did not attend their appointments then they would check with the GP and resend the appointment. They said they checked on repeated cancellations and patients that did not attend. They said they would contact the school nurse (if a child) and the local safeguarding team.
- There was a radiation safety infrastructure in place which included the reporting of radiation incidents from local clinical teams and section heads into one of five radiation safety sub groups for; Ionising radiation (x-ray), non- ionising radiation (MRI and Ultrasound), radiotherapy (sealed sources), nuclear medicine (unsealed sources) and dental (x-ray).
- The purpose of the sub groups and RSSG was to ensure radiation safety issues requiring action by the trust were reported and acted upon appropriately. This ensured on-going legislative compliance and kept staff, public and patients safe.
- The minutes and action notes from the February and July 2015 RSSG meetings included radiation safety reports from each sub group. These reports were reviewed the meetings and any further actions recorded and followed up appropriately.
- The World Health Organisation (WHO) developed safety checklists after 'extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery'. The directorate used two types of checklists the WHO radiology intervention and an adapted check list the 'Sheffield Teaching Hospitals Surgical Safety Checklist Interventional Radiology' to ensure it was suitable for the setting in which it is used. Staff told us only vascular clinicians used the WHO checklist. The directorate's governance coordinator confirmed this.
- We saw different methods employed by clinicians for recording each of the checks. Some clinicians preferred to tick at the side of each safety check and enter N/A when not appropriate, others clinicians signed each section of the checklists.
- One clinician had signed all three sections of the checklist, which included the section to indicate an anaesthetic had been given. We discussed this with one of the radiographers and they confirmed that an anaesthetic had not been given in either case.
- Standard procedures for completing the checklists were not clear in the MIMP policy for the use of the 'WHO Safe Radiology Checklist in Medical Imaging and Medical Physics' 07 January 2015, Reviewed November 2015.
- The trust's objective was that 100% of interventional procedures had a checklist completed accurately and a copy scanned into the patient records on RIS. Following an audit in March 2015, results showed that overall the directorate achieved 30% compliance for accuracy completion and having a scanned copy into the patient records on RIS. Actions to improve education and training of staff were implemented to assist in achieving the target of 100% compliance.
- The November 2015 Surgical Check list re-audit report to the clinical effectiveness committee showed improvements. Checklists scanned into the patient records on RIS was 69% compliant and of accurate completion of checklists was 70% compliant. This meant that, despite action taken in March 2015, re-audit in November identified they were still not achieving 100% compliance with safety checklist completion.

Mandatory training

- Staff we spoke with all confirmed they were up to date with their mandatory and statutory training. The trusts mandatory training and local supervisions were completed within the departments.
- Mandatory training data submitted by the trust showed that compliance in OPD was 90% over all of the directorates. This data was not broken down by site. The highest compliance rate for OPD services at RHH was in musculoskeletal (99%), compliance in ophthalmology was 88.5% and diabetes and endocrinology had the lowest compliance rate (77%).
- Staff used the trusts Personal Achievement and Learning Management System (PALMS) for their mandatory training and each had their own 'log in.' Annual mandatory training included fire and health and safety.

- In pathology, 93% of staff had completed their mandatory training and we reviewed documents, which showed there were clear plans for all staff to complete their mandatory training.
- Staff in the eye clinic in ophthalmology told us mandatory training was up to date and included training in cardiopulmonary resuscitation. Senior nursing staff told us the combined compliance rate for mandatory training across ophthalmology was 91.5%.
- The OPD bookings supervisors told us PALMS sent reports through showing when their staff's mandatory training was due. One of the senior nursing staff in medical OPD showed us a mandatory training report for the staff in their area; we saw that any gaps in training were identified and plans put in place. They produced a monthly report of staff training; each member of staff was clear about their 'required learning' and time was allocated to complete this.
- The MIMP directorate report for appraisal and mandatory training compliance from 15 December 2014 to 10 December 2015 showed all specialities at all locations were achieving good compliance. For example, 95% mandatory and statutory training course compliance.
- Staff we spoke with in radiology confirmed they were up to date with their mandatory and statutory training. A number of new staff we spoke with showed us their personal induction records, which included appraisals, trust mandatory training and supervision completed within the departments.

Assessing and responding to patient risk

- The OPD and radiology services assessed risks and responded appropriately in order to maintain patient safety.
- The Sheffield Early Warning Scoring system was used to monitor the patient's condition prior to during and following radiology interventional procedures. Staff in other departments, including the eye clinic, told us they also used this system. Trust wide emergency teams were available to respond and support any medical emergencies.
- Senior nursing staff in the eye clinic in ophthalmology told us they would call 2222 in the event of a deteriorating patient. They said the department had examples of using this successfully.
- The hospital porters told us if they were transferring patients on their own and became concerned about the patient's health they took them immediately to the nearest clinical area to obtain support.
- Staff in the neurology and ear, nose and throat OPD told us the services ran outreach clinics, which were patient-centred. Ear, nose and throat staff told us they carried out home visits for bariatric patients and patients with learning disabilities and held 'hearing aid mornings.'
- Staff in the sexual health clinic told us they had close links with the city centre clinic and ran a second 'spoke outreach' clinic. There were good links with community teams, public health and health prevention teams.
- Staff in the diabetes centre told us the service held community diabetic clinics in sports centres for patients with type 2 diabetes. They explained these also encouraged patients to use the sports centres for exercise.
- Radiology protection advisors (RPAs) had good systems for monitoring radiation and protection and radiography practice within the departments.
- In radiology, we looked at three patient electronic records on RIS to ensure staff had completed pregnancy safety checks prior to exposures being undertaken. We saw staff had not completed the pregnancy checks in one of the records. We were later informed by the manager that a pregnancy check had been completed, but the radiographer had not pressed the save function within the electronic record.
- We looked at four MRI safety checklists scanned into RIS and saw staff had not completed two of these correctly. The radiographer had signed but not dated the third checklist and the radiographer had not signed the fourth checklist. The patients had signed all four the checklists. The trusts policy stated that the safety checklists 'should be signed and dated by the patient and by the radiographer undertaking the scan.'
- We looked at records on RIS for five patients who had undergone interventional radiology procedures. We were checking to ensure non-surgical intervention radiology safety checklists were completed and electronically scanned into their records. All five records included a completed safety checklist and the responsible clinician had signed them.

Nursing staffing

Outpatients and diagnostic imaging

- There were sufficient qualified staff in the OPD and radiology services to keep people safe.
- The majority of departments we visited told us their staffing was good. Staff told us the OPD used bank and agency staff.
- Staff in neurology told us there were 10 nurses in the team and agency staff were not used.
- Staff in the eye clinic in ophthalmology told us there were two vacancies for staff nurses and two for part time support workers. They told us the department did not use agency staff, and would cover any extra clinics by using volunteers from the permanent staff.
- Staff in the ear, nose and throat OPD told us staffing was "difficult at times." They explained this was partly because of long-term sickness and vacancies. They said the trust was recruiting from abroad (Spain and Romania) because of the difficulties recruiting appropriately skilled staff.
- The two OPD bookings supervisors, who were band five, told us there were 43 clerical and secretarial staff covering booking appointments for OPD. They told us the team had agency staff, apprentices and work experience students. They told us there were two vacancies in the contact centre, due to retirement and changes in working hours. One new staff member was due to start.
- The band seven nurse in medical OPD told us it was, "a major plus" that they had cross-city responsibility for medical OPD. This meant there was flexibility across the two main hospital sites (RHH and NGH), both in staff numbers and skill mix. They said agency staff were used to fill day-to-day gaps in the rotas. The trust confirmed they used bank staff, rather than agency staff, when possible.
- Staff in the sexual health clinic told us there were no vacancies. The service employed eight nurses, eight support workers, 19 sexual health practitioners, seven sexual health advisors, one senior sexual health advisor, two charge nurses and a matron.
- Sickness absence across the trust was 4.2% in May 2015 compared with the trust wide target of 4%. The position had improved from over 5% in January 2015. Senior nursing staff in medical OPD showed us a copy of their monthly report of sickness absence in the department.
- The trust reported that 'a workload based staffing tool was currently under development and STH was working in collaboration with external consultants to refine and test the methodology'.
- The MIMP directorate employed over 600 staff with expertise in clinical sciences and medical engineering, nuclear medicine, medical physics, nursing, administration, interventional radiology, multi imaging and diagnostics modalities for MRI, CT, fluoroscopy, cardiac, neurology and vascular angiography, breast screening, general X-ray and ultrasound.
- Radiation Protection Advisors (RPA's) and Radiation Protection Supervisors (RPS's) were employed within the MIMP directorate.
- The December 2015 MIMP staffing report showed the directorate was carrying around 26 whole time equivalent (WTE) vacancies across all specialities, recruitment to fill these vacancies was on going at the time of our visit. We found agency staff were used to maintain adequate staffing levels and skill mix within a number of radiology modalities.
- Radiology had a number of staff who rotated across hospital locations to support services. Approximately 79 WTE radiographers, 22 qualified nurses and a number of clinical imaging support staff rotated across sites.
- Staff rotas included permanently based and rotational staff. There was sufficiently qualified and unqualified radiography and nursing staff on duty to cover the capacity and demands of the imaging services we visited.
- In radiology, agency staff were occasionally used and inductions for this group of staff were completed. On the day of our visit, we saw by a permanent qualified nurse inducting and mentoring one of the agency nurses in the department.

Medical staffing

- There were sufficient medical staff in the OPD, radiology and pathology services to keep people safe
- For example, there were 23 consultant medical staff in histopathology and cytology (18.1 whole time equivalent, WTE). Staff told us there had been a recent vacancy which had been rapidly filled and there was a vacancy which was about to be advertised.
- There were around 35 consultant radiologists employed by the MIMP directorate. They covered the range of specialisms and supported the multi-disciplinary teams (MDT).
- Arrangements for on call and out of hours cover were in place.

- The trust provided all facets of radiology training for doctors throughout the five-year training programme. Staff told us that a number of recent graduates were appointed into consultant radiologist posts.

Major incident awareness and training

- Major incident (MAJAX) training was part of the mandatory and statutory training programme for front line staff. The MIMP training report showed 95% of staff were compliant with their mandatory and statutory training and the OPD training report showed 90% of OPD staff had completed their mandatory training. These figures were not broken down into specific outpatient areas.
- To support the trust a MAJAX plan, the directorate had developed a range of guidelines for staff to follow in the event of a major incident. This information was accessible electronically to all staff on the MIMP shared drive and hard copies were retained within the departments.

Are outpatient and diagnostic imaging services effective?

Effectiveness was inspected but not rated. We found;

- People's care and treatment reflected relevant research and guidance, including NICE guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment, staff were aware of the mental capacity act and deprivation of liberty safeguards legislation.
- The outcomes of people's care and treatment was monitored and actions taken to make improvements.

We found excellent examples of multidisciplinary working in OPD, radiology and pathology

Evidence-based care and treatment

- People's care and treatment reflected relevant research and guidance.
- Senior nursing staff in ophthalmology told us the service contributed to numerous research projects. This included research into wet and dry macular degeneration. One of the band 7 nurses in the department had received a trust award for their work into low vision.
- The service manager in ophthalmology told us the service followed NICE guidelines. The governance manager in ophthalmology told us the service had an audit programme, which included cataracts, endophthalmitis and oncology. They said there were targets for each centre and these were presented at the CQUINS meetings.
- In radiology, diagnostic reference levels (DRL's) were developed as an aid to optimisation in medical exposure IR(ME)R safety advice. Trust policy was that radiation exposures doses should be audited on a regular basis.
- As part of the MIMP directorate's on-going quality monitoring of annual dose audits, a three yearly review of DRLs was undertaken. The audits carried out in 2014 and 2015 showed the results were good when compared against the new national levels in accordance with the relevant legislation. The audit reports included the detail of any actions required to aid optimisation.
- In radiology, we saw that policies and procedures within the directorate had been developed and referenced to NICE and Royal Colleges guidelines. These were available to all staff on the directorate's electronic shared drive.
- The MIMP directorate recognised the importance of innovation and the development of new techniques and treatments to improve patient care. For non-NICE guidance proposals, the service had developed systems and processes through the directorate clinical governance committee, in conjunction with the trusts executive group, for considering all these proposals. This was to ensure the proposals were appropriate, effective, and safe and the staff involved had the relevant expertise.
- Radiology reported that they had recently submitted two non-NICE proposals for consideration in relation to ethanol ablation of neck lymph nodes (a treatment for thyroid cancer) and fluoroscopically guided selective tubal cannulation (a treatment for ovarian cancer).
- Following audit of NICE (CG80) guidelines in July 2013 the trust identified it was not compliant in providing annual mammography (100% target) for all patients with breast tumour for five years from the time of diagnosis. Actions to change practice as a result from the audit were introduced to improve compliance. The re-audit results reported March 2015 showed that, because of changed practices, 100% compliance had been achieved.

Outpatients and diagnostic imaging

Patient outcomes

- The outcomes of people's care and treatment was monitored and actions taken to make improvements.
- Senior nursing staff in ophthalmology told us one of the consultants was auditing the outcomes for patients undergoing radiation treatment for wet macular degeneration.
- The MIMP directorate manager told us the service participated in the Imaging Services Accreditation Scheme (ISAS). They envisaged an application for accreditation would be submitted in the autumn of 2016. The manager also told us the audiology service had achieved accreditation for Quality in Physiological Services (IQIPS) scheme in October 2015.

Competent staff

- Staff had the appropriate skills, knowledge and experience to deliver safe effective care to patients. All of the staff we spoke with told us their appraisals were up to date.
- In pathology, all biomedical and medical staff (apart from one) had completed their annual appraisal and we reviewed documents, which confirmed this. Staff explained that the one consultant was overdue their appraisal due to extenuating circumstances.
- In pathology, biomedical scientists had been provided with additional training so that they could carry out procedures previously performed by consultants. For example, three advanced practitioners could report on cervical cytology samples and they were accredited to work at this level. In histopathology, an advanced practitioner was trained to report on ophthalmic pathology. This showed pathology had a positive approach to staff training and development.
- Senior nursing staff in ophthalmology told us the service had a 97% compliance rate for completion of appraisals.
- One of the senior nursing staff in medical OPD told us appraisals for staff at RHH was 90%, against the trust target of 90%. They said this was lower than medical OPD at NGH (100%) because staff were not available due to the clinics being so busy. They showed us the medical OPD appraisal records on the trust's intranet.
- The matron in medical OP told us the haematology clinic was nurse led.
- The neurology service had neurology nurse practitioners, who had extended their clinical practice to include lumbar punctures and Botox administration. The service manager in ophthalmology told us nurses working in the department had extended roles. These included performing intra vitreal injections and prescribing medications.One nurse in the eye centre told us it would be useful if more nursing staff could carry out procedures such as minor operations and intravitreal injections. They explained that only certain staff could currently carry out these types of procedures.
- Senior nursing staff in the respiratory clinic told us the core staff had specific skills, such as knowledge about tuberculosis. They told us the trust's learning and development team supported staff training and competency. For example, they ran a structured development day on venepuncture (taking blood samples).
- The OPD supported the modern apprentice's scheme; apprentices spent four days a week in the department and one day a week at college. The matron told us there was good retention of apprentices within the services when they had finished their apprenticeship.
- Staff told us bank and agency staff in OPD received induction before they worked in the clinics.
- Radiology employed a full time dedicated training and development manager responsible for the co-ordination and efficient management of the recruitment, training and development programmes.
- Radiology had a high staff retention rate and encouraged role extension. As a result, many of the areas benefited from having advanced practitioners such as nurse seditionists, advanced gastro intestinal (GI) radiographers, reporting radiographers nurse specialists in nuclear medicine and nurse GI interventionist.
- We saw examples of a wide range of training and development competence programmes, which included CT vetting competencies, vascular angiography training pack, and initial competency assessment for band 5 radiographers. We observed examples of completed CT staff training records held electronically.
- Radiology provided well-established and highly regarded training programmes with Sheffield and other universities for medical staff training and development at every stage of their five-year programme and for student radiographers.
- Radiology had an established faculty with many of the consultants at its core and representatives on the Royal

College of Radiologist' Education Board. Staff told us that the most recent Training and Accreditation Committee recently commended the directorate for its commitment and enthusiasm.

- Radiology provided examples of the records to show who was certificated within Nuclear Medicine to administer radioactive material. 'The Administration of Radioactive Substances Advisory Committee' (ARSAC) license holders.
- The ARSAC electronic database managed by two research nurses provided monthly reviews of certificate holders, certificates held for each clinician for both diagnostic and therapeutics, serial numbers included on each certificate, which site each certificate covered for each clinician and the expiry date of each certificate.
- There were 15 qualified RPSs within the directorate covering all modalities within MIMP locations. We saw evidence of their up to date training 2014 to 2015.The trust provided evidence of a competence update for one its RPS in 2015.
- The MIMP directorate had six qualified advanced reporting radiographers. The reporting practices of all six were regularly audited. We observed an example of a completed audit and saw the practitioner had to achieve the required standard of report accuracy to prove competence to practice.
- We found 92% of staff across all of the MIMP directorate's modalities had completed appraisals. As part of induction, staff were provided with a supervisor/ mentor and a training portfolio. This included evidence of supervision as part of the trust continuing professional development (CPD) programme.
- Radiology staff we spoke with confirmed the positive training and development culture and opportunities to develop advancement in practice throughout the directorate.

Multidisciplinary working

- We found excellent examples of multidisciplinary team (MDT) working in both radiology and OPD. MDT working underpinned service development and effective care delivery.
- For example, in the foot clinic in the diabetes centre, staff told us staff nurses, doctors and podiatrists attended the MDT meetings.
- Staff in neurology told us the service had good MDT working and physiotherapists, occupational therapists, nurses and doctors attended the MDT meetings.
- The ear, nose and throat OPD held weekly MDT meetings, which were attended by consultants (from Sheffield and other areas), MacMillan nurses and speech and language therapists. They said oncology patients were discussed and these patients were followed up by the service for five years.
- A staff nurse who worked in ocular oncology, in ophthalmology told us they had completed a six-month secondment with the MacMillan nurses for two days a week.
- Radiologists were part of the multi-disciplinary teams and we saw examples of attendance rates for the breast and head and neck MDT meetings. The clinical director confirmed that radiologist attendance at MDT meetings was a priority.
- The directorate supported MDT working across the trust and has a well-established process to authorise non-medical staff to request radiology in compliance with legislation. Training and development was provided and the directorate retained a database of authorised users.

Seven-day services

- Staff in the eye clinic in ophthalmology told us the service was open from Monday to Friday. They said there were sometimes extra clinics on Saturdays, which were staffed by regular staff. Other staff told us the service had been running clinics on Saturdays for a few months to reduce the backlog of cataract patients. They said the consultants offered their services for these clinics.
- The eye centre was open from 8am to 5.15pm and the last appointment was at 4pm. The MIMP directorate provided seven-day services. MRI and core hours have extended within most modalities from 8am to 8pm. CT services are provided 24 hours seven days (24/7) a week at the Northern General Hospital and out of hours support to the stroke service at the Royal Hallamshire Hospital.
- Staff in neurology told us the service was open six days a week and occasionally seven days a week. The service held evening clinics.
- Radiology services supported major trauma services, cardiac and vascular directorates both in and out of hours.

Access to information

- The hospital did not monitor the availability of patient's records in the outpatients departments. During our inspection, we did not identify issues with access to records. Staff reported they had access to information they needed to deliver care and treatment to patients in an effective and timely way.
- Senior nursing staff in ophthalmology told us the service used the ICE system for access to diagnostic test results. They said the system was reliable. This system allowed staff to see patients' pathology and radiology results electronically.
- The MIMP directorate used a Radiology Information System (RIS). The RIS is a dedicated computer system, which supports a range of functional requirements such as radiology operational workflow, business analysis and storage of patient data contributing to the electronic patient record across all modalities.
- RIS was combined with the Picture Archiving and Communications System (PACS) a nationally recognised system used to report and store patient images. Authorised user groups such as radiographers, radiologist and system administrators had individual user login and password authentication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training data submitted by the trust showed that staff in both OP and radiology were up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were knowledgeable about the requirements of this legislation.
- Senior nursing staff in the eye clinic in ophthalmology told us the department held best interest meetings once a month. They said they identified patients on referral or attendance. A nurse would contact the carer or relative to explore the patient's needs. They said staff received mental capacity training as part of the head and neck service's training. They said they sometimes used an Independent Mental Capacity Advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.
- Staff in the diabetes centre showed us on the computer screen how a patient records could be shared with their GP if they had given consent. They explained that these records could only be seen by the GP when patient consent had been obtained. The screen said, 'Please will you share this record; the patient has consented to share.'
- The trust had policies and procedures in place for staff to follow to obtain consent from patients receiving diagnostic procedures. General x-ray procedures were performed using implied consent from the patient. The trusts written consent procedures were followed when performing more complex or interventional radiological procedures.
- Patients' identities were checked and confirmed against the original referral details on arrival in the department and prior to the procedure. Local guidance was in place for staff to follow if patients arriving in the department lacked capacity and where clear indications of consent and best interest decisions could not be determined.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because people were respected and valued as individuals and were empowered as partners in their care. We found;

- People experienced care, treatment and support that met their needs and protected their rights.
- People understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- People received emotional support to help them cope with their care, treatment and condition. We spoke with 46 patients and two care workers / supporters; the feedback we received from all of the people we spoke with was outstanding.

However:

- In radiology, curtains between bays were fitted to promote and maintain patient's privacy and dignity, but these were not routinely drawn.

Compassionate care

Outpatients and diagnostic imaging

- All of the patients we spoke with praised the service and staff. Staff were friendly, polite and courteous when caring for patients. Staff treated people and their families with compassion, kindness, dignity and respect. Staff responded to patient's individual needs in a timely manner.
- All five patients we spoke with in the breast clinic were very complementary about the service and staff. Patients told us the staff caring for them were, "patient" and "always helpful" and treated them with respect.
- In the diabetes centre, we noted that there was a very calm atmosphere. We spoke with five patients in the diabetes centre and they all spoke highly of the staff and the care they received. Four said they usually saw the same doctor at most visits. Comments included, "Really helpful," ""caring" and "There's always someone on the end of the phone."
- Patients in other OPD said that staff listened to them and that all their needs were met.
- Patients from all areas told us they were very happy to receive treatment from the OPD services.
- In ophthalmology/orthoptics, patients recommended the service they received.
- The patients explained that seeing the same staff made a difference. Staff were able to get to know them and their families, one patient told us that the staff even remembered their children's names.
- Overwhelmingly patients told us that staff were fabulous and their experiences of the service were great.
- One patient told us that they felt very safe when they did the operation. The staff were very efficient and competent."
- A higher percentage of family and friends recommended the trust than the England average between July 2014 and December 2014. From January 2015 to June 2015, the trust performed around the England average. In outpatients, the score for family and friends test in November 2015 was 94%, which was above the national average. This meant 94% of patients would recommend the OPD services at the Sheffield trust.
- In radiology, we saw staff introducing themselves to the patients and explaining the next steps in their treatment pathway. The ward or departmental staff assessed whether inpatients were fit for transfer on their own or whether they required a nurse escort.
- We observed excellent care and support provided to a patient with special needs. The staff team worked together to provide positive emotional support to the patient and their relatives and ensured they were kept informed at each step of the treatment and care process.
- A central mixed sex recovery bay area was used to care for inpatients prior to and following their procedures. This bay was situated adjacent to the CT and MRI seated waiting area. Curtains were fitted between bays to promote and maintain patient's privacy and dignity, but these were not routinely drawn. This practice did not maintain the patient's privacy and dignity.
- We saw staff consulted patients and people close to them prior to procedures. Staff were attentive to their patient's needs and we saw no undue delays in their treatments.
- The MIMP directorate reported they hosted the 'Devices for Dignity (D4D) Healthcare Co-operative'. A national initiative to drive forward innovative products processes and services to help people with long-term conditions'.

Understanding and involvement of patients and those close to them

- People who used the service were given appropriate information and support regarding their care or treatment. Staff told us they provided patients and their families with the information they needed, both verbally and in the written leaflets.
- In the eye clinic, we observed a range of patient information and leaflets relating to visual impairment and types of treatment. Staff in ophthalmology told us the service provided patients with information about how to register as sight-impaired. They also sent out leaflets to patients before their clinic appointments.
- In the diabetes centre, we reviewed downloads of patient records. We saw good evidence of patient involvements in decision-making.
- Staff in the sexual health clinic showed us the 'Sexual health Sheffield' website. We saw this was a comprehensive resource, which provided all aspects of patient information regarding sexual health. The sexual health team had designed this website. The clinic also made regular use of Twitter and Facebook. This showed the service was making use of current technology and social media to provide their patient groups with the information they needed.
- In radiology, we saw a range of information leaflets available and provided to patients in relation to

diagnostic imaging for example CT and MRI information leaflets were sent out in the post with the patient's appointment times. These leaflets were also available in other languages and formats.

- We spoke with five patients in the diabetes centre; they were all happy with the discussions and involvement in decisions about their care. They said the communication was good. One young patient, showed us a copy of their letter, which was addressed to them personally (rather than to a parent).
- Patients in the diabetes centre told us that staff explained clearly what was going to happen to them.
- One patient in ophthalmology/orthoptics said, "The doctor made me feel as though he was a friend; he explained everything that was going to happen to me."
- In radiology, three out of six patients told us they had asked questions of the radiology staff and they had directed them to the website. One said, "Today was an opportunity to ask them (staff) about my anxiety but they kept referring me to the website" and another said, "I had a lot of questions but have been referred to the website."
- In neurology OPD one patient said, it was difficult to find the neurology department.

Emotional support

- Patients received emotional and psychological support to help them cope with their care, treatment or condition. For example, the ophthalmic oncology nurses phoned their patients regularly. Staff in ophthalmology told us the service provided good support for patients.
- In breast screening / breast clinic, we saw a specialist breast care nurse supporting patients. We heard them inviting their patient in by name and asking whether their friend wanted to come in to the consultation too. We observed kind, caring interactions between the nurse and patient.
- In the same clinic, we spoke with a staff nurse who was on rotation from surgical OPD. They told us the emotional support offered to the patients using the service was an important part of the role. They said there were two patients out of 27 on the list for that day which staff had identified as needing additional emotional support.
- Breast services had a psychologist in the department every time patients attended this service. They provided additional support and counselling.
- In diabetes and endocrinology clinics, there was evidence of compassionate care. Many patients attended the same clinics on multiple occasions and developed relationships with the staff team.
- In neurology OPD, we spoke with a patient and their carer. The patient was living with learning difficulties. The carer told us the patient was anxious but the staff had been "Very reassuring."
- The motor neurone service had a benefits advisor, who supported patients and helped them navigate the benefits system.
- The audiology OPD had recently set up a Sheffield tinnitus support group. This group was to provide people with free access and advice about tinnitus.
- In radiology, we observed excellent care and support provided to a patient with special needs. The staff team worked together to provide positive emotional support to the patient and their relatives and ensured they were kept informed at each step of the treatment and care process.
- Staff altered their body positions and voice tone appropriately to reassure, encourage and secure the patients cooperation. They spent time calming the patient and explaining the procedure and answering questions to help the patients understanding.
- The procedure was unhurried, which allowed the patient to be reassured by their relatives and to progress at their own pace. Once the patient had been safely transferred for treatment, the staff provided the relatives with positive emotional support.
- We observed chaperone notices on display in the OPD clinic areas we visited.
- Staff in the emergency eye clinic told us how they understood the potentially life changing consequences of the injuries they treated, and how emotional support was a big part of their role.
- Advice relating to support groups was available and staff were knowledgeable and respectful of the feelings of patients.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

We judged the responsiveness of these services to be good because patient's needs were met through the way services are organised and delivered. We found;

- Access and flow in the OPD and radiology departments was well managed, even though all of the departments were busy.
- Referral to treatment times (RTT) were being met in the majority of services and the 'did not attend' (DNA) rates were lower (better) than the national average.
- People's individual needs were being met. There was good support for patients with additional needs such as learning disabilities and appropriate equipment for bariatric patients. Many of the services ran 'hotlines' so that patients could access clinical advice by telephone.
- There were initiatives in place to speed up diagnostic processes. These included hot reporting of x-rays (in 20 minutes), and a walk in radiology service for GPs where the report went back on-line.

However:

- Patients sometimes waited for long periods (up to four hours) for ambulance transport. The waiting area was cold and draughty with no television, magazines, notice boards or refreshments provided. Many of these patients were in wheelchairs. In the OPD areas patients requiring transport were given priority to be seen.

Service planning and delivery to meet the needs of local people

- The trust planned and delivered services to meet the needs of local people. For example, in medical OPD, staff told us ambulance patients were given priority so that they could get back home.
- The service manager in ophthalmology told us the service was looking at less invasive techniques.
- The ear, nose and throat OPD told us scientists led the audio vestibular service for complex hearing.
- Some OPD clinics offered a one-stop service and/ or hot clinics, including the haematology, neurology and urology OPD clinics.
- Staff in the diabetes centre explained that they provided a comprehensive diabetes service; the service provided antenatal care, adolescent transition and renal care. The diabetes service had a strong commitment to patient education and had its own diabetes call centre.
- Staff explained they were a pilot site for the original DAFNE project. Dose Adjustment for Normal Eating (DAFNE) is a way of managing Type 1 diabetes and provides people with the skills necessary to estimate the carbohydrate in each meal and to inject the right dose of insulin. They were involved in the rollout and development of DAFNE.
- Staff in the diabetes centre told us the foot clinic had a high profile for being responsive to patients' and was nationally recognised for its good practice.
- Other services empowered patients to take responsibility for more of their care. For example, in renal OPD patients checked their own blood pressure readings and the neurology service ran group sessions for patients, which benefitted patients and encouraged self-management.
- Staff in the diabetes centre told us a diabetic specialist nurse was on cover from 9am to 5pm five days a week. They took calls and queries from patients, GPs and community nurses. We reviewed the call logs for the previous two days and saw that staff had recorded the time and date of the query, what the query was, who was dealing with it and exactly what was being done.
- The endocrinology clinic ran a range of clinics, which included pituitary, bone, neuroendocrine and adrenal clinics. We witnessed two clinics, one for 'late effects' and one for transition. The late effects clinic had two new patients and 11 follow up patients.
- The OPD management team told us there was a 'patient transport improvement group,' whose remit was to improve patient flow.
- Staff in the sexual health clinic told us the service covered a wide geographical area and provided care for all aspects of sexual health. This included health protection, psychological support and community engagement. The sexual health service had a 'duty doctor' who was on duty each day from 8.30am to 4.30pm. Their role was to answer telephone queries from patients and other healthcare professionals about any genitourinary issues.
- Nursing staff had extended their clinical practice to meet the needs of patients. For example, the neurology service had neurology nurse practitioners, who had

extended their clinical practice to include lumbar punctures and Botox administration; the service manager in ophthalmology told us nurses working in the department had extended roles to include performing cannulations and prescribing medications and in the OPD breast screening / breast clinic, staff nurses on rotation from surgical OPD administered local anaesthetic to patients.

- Radiology performed investigations for approximately 500,000 attendances per year. The directorate had a five-year strategy developed for Medical Imaging and Medical Physics.
- Radiology staff told us the service provided same day services were, where practicable, for CT examinations. Direct referrals were available from GPs for CT, MRI, ultrasound, fluoroscopy and other specialised imaging. Radiology provided walk in services for x-ray plain film examinations.
- Radiology had made a successful bid to introduce a new breast tomosynthesis machine. This would produce 3D breast images and improve the sensitivity of the imaging in younger women with dense breasts.

Access and flow

- Access and flow in the OPD and radiology departments was well established. We saw all of the departments were busy during our inspection, but patient flow was generally maintained.
- Referral to Treatment (RTT) within 18 weeks had been performing above the national average since September 2014 and the 'did not attend' (DNA) rates were better (25%) lower than the national average. In ophthalmology, senior staff told us glaucoma pathway appointments were all completed within the 18-week target.
- The percentage of people waiting less than 31 days from initial cancer diagnosis to first treatment was better than the national average at 96.5% (September 2015). The percentage of people seen by a cancer specialist within two weeks and the percentage of people waiting less than 62 days from an urgent GP referral to first cancer treatment were both in line with the national average.
- There was a text reminder system in ophthalmology, staff told us older people may not like it and they could be removed from the system. Staff told us there had been a positive impact on did not attend (DNA) rates since the introduction of the text reminder service.
- Staff in neurology told us the service ran between 10 and 20 clinics per day. They said there was usually only one patient a week that did not attend their appointment. Patients attended neurology from a large geographical area. Staff told us the service had seen patients from other countries, including Italy and America. Three out of four patients we spoke with in neurology told us their appointments were on time; one person said they had been seen on time six times.
- Staff in neurology told us the service utilised time effectively by having OPD slots available while the consultants were on call.
- An audit of waiting times in neurology showed that the late arrival of the consultants was a key theme. Staff told us practice had been changed because of this audit and consultant's arrival times had improved.
- We spoke with five patients in the OPD diabetes centre; they were all happy with the waiting times.
- When we visited the endocrinology clinic, it was running on time and none of the patients had to wait. We observed a patient who had been referred to the late effects clinic in endocrinology. This patient had been attending a haematology clinic and staff had realised that they needed an urgent endocrinology appointment. The patient was transferred from the haematology clinic and the doctor saw them straight away.
- Staff told us the OPD anti-coagulation team in the haematology clinic told service had increased the referrals actioned within three hours to 86%. This had also reduced staff overtime and therefore improved staff engagement and morale. Staff told us a contact centre had been developed. As a result, staff called the patients more often about their care and treatment.
- Staff in the ear, nose and throat OPD told us the service ran 16 clinic sessions a day. They said patients with tinnitus and balance issues were seen at a one-stop clinic.
- In the foot clinic, which was part of the diabetes service, staff told us the team met before the clinic, in order to improve the flow.
- In the sexual health clinic, two nurses had been trained to do microbiological diagnosis of certain conditions in the clinic. This meant patients got their results more quickly, as samples did not have to be sent to the microbiology laboratory for testing.
- The eye clinic in ophthalmology ran a one-stop clinic for patients with macular degeneration. Staff told us they

saw around 33 patients each morning and around 180 per week. The service manager in ophthalmology told us one-stop clinics took around one and a half hours and the service also ran two-stop clinics.

- A staff nurse who worked in ocular oncology told us patients could contact the ward 24 hours a day.
- Senior nursing staff in ophthalmology told us the service was the first in the country to use radiation treatment for wet macular degeneration. They told us this treatment took four minutes and reduced the need for patients to have injections.
- Staff in the eye clinic in ophthalmology told us there were capacity issues; this was due to the number of clinic rooms available. They said there were problems, "every week."
- The ophthalmology bookings manager told us there were two contact centres dealing with phone calls. The explained that the system documented how many calls were made and how many were waiting to be answered. They said they identified busy times and planned staff leave and working hours to meet the demands at peak and quiet times.
- One patient in orthoptics told us, "I have had two rounds of surgery; it has made an enormous difference to my life." Another said, "I have had this squint all my life and now it's gone. They were great."
- In the diabetes OPD clinic, staff told us phlebotomy was available on a different floor in the same building. However, to improve patient flow, nurses in the department were being trained in taking blood samples from patients. They said this was a positive development for patient care.
- Staff in several OPD clinics told us patient appointment letters were sent out by first class post. Diabetes patients were sent letters about their care and treatment and their GP was copied in.
- Staff in the diabetes centre explained that the electronic booking system had an instant messaging facility. They gave an example from earlier that day when a patient had phoned to say they would be late for their appointment at the community clinic in a sports centre. This meant staff were able to let the doctor know, even though they were not on site.
- Staff in the diabetes centre also explained how the electronic system alerted them if a patient was admitted to the hospital. They showed us an example of a patient admitted who was not in an endocrinology bed/ward. They had contacted the patient's consultant and reminded them to visit them. The system showed patient locations across sites, including outliers (in different wards). This meant that doctors would not miss seeing any patients they should.
- Staff in the diabetes centre told us that new patients referred to the service were seen within 24 hours. Quotes from patients in the diabetes centre included: - "I know I can phone anytime; I've got no problems."
- In radiology waiting area one relative said, "I've been waiting 45 minutes; it's difficult with a two-year old."
- Patients waiting in orthoptics/ophthalmology told us there had been problems with appointments one patient had to contact the department to get an appointment and another patient told us that due to a member of staff being off the appointment could not be made. .
- In ophthalmology, we spoke with six patients. They all gave positive feedback and said there were no problems with waiting times. Comments included, "I think things run smoothly here" and "brilliant."
- Redesign of the cystic fibrosis clinic had been had reduced patient waiting times from 50 minutes to 5 minutes. Staff told us this had improved the interactions and discussions with patients. Staff documented what had changed by carrying our audits before and after the changes were made. Staff told us the compliance rates for treatment in the cystic fibrosis patient group had improved.
- We spoke with five patients and a care worker waiting for ambulance transport in the ambulance waiting area. One patient had been waiting three hours and 40 minutes, other people had waited between 30 minutes, and two hours, two patients told us waits were usually around two hours. The waiting area was cold and draughty with no television, magazines, notice boards or refreshments provided. Many patients were in wheelchairs. Patients were not given any information about the expected times of their ambulance.
- We spoke with a healthcare assistant working in this area who told us they were, "Not able to provide nutrition due to cutbacks." They said they had suggested putting on the patient's letters to bring food with them because of the long wait times; they were awaiting feedback on their suggestion. They said they could get diabetes patients a sandwich. However, they said patients were never left unattended and would take patients to the toilet if they needed it.

Outpatients and diagnostic imaging

- A team of around 14 dedicated radiology porters transferred patients between the wards and departments. This meant radiographers were in control of scheduling the times of arrival and departures of inpatients to and from the department.
- There were separate dedicated reception teams for managing inpatient and outpatient flow through the radiology department. Patients reported they did not have to wait long for their appointments. Staff arranged any further appointments prior to the patients discharge. Patients were given a choice of dates and times; staff offered appointments that suited the patient best.
- We did not observe any undue delays in radiology departments at the time of our visit. Staff told us, in the event of any delays, they kept patients informed. Inpatient examinations were performed within 24 hours to assist reductions in length of stays. The service provided walk in GP services for plain film examinations.
- The sonographers reported they had been involved in establishing and providing one-stop urology clinics.
- The MIMP directorate monitored turnaround times and produced a radiology report. The report for March to August 2015 showed the directorate was reporting CT, MRI and plain film reports within three days from the time of the scans. Sonographers reported ultrasound scans on the same day.
- The MIMP directorate waiting times and did not attend (DNA) report for December 2015 showed that the majority of patients appointments following referral were booked within two weeks. DNA rates were consistently low across all areas.
- Shorter diagnostic waiting times are linked to treatment waiting times and are of benefit to patients getting quicker access to treatment. The six week diagnostic wait target introduced by the DOH in 2008 is to ensure patients receive timely and appropriate treatment. The targets were being met consistently.
- We visited the MIMP directorate central appointments/ call centre. We spoke with the manager and they showed us that the majority of non-urgent appointments for all modalities were booked within two weeks of referral. The radiographers and sonographers were responsible for vetting all referrals for radiology procedures.
- The majority of radiology reporting was by the permanent staff in radiology. However, there were times, due to consultant radiologist's workloads, when radiology reports were outsourced to an external provider under contract. Systems and processes were in place for monitoring and reporting on the clinical quality, tracking and timings of outsourced radiology reports in compliance with an agreed range of key performance indicators.
- Staff told us the introduction of a breast fast track microsystem quality improvement methodology had improved breast fast track clinic workflow and waiting times. Measurable results of 22% reduction in patient cycle times and a 25% increase in the capacity of the clinics were reported.

Meeting people's individual needs

- Services took account of different people's needs, including those in vulnerable circumstances, with disabilities or complex needs. There were numerous leaflets and signs available.
- Translation services were available for patients to request and these services were available through appointment bookings. Staff told us they were aware and knew what procedures to follow to secure the services of translators. In one OPD clinic staff told us there was a 'special language machine' for interpreters to use, which allowed a three way consultation over the phone.
- Staff were able to describe how they cared for patients with memory impairments and learning disabilities. They told us they would fast track patients through the departments to reduce waiting times for these patients whenever possible. Staff in the emergency eye clinic were happy to make practicable changes to accommodate the needs of different people, and were able to tell us of care they had offered to patients with specific needs such as learning disabilities or religious beliefs.
- One patient waiting in the orthoptics department said, "They are very good. I can't understand English very well but they explain clearly."
- We looked at information for patients attending the eye department. We saw this had large clear writing and pictures, making it easy to read for people who were visually impaired. Staff who managed the glaucoma pathway told us their patient clinic letters were printed on yellow paper with larger print.
- Senior staff told us there were dementia leads and trainers in all services across the trust.

Outpatients and diagnostic imaging

- Ophthalmology ran a specialist clinic, which was run by a mental health nurse. This clinic was for patients with mental health, dementia and learning disabilities. Staff told us the patient's electronic health record showed whether patients had any additional needs.
- Staff in the ear, nose and throat OPD told us the service ran separate clinics for patients with learning disabilities, which had longer appointment times. They told us they were passionate about caring for this patient group. Staff told us they received bespoke training in caring for patients with dementia and learning disabilities.
- The diabetes service had a young person's diabetic specialist, a young adult diabetic specialist, and ran a 'WICKED' diabetes course for young people. This was a five-day course, which dealt with issues such as alcohol, drugs and sex.
- Staff in the diabetes centre showed us an example of a 21-year-old diabetic patients plan for moving into the adult diabetic service. We saw they were offered supportive transitional care.
- In the sexual health clinic, we saw there were separate waiting areas and clinic rooms for male and female patients attending the service.
- The main complaint from patients attending all of the OPD clinics was finding a parking space one patient told us that it could take 20 minutes.
- In radiology, we saw one patient with special needs attend the department for treatment escorted by their relatives. We saw staff handled both the patient and relatives empathetically; they were first on the list and were not kept waiting.
- Breast screening staff had recently been engaged in supporting health promotion initiatives for women with learning disabilities and different ethnic groups in the community.
- Staff gave patients choice for booking the location dates and times of appointments. Staff offered patients with special needs longer appointment times to ensure their additional needs could be accommodated.
- Patients we spoke with confirmed staff offered them appointments that suited their needs. Some patients confirmed that staff made appointments within two weeks of their referral; others commented that they did not have to wait a long time before they received their appointment.

Learning from complaints and concerns

- The provider took account of complaints and comments to improve the service. Staff we spoke with were able to describe the trust's complaints process.
- There were systems and processes in place to acknowledge, investigate and respond to complaints within a defined period. Complaints were discussed to share findings and identify learning outcomes at departmental and governance meetings. Minutes we reviewed confirmed this.
- For example, when we reviewed the minutes of the sexual health quality governance meeting for 10 December 2015 we saw complaints was a regular agenda item.
- The OPD management team explained that a contact centre had been set up three years ago, because of patient feedback. They told us since the introduction of the contact centre approach, there had been no complaints from patients about not being able to contact the departments by telephone.
- The matron in medical OPD told us complaints were dealt with at specialty level.
- Staff in neurology told us the service had low numbers of complaints, about one per month. They said the main theme was waiting times.
- Senior nursing staff in the eye clinic in ophthalmology told us they passed on any complaints to the patient partnership team if they could not be resolved at a local level. They reported complaints on the electronic reporting system.

Are outpatient and diagnostic imaging services well-led?

Outstanding ☆

We judged the well-led domain for this service to be outstanding because: the leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. We found;

- Services had a clear vision and strategy which staff were aware of and passionate about.
- There was a well-established culture of continuous quality improvement, which was supported by robust governance, risk management and quality monitoring.

Outpatients and diagnostic imaging

- Staff in radiology, OPD and pathology were happy and felt well-supported. There was evidence of good team working, both within and between teams, and a positive open culture.
- People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. For example, the public were involved in a survey to improve access and flow in the foot and ankle clinic.
- There were numerous examples of innovation and improvement across all of the services inspected.

Vision and strategy for this service

- Services had a clear vision, mission and strategy which staff were aware of and passionate about. Staff we spoke with were aware of the needs of their services and how the services planned to develop.
- The OPD management team told us there was an OPD service improvement programme, which had been in place for about three years. They explained there were 50 OPD teams working on improving their services and that many had 'flourished.'
- Services had looked at waiting times and redesigning services to better meet patients' needs. Many services already ran telephone clinics, but the vision was to expand this by using technology such as Skype.
- The OPD care group vision was 'what is important for patients.'
- The MIMP directorate had a five year strategy developed that set out a range of developments in services and technologies to improve the quality of patient care and treatments. For example;
  - growth in, and technological advancement of, cross sectional imaging
  - introduction of new imaging technologies such as breast tomosynthesis
  - The 3D imaging lab to become central to radiology workflows
  - New PACS and RIS systems.

Governance, risk management and quality measurement

- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring.
- Senior nursing staff in ophthalmology told us the service had its own governance lead. They said their service's risks included space, overdue glaucoma reviews and medical retina capacity; the governance lead had escalated these risks to trust level.
- Histopathology and cytology were accredited with Clinical Pathology Accreditation (CPA) and the United Kingdom Accreditation Service. There were no significant outstanding issues from the most recent inspections. Pathology had a comprehensive audit programme, which included the cervical cytology service, which they provided for laboratories in Jersey.
- The clinical, scientific and nursing directors together with the matron, directorate and governance managers attended the radiology monthly clinical governance committee meetings. The committee routinely reviewed and monitored the directorate's overall governance performance. It also routinely reviewed all incidents, complaints, claims and inquests in order to identify and monitor trends.The management team told us teach OPD speciality had its own risk register and these fed into the trust wide risk register. When we asked about current risks, they said the main risks were:-
  - Estate – the environment and space could be improved
  - Access – parking problems have a negative impact on patient's experience
  - Children in adult clinics, such as ophthalmology
- The Safety and Risk Management Board met monthly and included a range of managers attending from each clinical directorate. This meeting discussed risks and learning across the trust. The MIMP governance manager attended these board meetings. We saw from the August, September and October 2015 minutes that patient safety alerts and safety reports were reviewed from a number of committees. The minutes included the learning from incidents, inquests, claims and complaints processes, health and safety, safety of medical devices and serious untoward incidents (SUI's).
- All five safety sub groups reported to the Radiation Safety Steering Group (RSSG) who in turn reported to the trusts Healthcare Governance Committee and then onwards to the Board of Directors.
- The June, July and September 2015 meeting minutes included reviews with action notes recorded. Actions from previous reviews were followed up appropriately at subsequent meetings.

Outpatients and diagnostic imaging

- The purpose of the sub groups and RSSG was to ensure 'radiation safety issues requiring action by the trust are reported and acted upon appropriately in order to achieve on-going legislative compliance and ensure the safety of staff, public and patients.
- The MIMP directorate employed Radiation Protection Advisors (RPA's) and Radiation Protection Supervisors (RPS's). Arrangements were in place to seek advice from the RPA's in accordance with the local rules. RPAs also supported procurement of radiology equipment, room planning, quality assurance, incident investigations and governance, radiology local rules and local risk assessments.

Leadership of service

- The trust operated a system of devolved leadership and clinically led care groups and clinical directorates were responsible for managing the majority of services. There were nine care groups.
- A clinical director, supported by scientific, operations and nursing directors, led the MIMP (Medical Imaging and Medical Physics) directorate. All the directors together with a number of other senior managers and service heads manage medical imaging and medical physics services and an integrated staffing resource of clinical, scientific and technical experts across the directorate.
- The medical imaging and medical physics (MIMP) clinical directorate was fully integrated, bringing together the services of radiology and medical physics at the Royal Hallamshire Hospital (RHH), Northern General Hospital (NGH) and Weston Park Hospital (WPH).
- Staff we spoke with reported that local leadership was positive. All of the staff we spoke with were aware of the changes at care group level and could access the relevant information from the intranet. Staff told us managers were visible in clinical areas.
- Staff we spoke with were overall very positive about the recent and future management of MIMP directorate. It was felt that the present management structure and the direction in which the directorate is going were clear and supportive. The teams working across the directorate had a strong bond with each other.

Culture within the service

- Staff told us they were happy and felt supported in their roles. They also told us team working was good.
- Staff in radiology and OPD told us they were proud of the services they provided and that patients rarely had to wait long for their appointments.
- In pathology, there were good links between management and clinical staff. They shared common values and ethos, which was evident through the high quality of the clinical work and pathology's programme of innovation.
- Staff spoke highly of the trust's support for staff training and development.
- Staff were aware of the trust's PROUD values; these had been incorporated into the appraisal process for all staff. PROUD was an acronym for:-
  - Patient first
  - Respectful
  - Ownership
  - Unity
  - Deliver
- Staff in ophthalmology told us the service had a "proud and happy team that worked well together."
- The internal reorganisation of the trusts medical imaging service was still in progress at the time of inspection. Senior managers envisaged this process was likely to continue for several months and it would take time for all the staff to adjust to the new ways of working.
- The majority of the staff we spoke with had a positive, optimistic and confident view about the recent changes introduced through the MIMP directorate and care group structure.

Public engagement

- Outpatients participated in the NHS England friends and family test (FFT).
- Staff in the sexual health service told us they carried out a patient engagement survey every three months. This was to ensure the service was providing a patient-focussed service. This was in addition to the trust's friends and family test (FFT) surveys. Staff told us this was an important way of capturing the patient experience.
- The OPD management team told us they had done a lot of work getting patient and staff views about services. This work identified a theme about how patients preferred to be contacted; this resulted in the introduction of the contact centres.

Outpatients and diagnostic imaging

- The OPD management explained there was now one triage point for patient referrals; this ensured they were allocated to the correct clinics. The team told us there had been engagement with patients and the service had been designed with input from patient groups.
- Staff in the diabetes centre explained how they involved patients in decision-making.
- Staff across the trust had undertaken customer service training; 587 staff had undertaken training (as of March 2015). This training was co-ordinated by the patient partnership.
- Staff told us the OPD anti-coagulation team had asked patients for feedback about the service when the service was process mapped and redesigned.
- Ophthalmology had carried out a 'glaucoma unit patient satisfaction survey' in 2015. This examined the service patients received and ways to improve. The overall rating of the service was very good and patients said they were seen on time or early.
- In neurology, neuro-psychotherapists involved patients in staff training. For example, patients had contributed to the neurology nurse training day in October 2015
- In radiology, the service sought patient opinion through the MIMP patient survey. The 2014 and 2015 survey reports showed patients were very positive and satisfied with the services provided. Managers used patient feedback in business planning.
- The outcomes from the surveys were shared with the service heads. The service agreed on focused actions, to build on to improve the quality of services provided to patients.

Staff engagement

- The NHS Staff Survey 2014 showed 11 positive indicators and 17 as 'expected' out of 31 indicators. The trust had on-going initiatives to improve staff engagement. For example, the diabetes and endocrinology directorate held an annual 'time-out.' This was a multidisciplinary event to celebrate the achievements of staff and to consider future priorities.
- Sheffield Teaching Hospitals was selected as one of the top 40 acute trusts to work for in the Health Service Journal's 'Best Places to Work' Awards.
- Staff in OPD told us that the trust's outpatient improvement programme and 'Listening into Action' groups were established within the directorate. Over 50 teams were undertaking improvement based work. Staff told us managers and senior staff asked for their ideas and solutions through local engagement.
- Staff in ophthalmology told us it was a good team. One said, "You're never turned away if you have an idea" and another said, "You can raise concerns." They told us there had been a time out to look at potential improvements to the service. They said there was no action plan yet, as the session was very recent. Ophthalmology staff told us there were suggestion boxes for staff to submit ideas for discussion at staff meetings.
- The OPD bookings supervisors told us there was a workplace well-being service, which offered services such as counselling for staff. They explained this was a free confidential service for NHS staff.
- Staff in OPD told us there were regular monthly meetings and emails were sent to staff that could not attend.

Innovation, improvement and sustainability

- The directorate hosted the 'Devices for Dignity (D4D) Healthcare Co-operative'. A national initiative to drive forward innovative products processes and services to help people with long-term conditions'.
- The Devices for Dignity (D4D) Healthcare Co-operative' had been recognised with a number of awards including; 2012 Advancing Healthcare Awards and Allied Health Professionals and Healthcare Scientist; Leading Together on Health Award.
- Sheffield ophthalmology was the only centre in the country that carried out stereotactic radiosurgery (SRS). This treatment uses radiation therapy and focuses high-power energy on a small area of the body. The service had been carrying out this procedure for the past 25 years. The service also carried out photodynamic therapy (PDT) to treat cancer and audits showed this treatment had an 85% success rate. Photodynamic therapy is a treatment that uses a drug, called a photosensitizer or photosensitizing agent.
- Staff in the diabetes service told us the service had just started a six-year National Institute for Health Research (NIHR) programme to further develop education about type 1 diabetes.
- Histopathology was using digital pathology. Six biomedical scientists at the NGH site had been trained to prepare frozen sections of tissue; this preparation

used to be undertaken by histopathology consultants. The biomedical scientists dissect and prepare the samples while on video link to the RHH so that the technique can be checked and quality maintained. Staff scanned and digitally transferred the resulting image to the histopathology consultants at the RHH site. This technique was time efficient and speeded up the process for the patient.

- Cancer services at the trust had won awards from the Health Service Journal and the Nursing Times. For example, in 2014 the service had received the Cancer Care Award.
- The development of the Sheffield 3D imaging lab is unique to the NHS and provides improved quality of scans and detail of brain tumour growth. Images could be processed quicker, in seconds rather up to an hour, saving time and money. The 3D lab was a finalist in the Yorkshire and Humber Medipex NHS Innovation awards.
- In addition to walk in services for general plain film imaging GP's can refer patients directly for CT, MRI, ultrasound, fluoroscopy and other specialised imaging examinations.
- There was a state of the art Medicines and Healthcare products Regulatory Agency (MHRA) Licenced Radiopharmacy, serving all of the trusts locations.
- Nuclear medicine staff were finalists in the Medipex NHS innovation awards 2014 after developing a new system for diagnosing debilitating digestive disorder that freed up the gamma camera, so reducing patient waiting times.

Outstanding practice and areas for improvement

Outstanding practice

- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- The use of duty floor anaesthetist role in theatre, developed in Sheffield, was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for minor injury patients; results were ready within 20 minutes
  - Histopathology was using cross-site digital pathology to speed up processing time for frozen sections.
  - On GCC and NCC there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered andit was fully integrated and provided real-time information across teams and services
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in Critical care.
- The one to one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- The rapid access clinic reduced readmissions of babies with feeding problems.
- The GRIP project responsible for getting research into practice improved services for maternity and gynaecology.
- The termination of pregnancy service gave women continuity of care in an appropriate caring environment. The seven day service gave women choice and improved accessibility.
- The use of the Enhanced Recovery programme in both maternity and gynaecology improved the service for women.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure the safe storage of IV fluids.
- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure that guidance is followed in the documentation of fetal heart rate monitoring's. In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitionerwere not always documented on the monitoring, in accordance with trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6).
- The trust must ensure that DNACPR records are fully completed.
- The trust must ensure a strategy for end of life care is implemented.

Action the hospital SHOULD take to improve

- The hospital should ensure that staff have attended mandatory training in accordance with the trust target.
- The MIU should improve the monitoring of time to be seen and total time in department.
- Although the MIU works closely with the A&E at NGH, audits specific to the MIU should be completed to show effectiveness and to monitor improvement to services and treatment offered in this location.

Outstanding practice and areas for improvement

- Review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.
- The trust should improve the compliance rates for medical and nursing staff receiving an annual appraisal.
- The trust should continue to take action to reduce the number of medical outlier patients across the trust.
- The trust should continue to take action to reduce the number of bed moves patients experience during their hospital stay.
- The trust should try to reduce the movement of staff to clinical areas outside of their speciality.
- The trust should introduce a robust process to share lessons learnt from incidents and mortality and morbidity reviews across directorates and care groups.
- The trust should review the labelling of babies prior to their removal from the obstetric theatre.
- The trust should ensure that the neonatal resuscitaires in labour suite has documented checks. We identified checklists that had signatures missing 22% of the time for the month examined.
- The trust should continue to improve consultant medical staffing on labour ward in accordance with Royal College of Obstetrician and Gynaecologists guidelines.
- The trust should review data collection methods and introduce a system to collect patient outcomes by surgical speciality within care groups.
- The trust should review the waiting times for patients with learning disabilities requiring dental treatment under general anaesthesia against the 18 week standard.
- The trust should ensure appropriate medical and nursing staffing on the neonatal unit to reflect current national guidelines for safe care.
- The trust should review patient centred care planning on the neonatal unit.
- The trust should consider improving the way in which medicines are constituted within the neonatal unit to ensure there is a safe environment to do this, and reduce risk of medicine errors.
- The trust should monitor preferred place of care for patients at the end of life.
- The trust should review access and the environment of the chapel and prayer room.
- The trust should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.
- The trust should undertake regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks.
- The trust should review oversight of the area and facilities for patients waiting for transport following the clinic appointments.
- The trust should monitor access to records in the outpatient departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How it was not being met: Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to : 1. assess, monitor and improve the quality and safety of services 2. 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 How it was not being met: In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with trust guidance (Intrapartum fetal monitoring - CTG, 5.5, 5.6).