The Newcastle upon Tyne Hospitals NHS Foundation Trust

Inspection report

Freeman Hospital
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

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

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

We carried out this unannounced inspection of six acute services provided by this trust as part of our continual checks on the safety and quality of healthcare services. These were urgent and emergency care, medicine, surgery, maternity, children and young people, and NECTAR, the trust's ambulance service.

We carried out an unannounced focused responsive inspection of the maternity service in response to six whistleblowing concerns about patient safety and the culture in the service. We reviewed some of the safe, effective, responsive, and well led key lines of enquiry.

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

We carried out a further targeted inspection into surgical cardiothoracic services on 28 September 2023 in response to increased concerns raised by whistleblowers following the core services inspection. The details of this are reported in a separate report dated the same.

We did not inspect critical care, diagnostic and imaging, outpatients, end of life and community.

Overall summary

Our findings

The Newcastle upon Tyne Hospitals NHS Trust received NHS Foundation Trust status in June 2006. The trust provided a full range of acute and specialist hospital and community services.

The Trust serves the City of Newcastle upon Tyne for secondary health services, and also provides specialist tertiary and quaternary services to the region and nationally. 14% of the population of Newcastle upon Tyne are aged 65 and over, compared to 18% nationally. The Local Authority (LA) had a similar breakdown by ethnicity to the national average, with 13% of the population being BAME (Black, Asian, and Minority Ethnic) residents.

Newcastle upon Tyne performed significantly below the England average for most of the indicators in the Local Health Profile, particularly on the mortality indicators. The health of people in Newcastle upon Tyne was generally worse than the England average.

Newcastle upon Tyne was one of the 20% most deprived districts/unitary authorities in England and about 25% (12,000) of children live in low income families. Life expectancy was 12.9 years lower for men and 10.4 years lower for women in the most deprived areas of Newcastle upon Tyne than in the least deprived areas.

The trust had approximately 1729 beds and employed 14710 members of staff. Activity at the trust was in the highest 20% of trusts nationally for inpatient admissions, outpatients and UEC (Urgent and Emergency Care) attendances. In the second highest quintile for deliveries (Mar 21 to Feb 22).

It is one of the largest teaching hospitals in England providing academically led acute, specialist and community services for adults and children to a large and diverse population across the North East and Cumbria as well as nationally and internationally.

The trust operated from six registered locations.

- The Royal Victoria Infirmary (which includes the Great North Children's Hospital)
- The Freeman Hospital which includes the Northern Centre for Cancer Care and Institute of Transplantation
- Campus for Ageing and Vitality
- The Dental Hospital
- The Centre for Life
- The Regional Drug and Therapeutics Centre
- Various community sites

The CQC had carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in January 2016. We rated effective, caring, responsive and well led as outstanding safe was rated as good.

Following that inspection, we inspected Emergency Care, End of Life and Diagnostic and Imaging services in May 2019. We rated effective, caring, responsive and well led as outstanding. Safe was rated as good.

Our findings

In November 2022 we carried out an unannounced focused inspection which looked specifically at the quality and safety of care provided to patients with a mental health need, a learning disability or autism. We carried out inspection activity in five of the acute services provided by this trust because we had concerns about the quality of services provided to people with a mental health need, a learning disability or autism.

Following our inspection of the trust's services in December 2022, we formally wrote to the trust to share our concerns about our inspection findings. The trust provided details of the immediate steps taken to ensure patient safety. In response to our findings, we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008. The Warning Notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in relation to patients with a mental health need, a learning disability or autism. We asked the trust to take action to improve the quality and safety of services.

In January 2023, we inspected maternity services as part of the CQC national programme. The service was rated requires improvement for safe and good for well led. This inspection report was published in May 2023.

After this inspection we have used our enforcement powers to impose conditions on the trust's registration. The conditions require the trust to make specific improvements within a specified timescale, and to submit monthly reports to CQC showing progress with actions taken to improve quality and safety. The conditions required the trust to:

Implement an effective governance system. This must assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for service users in line with the regulations.

Our rating of services went down. We rated them as requires improvement because:

- We rated well led as inadequate, safe, effective, and responsive as requires improvement, and caring as good.
- We rated 5 of the trust's 9 services as requires improvement and 1 as inadequate. In rating the trust, we took into account the current ratings of the 8 services not inspected this time.
- Some of the services did not always have enough staff to care for patients and keep them safe. However, we saw evidence of staffing escalation frameworks to maintain patient safety. Staff did not always assess monitor or manage risks to patients, act on them or keep good care records. They did not always store and manage medicines safely. Not all staff reported incidents in a consistent and standardised way. Services did not always define the correct levels of harm according to the NRLS (National Reporting and Learning System) definition. Staff we spoke to did not always receive feedback or learning from incidents. However, the CQC noted the results of the national staff survey which showed that the trust was above sector average in scores relating to reporting of errors, incidents and near misses.
- Care and treatment was not always delivered in accordance with national guidance or evidence-based practice. Managers did not always monitor the effectiveness of the service or always work well together for the benefit of patients.
- People could not always access the services when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Senior staff were not always visible and approachable in the services for patients and staff. They did not always use systems to manage performance effectively or make decisions and improvements. They did not have clear oversight

of the key risks and had not always mitigated immediate risks. Staff did not always feel respected, valued, and supported. The trust did not have a culture where staff could raise concerns without fear as they were not always managed appropriately. Although the NHS Staff Survey showed that in 2022 74% of staff felt secure about raising concerns about unsafe clinical practice. This is the same as the regional average for acute Trusts and higher than the national statistic of 71%. However, CQC staff survey indicated that the trust did not have a culture where staff could raise concerns without fear.

- It should be noted that the NHS staff survey was completed in 2022, a different time period to the CQC staff survey completed as part of this inspection.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- Staff had training in key skills and understood how to protect patients from abuse.
- There were ongoing examples of innovation and research.

How we carried out the inspection

The team that carried out the core services and well led inspection included two deputy directors of operations, an operations manager, 10 hospital inspectors, three mental health inspectors, two pharmacy inspectors and an inspection planner. In addition, there were 10 specialist advisors with clinical expertise in the core services areas. There was an executive reviewer plus four specialist advisors experienced in executive leadership of NHS trusts. The inspection team was overseen by Sarah Dronsfield, Deputy Director of Operations.

During the inspection we spoke with a variety of staff including consultants, doctors, therapists, nurses, healthcare support workers, pharmacy staff, domestic staff and administrators. We held staff focus groups attended by representatives of all grades of staff across nursing, midwifery, allied health professions and medical staff networks. We also carried out a confidential staff survey. This was to enable staff to share their views with the inspection team.

Outstanding practice

We found the following outstanding practice:

Freeman Hospital

Children and young person's services

- Staff worked collaboratively to encourage children, young people and their loved ones to explore care and support options including advanced decisions including preferred place of death with particular care and sensitivity.
- Staff came up with creative ways to ensure they were prepared in the event of an emergency by making an emergency medication calculator and grab bag.

Our findings

- The service had created bespoke tools to increase patients' ability to monitor their health from home to decrease hospitalisation, repeat visits and mortality rates.
- The service provided accommodation options for parents that did not live locally to the Freeman to ensure seeing their child was as accessible as possible.
- The service was exceptional in supporting families and loved ones to understand a child's condition and be actively involved in the observation and escalation process of any deterioration in their condition to improve the timeliness of intervention.
- Staff had developed innovative and creative ways to communicate with each person using the service.
- Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary.
- Staff actively sought feedback from children, young people and their families when planning to make improvements to the service.
- Children, young people and their loved ones emotional and social needs were seen as being as important as their physical needs and the service created innovative ways to promote positive wellbeing.
- The service continually participated and led research projects to proactively seek sand embed new and sustainable practice.

Royal Victoria Infirmary

Children and young person's services

- The service provided accommodation options for parents that did not live locally to GNCH to ensure seeing their child was as accessible as possible.
- The service provided transport services to support families and loved ones in being as close to their child as possible.
- The service was exceptional in supporting families and loved ones to understand a child's condition and be actively involved in the observation and escalation process of any deterioration in their condition to improve the timeliness of intervention.
- Staff found innovative and creative ways to communicate with each person using the service.
- Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary.
- Staff actively sought feedback from children, young people and their families when planning to make improvements to the service.
- The service continually participated and led research projects to proactively seek sand embed new and sustainable practice.

Maternity

- The service provided a maternal medicine centre for the North East and North Cumbria region. This provided a multidisciplinary approach to pre-pregnancy, antenatal and postnatal care across a number of providers and NHS trusts for women, and birthing people, who had significant medical problems.

Our findings

- All staff made every effort, under difficult circumstances, to meet the needs and care for women, birthing people, and babies. They had the resilience to continue to provide care in difficult staffing circumstances.

Areas for improvement

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

Action the trust MUST take to improve:

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

Trust wide

- The trust must ensure it supports all staff, including those with particular equality characteristics, to feel respected and valued and support an environment where staff are encouraged to speak up and raise concerns without fear of blame or reprisal. **Regulation 18 (2)(a).**
- The trust must demonstrate it supports its staff by challenging unacceptable behaviours and language. This includes but is not limited to discrimination. **Regulation 18 (2)(a).**
- The trust must ensure that feedback from staff is used to drive improvements to the quality and safety of services, and once improvements are identified they are made without delay. **Regulation 17 (2)(e).**
- The trust must ensure that staff are able to report service user safety concerns without fear of reprisal, retribution or detriment using internal routes and in line with policies and procedures. **Regulation 17 (2)(e).**
- The trust must ensure it encourages the identification, reporting and investigation of incidents and risks in a timely fashion and shares learning to improve safety and quality of the service. **(Regulation 17 (2)(b).**
- The trust must ensure that risks recorded at corporate level and in the board assurance framework are current and have clear actions for mitigation which can be monitored and measured. **Regulation 17 (2)(b).**
- The trust must ensure that high level risks are fully assessed and mitigated to the lowest level of risk. **Regulation 17 (2)(b).**
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. **Regulation 17.**
- The trust must ensure there is full clinical engagement to support operational performance and that challenges are resolved with a focus upon patient safety across the organisation. **Regulation 17 (2)(a).**
- The trust must ensure all staff are aware of and consistently follow the trust policy, systems and processes to safely prescribe, administer, record and store and dispose of medicines. **Regulation 12 (1) (2)(g).**
- The trust must maintain securely an accurate, complete, and contemporaneous record including a record of the care and treatment provided to patients and of decisions taken in relation to the care and treatment provided. **Regulation 17 (1)(2)(c).**

Our findings

- The trust must ensure that all premises and equipment are clean, secure, suitable for the purpose for which they are being used, properly used and properly maintained. This includes but is not limited to daily checks of emergency equipment and COSHH chemicals. **Regulation 15 (1)(a)(b)(c)(d)(e).**

NECTAR service

- The service must ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in delivery of regulated activities, in line with national guidance and frameworks. **Regulation 17 (2)(a).**
- The service must ensure that all staff complete required mandatory training. **Regulation 12 (1)(2)(c).**
- The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity. **Regulation 17 (1)(2)(a).**
- The service must use performance data to identify and drive improvements.**Regulation 17 (1)(2)(a).**
- The service must ensure there are clearly defined assurance processes, including audits, and that all staff are aware of the required frequency and recording of these. **Regulation 17 (1)(2)(b).**
- The service must ensure ways to improve access to management, the staff experience, and methods to improve staff morale. **Regulation 18 (1)(2)(a).**

Freeman Hospital

Children and young person's services

- The service must ensure that mandatory training compliance meets the trust target. **Regulation 12 (1)(2)(c).**
- The service must ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. **Regulation 12 (2)(c).**
- The service must ensure that patient records include plans for managing risks. **Regulation 12 (2)(b).**
- The service must ensure they are doing all that is reasonably practicable to mitigate risks including following best practice guidance. **Regulation 12 (2)(b).**
- The service must ensure equipment used by staff to provide care and treatment is properly maintained. **Regulation 12 (2)(e).**
- The service must ensure that persons providing care or treatment to children and young people have the qualifications, competence, skills, and experience to do so safely. **Regulation 12 (2)(c).**
- The service must monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress is not achieved as expected. Regulation **17 (1)(2)(a).**
- The service must implement an effective system to ensure incidents are appropriately reported to external systems within appropriate timescales. **Regulation 17 (1)(2)(a)(b).**
- The service must ensure that Duty of Candour is given in full to patients when incidents occur. **Regulation 20 (3).**

Medical services

Our findings

- The service must ensure that all staff receive training at a level appropriate to their role in how to respond appropriately to the needs of autistic people. **Regulation 12 (1)(2)(c).**
- The service must ensure arrangements are in place and adhered to in order to ensure prevention and control of the spread of infections. **Regulation 12 (1)(2)(h).**
- The service must ensure that all gas cylinders are stored securely. **Regulation 15 (1)(b).**
- The service must ensure that all nutritional supplements are stored according to guidelines. **Regulation 12 (2)(g).**
- The service must ensure risk assessments have been carried out to minimise ligature risks and ensure that the premises and equipment used by the service users are done so in a safe way. **Regulation 12 (1)(2)(e)(f).**
- The service must ensure that all staff complete safeguarding training appropriate to their role. **Regulation 13 (1).**
- The service must have robust procedures in place for the identification, review and management of clinical risk when providing care and treatment. **Regulation 12 (1)(2)(a)(b).**
- The service must ensure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences. **Regulation 9 (1)(2).**
- The service must ensure that there is timely review of dementia friendly environments, ensuring that premises used by the service provider are safe to use for their intended purpose. **Regulation 12 (1)(2)(d).**
- The service must ensure that staff complete mental capacity and best interest decisions, when obtaining consent and that they clearly document the assessment and decision making process. **Regulation 13**.
- The service must ensure there are clear processes and timescales for carrying out audit and re-audit of activities including the use of hospital passports in order to improve practice. **Regulation 17 (1)(2)(f).**
- The service must ensure robust oversight and management of incidents and ensure incidents are shared across the health group. **Regulation 12.**

Surgery (including cardiothoracic surgery)

- The service must ensure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences **Regulation 9 (1)(2).**
- The service must ensure that mandatory and core competency training compliance meets the trust target. **Regulation 12 (1)(2)(c).**
- The service must ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. **Regulation 12 (2)(c).**
- The service must ensure arrangements are in place and adhered to in order to ensure prevention and control of the spread of infections. **Regulation 12 (2)(h).**
- The service must ensure care and treatment is provided in a safe way. This includes assessing the health and safety risks for service users receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to the use of bed sides. **Regulation 12 (1)(a)(b).**
- The service must ensure all staff are engaged with and participate in all steps of the World Health Organisation (WHO) surgical safety checklist, the checklist is fully completed, and observational and record audits are undertaken to monitor compliance. **Regulation 12 (1) (2)(a)(b)**.

Our findings

- The service must ensure that staff complete mental capacity and best interest decisions, where appropriate, when obtaining consent and that they clearly document the assessment and decision-making process. **Regulation 13 (4)(d)**.
- All premises and equipment used by the service provider must be secure and suitable for the purpose for which they are being used, properly used, properly maintained, and appropriately located for the purpose for which they are being used. This includes but is not limited to the storage of medical gases. **Regulation 15 (1)(b)(c).**
- The service must ensure clinical care and treatment are delivered and monitored in accordance with national guidance and best practice. **Regulation 17.**
- The service must ensure learning from never events is shared with all staff. **Regulation 17.**
- The service must improve its monitoring and auditing of surgical safety checklists and ensure the finding of these audits are shared with staff. **Regulation 17.**
- The service must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance. **Regulation 17 (1).**
- The service must ensure a robust audit plan is in place and key audits are conducted, which include record keeping, medicines management and infection prevention and control audits. The service must ensure relevant actions identified by local audits are acted on. **Regulation 17 (1)(2)(a)(b)**.
- The service must operate effective systems and processes to make sure they assess and monitor their service. This should include the auditing of surgical safety checklists, documentation, infection prevention and control. **Regulation 17 (1).**
- The service must monitor progress against plans to improve the quality and safety of services and take appropriate action without delay, where progress is not achieved as expected. **Regulation 17 (2)(a).**
- Senior managers must ensure robust systems and processes are in place to identify, manage, mitigate and if appropriate escalate risks. This must ensure senior managers and the board members have clear oversight of service risks. **Regulation 17 (1)(2)(a)(b).**
- The service must ensure that there are sufficient numbers of suitably competent, skilled, medical staff to meet minimum staffing levels and meet the care and treatment needs of service users. **Regulation 18.**

Royal Victoria Infirmary

Children and young person's services

- The service must ensure that mandatory training compliance meets the trust target. **Regulation 12 (1)(2)(c).**
- The service must ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. **Regulation 12 (2)(c).**
- The service must ensure that timely care planning takes place where responsibility for care and treatment is shared with, or transferred to other services. **Regulation 12 (2)(i).**
- The service must ensure equipment used by staff to provide care and treatment is properly maintained. **Regulation 12 (2)(e).**
- The service must ensure that persons providing care or treatment to children and young people have the competence, skills, and experience to do so safely. **Regulation 12 (2)(c).**

Our findings

- The service must monitor progress against plans to improve the quality and safety of services and take appropriate action without delay where progress is not achieved as expected. **Regulation 17 (1)(2)(a).**
- The service must ensure they have an up to date and robust risk register in place, and there is appropriate oversight and management of this. **Regulation 17 (1)(2)(a)(b).**
- The service must implement an effective system to ensure incidents are appropriately reported to external systems within appropriate timescales. **Regulation 17 (1)(2)(a)(b).**
- The service must ensure that Duty of Candour is given in full to patients when incidents occur. **Regulation 20 (3).**

Medical services

- The service must ensure that all staff receive training at a level appropriate to their role in how to respond appropriately to the needs of autistic people. **Regulation 12 (1)(2)(c).**
- The service must ensure arrangements are in place and adhered to in order to ensure prevention and control of the spread of infections. **Regulation 12 (1)(2)(h)**.
- The service must ensure that all gas cylinders are stored securely. **Regulation 15 (1)(b).**
- The service must ensure risk assessments have been carried out to minimise ligature risks and ensure that the premises and equipment used by the service users are done so in a safe way. **Regulation 12 (1)(2)(e)(f).**
- The service must ensure that all staff complete safeguarding training appropriate to their role. **Regulation 13 (1).**
- The service must have robust procedures in place for the identification, review and management of clinical risk when providing care and treatment. **Regulation 12 (1)(2)(a)(b).**
- The service must ensure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences **Regulation 9(1)(2).**
- The service must ensure that there is timely review of dementia friendly environments, ensuring that premises used by the service provider are safe to use for their intended purpose. **Regulation 12 (1)(2)(d).**
- The service must ensure that staff complete mental capacity and best interest decisions, when obtaining consent and that they clearly document the assessment and decision making process. **Regulation 13.**
- The service must ensure that guidance in policies is up to date and systems and processes are embedded and operated effectively to ensure compliance with the Mental Capacity Act. **Regulation 17 (1)(2)(a).**
- The service must ensure there are clear processes and timescales for carrying out audit and re-audit of activities including the use of hospital passports in order to improve practice. **Regulation 17 (1)(2)(f).**
- The service must ensure all staff are aware of and consistently follow the service policy to safely prescribe, administer, record and store and dispose of medicines. **Regulation 12 (1) (2)(g).**
- The service must ensure robust oversight and management of incidents and ensure incidents are shared across the health group. **Regulation 12.**

Surgery

- The service must ensure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences. **Regulation 9 (1)(2).**

Our findings

- The service must ensure that mandatory and core competency training compliance meets the trust target. **Regulation 12 (1)(2)(c).**
- The service must ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. **Regulation 12 (2)(c).**
- The service must ensure arrangements are in place and adhered to in order to ensure prevention and control of the spread of infections. **Regulation 12 (2)(h).**
- The service must ensure care and treatment is provided in a safe way. This includes assessing the health and safety risks for service users receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to the use of bed sides. **Regulation 12 (1)(a)(b).**
- The service must ensure that staff complete mental capacity and best interest decisions, where appropriate, when obtaining consent and that they clearly document the assessment and decision-making process. **Regulation 13 (4)(d).**
- All premises and equipment used by the service provider must be secure and suitable for the purpose for which they are being used, properly used, properly maintained, and appropriately located for the purpose for which they are being used. This includes but is not limited to the storage of medical gases. **Regulation 15 (1)(b)(c).**
- The service must ensure clinical care and treatment are delivered and monitored in accordance with national guidance and best practice. **Regulation 17.**
- The service must ensure learning from never events is shared with all staff. **Regulation 17.**
- The service must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance. **Regulation 17(1).**
- The service must ensure a robust audit plan is in place and key audits are conducted, which include record keeping, medicines management and infection prevention and control audits. The service must ensure relevant actions identified by local audits are acted on. **Regulation 17 (1)(2)(a)(b).**
- The service must operate effective systems and processes to make sure they assess and monitor their service. This should include the auditing of surgical safety checklists, documentation, infection prevention and control. **Regulation 17 (1).**
- The service must monitor progress against plans to improve the quality and safety of services and take appropriate action without delay, where progress is not achieved as expected. **Regulation 17 (2)(a).**
- Senior managers must ensure robust systems and processes are in place to identify, manage, mitigate and if appropriate escalate risks. This must ensure senior managers and the board members have clear oversight of service risks. **Regulation 17 (1)(2)(a)(b).**
- The service must ensure that there are sufficient numbers of suitably competent, skilled, medical staff to meet minimum staffing levels and meet the care and treatment needs of service users. **Regulation 18.**

Maternity

- The service must ensure that mandatory and core competency training compliance meets the trust target. **Regulation 12 (1)(2)(c).**
- The service must ensure premises are safe. This includes but is not limited to ensuring storeroom doors are not left open or unlocked. **Regulation 12 (1)(2)(d).**

Our findings

- The service must ensure there are sufficient quantities of cardiotocography (CTGs), central monitoring equipment and cleaning equipment to ensure the safety of women, birthing people, and babies. **Regulation 12 (1)(2)(f).**
- The service must ensure they are delivering fundamental standards of care that meets the needs of women, birthing people, and babies. This includes assessing the health and safety risks and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to staffing, risk assessments and security. **Regulation 12 (1)(2)(a)(b).**
- The service must ensure that there are sufficient numbers of competent, skilled, and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies. This includes but is not limited to ensure that the skill mix supports the acuity of patients. **Regulation 18 (1)(2)(a).**
- The service must ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to enable them to carry out their duties. **Regulation 18 (1)(2)(a).**
- The service must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. **Regulation 17 (1)(2)(a)(b).**
- The service must assess, monitor, and improve the quality and safety of the services and mitigate the risks relating to the health, safety and welfare of women, birthing people, and babies. **Regulation 17(1)(2)(a)(b).**

Urgent and Emergency Care

- The service must have robust procedures in place for the identification, review, and management of risk. **Regulation 12**
- The service must ensure that mandatory training compliance meets service and trust targets. **Regulation 12 (1)(2)(c)**
- The service must ensure that staff complete mental capacity and best interest decisions, when obtaining consent and that they clearly document the assessment and decision making-making process. **Regulation 13**
- The service must ensure a robust audit plan is in place and key audits are conducted, including record keeping, daily checks and medicines management audits. The service must ensure relevant actions identified by local audits are acted upon. **Regulation 17 (1)(2)(a)(b)**
- The service must ensure it has an up to date and robust risk register in place with appropriate oversight, management, and implementation of identified actions. **Regulation 17 (1)(2)(a)(b).**
- The service must ensure systems and processes are established, operated, and audited effectively to ensure compliance with the requirements to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. **Regulation 17 (1) (3)**

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider ensuring all recording and timelines for grievances and disciplinary processes are a complete and contemporaneous record.

Freeman Hospital

Children and young person's services

Our findings

- The service should continue to act on concerns to improve culture within the Paediatric Intensive Care Unit.
- The service should consider how performance information is disseminated to staff at all levels.
- The service should ensure that records are accessible to all people as necessary to deliver people's care and treatment in a way that meets their needs and keeps them safe.

Medical services

- The service should ensure they continue to strive to achieve mandatory training compliance figures to achieve the trust target.
- The service should ensure regular completion of the clinical assurance tool and clear action plans are available for all staff.
- The service should ensure that all clinical waste and sharps bins are marked and stored properly.
- The service should ensure that all equipment that requires removal from ward areas is stored securely.
- The service should ensure that service user records are stored securely.
- The service should ensure that there are effective communication systems and processes to seek and action feedback from staff on the services provided in the provision of the regulated activities. This includes visibility of the senior leadership teams.

Surgery (including cardiothoracic services)

- The service should further improve the quality of food provided to all patients and seek regular patient feedback.
- The service should consider increasing the numbers of discharge co-ordinators across the speciality.
- The service should consider the reintroduction of volunteers across the speciality

Royal Victoria Infirmary

Children and young person's services

- The service should consider a review of staffing on the Paediatric Intensive Care Unit to ensure that the skill mix supports the acuity of patients.
- The service should consider how performance information is disseminated to staff at all levels.
- The service should ensure that records are accessible to all people as necessary to deliver people's care and treatment in a way that meets their needs and keeps them safe.

Maternity

- The service should ensure the guidance within their PPH policy is clear about defining and grading maternal blood loss in accordance with national guidance.
- The service should ensure that clinical sharps waste bins are dated and labelled in accordance with national guidance.

Surgery

- The service should further improve the quality of food provided to all patients and seek regular patient feedback.

Our findings

- The service should consider increasing the numbers of discharge co-ordinators across the speciality.
- The service should consider the reintroduction of volunteers across the speciality.

Medical services

- The service should ensure regular completion of the clinical assurance tool and clear action plans are available for all staff.
- The service should ensure they continue to strive to achieve mandatory training compliance figures to achieve the trust target.
- The service should ensure that there are effective communication systems and processes to seek and action feedback from staff on the services provided in the provision of the regulated activities. This includes visibility of the senior leadership teams.

NECTAR service

- The service should consider methods of recording pain relief that allows for review of care given.
- The service should ensure that consent is recorded in all patient contact.
- The service should ensure that information for patients is available in languages other than English and in alternative formats.

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the trust. They understood but did not always manage the priorities and issues the trust faced in a timely way. They were not always visible and approachable in the trust for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership of the trust had had some changes since our last well led inspection in 2019, including the appointment of a new Chief People Officer and Director of Finance, but overall, it had remained relatively stable.

The trust had some challenges in terms of performance, quality of patient care, and culture in some services. Although the board was sighted on these challenges and had the appropriate skills and knowledge, there was a lack of understanding of the scale and nature of the concerns, particularly in relation to culture. Some of these challenges had been ongoing for a period of time and action had not always been taken in a robust or effective way.

We heard from staff at all levels, that board members were not always visible within the organisation. We developed and collated a staff survey as part of this inspection, to enable all current staff to feedback regarding their experience of working within the trust. Leadership was an important theme for respondents of this survey who often described a culture of top-down communication, of feeling unheard, and disconnection with the Trust and the board. Respondents felt information was cascaded down from management, rather than in dialogue with them. They did not always feel

there were many opportunities for feedback. Staff told us many senior leaders and managers were not visible to them whilst at work, further reducing feedback opportunities. For many respondents, issues around communication and visibility compounded feelings of disconnection between management, this seemed particularly relevant with senior clinical staff in the organisation.

Visibility of senior management teams across the trust was another issue identified within our staff survey. Many respondents wrote about the visibility of management teams. This was experienced unevenly across different teams and within different staff groups. Some staff praised managers for their visibility, receptiveness, and their support. Staff reported management was visible and accessible to them, reporting that they had been introduced to managers following the restructure and they could access senior leaders when needed. They felt this was in contrast to the previous leadership. Others were positive regarding immediate line management and praised their visibility and receptiveness. This led to strong feelings of being supported and reassured, especially when the climate at work was pressurised or difficult.

“My line manager [name redacted] is actually really receptive to any problems and always acts on things. They are approachable and makes it feel like a very safe place to work.”

However, the overwhelming sentiment was negative, with many reporting that senior managers and higher tiers of leadership were not visible to them and therefore inaccessible. Some reported lack of opportunities to meet the Chief Executive Officer (CEO) or senior leadership, including lack of forums to raise concerns.
Respondents told us managers “came out of offices” for photo opportunities or regulatory activity. They reiterated an absence of feedback procedures, explaining “there is no longer a forum for meeting them [management] to express difficulties.”

"Executives are invisible to the RVI and have remained aloof with a concentration on the appearance of the Trust and the image of the Trust rather than the staff and patient wellbeing. They are noted for their absence rather than presence".

The board did not always function as a unitary board. We heard examples where some members of the executive team were not fully informed on issues and were not meaningfully involved in decision making. Board members did not always feel able to challenge which was confirmed by several people we spoke with. We were also told that engagement with clinicians was not always addressed by executive directors, which could impact upon overall confidence and performance of the trust. Some of these issues were replicated in a well led governance report commissioned by the trust in June 2022, this report highlighted that 16% of them did not feel challenge was welcomed at the board or that they could speak openly.

Board development was in progress. Board development sessions were scheduled and delivered regularly to ensure both strategic and developmental improvements were made.

There were also leadership development programmes for medical and nursing staff. There was an interim leadership and talent management strategy which incorporated an organisational development framework. Leaders stated that this strategy was interim in recognition of the transitional period between Covid and future challenges.

Providers are required to ensure that directors were fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience to ensure compliance with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

Our findings

During the inspection we carried out checks to determine if the trust was compliant with this regulation. We reviewed five director files, two executive and three non-executive directors. All files reviewed contained the employment checks for executive and non-executive staff in line with the Fit and Proper Persons Requirement (FPPR) Regulation 5. The trust had a policy for the requirement of the Fit and Proper Persons Test (FPPT) for directors.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action. Whilst this was in place, some strategies required further development and embedding. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had embedded vision and values which were developed by staff. Values included being kind and caring, having high standards, being proud, inclusive, and innovative.

The Trust had an overarching strategy in place, which set out the strategy of the Trust for 2019 to 2024. The strategy builds on the Trust's partnership working, including with other acute providers and local academic institutions in the region. Board members acknowledged that the strategy of the Integrated Care Board and local ICS (Integrated Care System) was ongoing, and this would be incorporated into the upcoming trust strategy from 2024.

There was a strategic framework in place, known at the fives Ps, which included how the trust would include patients, people, partnerships, performance and be pioneers going forward.

The trust's pharmacy strategy and delivery plan (OGIM - Objectives, Goals, Initiatives and Action Plans) was aligned with the trust vision and strategic framework 2019-24. The OGIM (reviewed April 2023) focused on all aspects of pharmacy and medicines optimisation. Key deliverables included engagement across pharmacy and the wider trust to review clinical pharmacy services (needs and offer), along with improved use of data, to focus activity on patients with the highest medicines related need. There was an identified lead for clinical pharmacy transformation and the developing workforce strategy was initially focused on staff engagement, wellbeing, and the clinical pharmacy service.

Most core services had a vision and strategy. Although, some of these were developed prior to the Covid -19 pandemic and therefore, were not current in reflecting the changing demands of health care post pandemic. The mental health strategy remained in progress despite CQC regulatory action being undertaken in December 2022 when a Warning Notice under Section 29A of the Health and Social Care Act 2008 was issued.

There was a piece of work to co-produce this strategy with service users as well as staff and partners within the local mental health trust. This had been supported by the trust's charity.

Culture

Although staff were focused on the needs of patients receiving care, they did not always feel respected, supported, and valued. Some staff told us they did not feel they could raise concerns without fear of blame or reprisal. The trust did not always promote equality and diversity in daily work.

During this inspection we spoke to a range of staff including consultants, junior doctors, nurses of all grades, midwives, and allied health professionals during our onsite visit. We also arranged focus groups which included these staff groups as well as community staff. In total over two hundred staff attended these. There were also 2,360 staff who responded to our staff survey.

Our findings

Most staff were proud to work for the organisation and delivered good care. The trust supported staff with the 'What Matters To You' programme which was in partnership with the Institute of Health Improvement. It included supporting leaders to engage and listen to their staff to understand what matters to them and to support building a culture across the trust. The trust had also developed a behavioural framework called the Newcastle Way, to support and enhance culture, values, and behaviour amongst staff. Through our interviews we heard there was a renewed focus on culture within the organisation and supporting staff by focusing on people and not just processes. This was in its very early stages and the impact of this work was not yet fully realised across the organisation.

However, we received 69 whistle blowing concerns leading up to and during the inspection. Most were in relation to bullying and fear of raising concerns which could lead to blame, reprisal, and detriment. This was in contrast to the previous inspection in 2019 when we had one whistleblowing concern raised with CQC and in the previous year between April 2022 and 31 March 2023 when we also received one concern.

To gain a wider view of staff morale and culture we developed and collated a staff survey as part of this inspection, to enable all current staff to feedback regarding their experience of working within the trust. We received a total of 2,360 respondents trust wide with 44% of staff working at the RVI and 33% working at the Freeman hospital. We saw 66% of respondents were clinical staff and 71% of staff had worked in their roles for at least 3 years. A total of 966 members of staff provided additional comments. The survey covered topics such as leadership, communication, bullying, harassment, and discrimination.

In relation to bullying and harassment, 38% of respondents reported they had witnessed harassment, bullying and abuse at work from colleagues or managers. Of these people, 51% stated that they or a colleague reported it. This was an improvement from the 46% score for the equivalent question in the 2022 NHS Staff Survey. In addition, 27% of respondents agreed that the organisation took appropriate action when they reported harassment, bullying and abuse, while 43% disagreed. Specifically in relation to bullying and harassment, the trust is not an outlier on the 2022 staff survey.

Some staff told us that bullying was “commonplace” and a “normal occurrence.” Several comments spoke of bullying from management towards junior staff, or more senior clinical staff towards junior doctors. Staff told of being intimidated, undermined, and belittled. Comments from staff noted a culture of being encouraged to “turn a blind eye”, and were discouraged, or threatened, from reporting the behaviour.

“I witness staff bullying in another department, staff are in tears. They do not say anything, as the manager will definitely make their life difficult. All the staff around know and nothing is done. I feel guilty as I also do nothing. I fear I will make things worse if I say anything. This has been going on for years.”

Staff did not feel that the organisation took action to reduce bullying, harassment, and discrimination, and as a result they felt they were not always treated fairly, were not supported, and had suffered detriments for raising concerns. Analysis from our staff survey indicated that some staff felt they faced unfair treatment because of hierarchical differences within the trust. Some commented that they did not feel valued or appreciated by staff from higher bandings. There was also a feeling that contractual arrangements such as flexible working or staffing rotas were sometimes not equitable.

Many comments reported favouritism and nepotism, citing a culture of “it’s who you know, not what you know” and a “ruling elite.” Some felt managers’ discretion was inconsistent between people, and that some were treated more favourably or received “special privileges.” Staff also felt this favouritism meant some people were “protected” when concerns were raised against them, such as bullying and harassment.

Our findings

The concerns raised about culture during this inspection were significantly different from our previous inspection in 2019, where staff described compassionate and inclusive working relationships among staff so that they felt respected, valued, and supported. Staff also felt empowered to make improvements and raise concerns and there was a strong focus on learning from incidents, sharing good practice, quality improvement initiatives and safe innovation.

Following our well-led inspection CQC wrote to the trust to give feedback on the culture within the cardiothoracic service, specifically in relation to concerns raised by whistleblowers including bullying and harassment and patient safety concerns. This letter recognised there had been a number of challenging circumstances but there was a need to focus on the culture within the service now as this was potentially impacting on patient care, delivery of the service and staff experience.

Freedom To Speak Up Guardian (FTSUG)

A FTSU (Freedom to Speak Up) Strategy has been produced and ratified in late 2022. There had been some delays in the communication of this across the Trust. The FTSU service had developed significantly in recent years and resource to do this role had been adjusted to ensure the service could meet demand. Service developments included establishing a network of freedom to speak up champions, reporting to and supported by the FTSUG; Enhanced staff training and awareness with inclusion in induction, education days, staff network links, online training development and attendance at staff forums, regional and national FTSU network links and supporting trust initiatives.

Between June 2022 and March 2023, the FTSUG had managed 73 cases which required intervention beyond advice and support being given to the complainant. This was an increasing level of activity from previous years. Themes from these concerns included management/policy, bullying, inappropriate comments, discrimination, information governance, patient and staff safety. In addition to the concerns raised which resulted in investigations, there were also themes in the issues raised with the FTSUG informally. These included inconsistent application of policy such as sickness management, flexible working arrangements, staff morale and communication between managers and staff.

All staff who accessed the service were given the opportunity to feedback via a questionnaire. Of those who responded, 100% said that they would recommend the service to a colleague and 100% rated it as 5 out of 5. Free text feedback highlighted the value of the service to staff in need, the responsiveness of the FTSUG, how helpful the insightful advice had been in trying to address challenging situations, and the speed in which the Guardian was able to help staff navigate to a positive resolution to their problems. Within the April 2023 paper on FTSU to the people committee it highlighted that staff were feeling more confident in speaking up, although it was recognised that staff continued to express concerns about possible repercussions, particularly when the issue related to their line manager; however, more (but not all) were confident in doing so after speaking with the FTSUG or colleagues who have used the service. Most concerns raised continued to relate to interpersonal relationships, particularly between line managers (or Human Resources) and staff.

Within the trusts speak up policy it identified numerous ways in which staff could raise concerns including their own manager, raising with members of the board including CEO and other exec members as well as FTSUG. The freedom to speak up strategy stated outcomes measures including staff survey, feedback to people, a biannual update and monitoring and triangulation of key data such as grievances, serious incidents and alternative speak up routes. As part of our data requests, we asked for any concern that had been raised with the board in the past 6 months in relation to patient safety. On reviewing this information, we found whistle blowing information shared with CQC was not included in this. When we asked the trust to explain why this was not included the trust responded to state that this information was not routinely recorded in their regular reporting processes. This was not in line with the trusts own FTSU strategy in monitoring and triangulation of data.

Our findings

For the 2022 national staff survey the response rate for the trust was 48.5%, slightly above national median scores. The trust performed in line with the benchmark group median for most sections of the survey. ‘We work flexibly’ and ‘We are a team’ were below the median scores nationally.

Staff responded less positively to questions around working flexibly and being able to achieve work/life balance. Also, less positive around questions related to line management and dealing with disagreements in teams effectively.

Staff responded more positively than comparators about teams working well together to achieve objectives and understanding each other's roles.

The trust had a strategy in place in relation to Equality, Diversity, and Inclusion (EDI) at the time of our inspection. Senior staff were aware and understood it. It also had staff networks and promoted diversity days. Equality and Diversity information was available at Trust Career Fairs and promoted through the Trust’s Facebook and Twitter Pages.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce.

A maximum of three high priority areas for improvement had been identified for the Trust.

- Indicator 6: harassment, bullying or abuse from staff in last 12 months against staff from ethnic minority groups' Indicator 1: Career progression in clinical roles (lower to middle levels)

- Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against staff from ethnic minority groups.

These were the areas from amongst the trust’s indicators with the worst percentile rankings against other trusts. There were no areas were identified for the trust being in the best 10% nationally.

The trust had a comprehensive WRES action plan which included objectives, goals, strategies, and measures to assess progress. There was a WRES working group which involved appropriate staff networks in devising and delivering on a WRES action plan.

The Workforce Disability Equality Standard (WDES) is a set measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. For most WDES questions, results at the trust were similar to the average for comparable organisations. There was a WDES action plan in progress . Key measurables to achieve were reduction in the number of disabled staff experiencing bullying and harassment from managers; reduction in disabled staff compared to non-disabled staff saying that they have felt pressure to come to work; monitor disability in EDI performance management framework; training and awareness on micro aggressions in place and development of cascade training. The Trust was a Disability Confident Employer and was working towards Disability Confident Leader status. These objectives were monitored through the WRES working group.

In terms of the CQC staff survey completed, some staff were positive regarding EDI. They felt the trust was inclusive and did its best to be supportive of people with specific protected characteristics. In the 2022 NHS staff survey 7.4% of staff at this trust said they had personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months. This was lower than the national average of 8.7%.

However, some raised specific concerns relating to discrimination in the CQC staff survey, some respondents felt that the trust did not do enough to support ethnic minority staff. This included not being considered for promotions and that there was "favouritism for White staff to go into higher posts." Some female staff reported gender discrimination, including related to pregnancy and maternity leave, and stating they did not have as many opportunities to progress within the trust, and were overlooked for leadership and management positions.

"Being female and of ethnic minority, I feel at times I am spoken to in a more condescending and less courteous manner. I am also asked to do more menial tasks and roles and from that I don't get upskilled. This affects my confidence at work and indirectly affects career growth."

A small number of comments reported discrimination because of disability. Of those staff, some felt the sickness policy was an issue, in that it was unfair towards those who had long term health conditions.

Disciplinary and grievance processes

During our inspection concerns had been raised with CQC from some staff who felt that HR processes were not always fair, properly investigated and outcomes shared. As a result, we sampled some of these processes to understand whether established HR practices had been followed. We reviewed 5 disciplinary records, of which 4 had been completed and 1 was ongoing. In these records, we found that the trust followed their own processes in terms of timescales for investigation, hearings, and outcomes. The decisions made were appropriate and in line with trust policy. However, not all meetings were adequately recorded and not all records were easy to find.

We reviewed 4 grievance records, of which 4 had been completed. In these records, we found that the trust followed their own processes both in terms of timescales for investigation and outcomes. The decisions made were appropriate and in line with trust policy. However, not all meetings were adequately recorded and not all records were easy to find.

The trust's human resource department reviewed disciplinary and grievance processes for themes and trends and worked alongside the freedom to speak up guardian (FTSUG) and EDI lead to pick up cultural issues which needed to be addressed.

Governance

Whilst governance processes were in place, they did not always operate effectively across the organisation to ensure risk and performance issues were identified, escalated appropriately, managed, and addressed promptly.

The trust's governance structure included 6 committees reporting to the board: quality; finance; people; charity; audit and appointments and renumeration. Each committee was chaired by a non-executive director. The membership of each committee varied and was set out in the terms of reference for that committee. The executive team had a role in reviewing and scrutinising the contents of these committee papers as well as providing assurance to the board. The trust also had a number of sub committees.

At the time of the inspection, the trust had very recently moved from a directorate structure to clinical boards. This involved moving from twenty-one directorates to eight clinical boards. Senior leaders stated this had been completed in consultation with staff to improve clinical engagement, patient safety and quality, and efficiency. The eight clinical boards were family health, Cardiothoracic services, Surgical and Associated Specialities (Freeman), Surgical and

Our findings

Specialist Services (RVI), Cancer and Haematology, Peri-operative and Critical Care, Clinical and Research Services, and Medicine and Emergency Care. The move to these boards had only happened three months prior to the inspection, with recruitment still ongoing to some boards. This structure was to be embedded, and due to the timing of the changes, the full impact of this change was yet to be determined.

The Trust had a board assurance framework (BAF) which was reviewed quarterly by the Board. The Audit Committee, as the assurance Committee for risk management, obtained assurances from the other Board Committees that risks held on the BAF were being managed effectively. The external well-led review identified that the format and use of the BAF and approach to risk management were in line with good practice. Each BAF risk was aligned to a Committee of the Board and each Committee received and reviewed the risks from the BAF relevant to them each quarter. The Trust also had in place an Executive Oversight Risk Register, which was received and reviewed by the Executive Group on a bi-monthly basis. There was also an operational risk register in place for the different services within the Trust. We reviewed the BAF 23/24 which had 15 open risks. However, although it identified gaps in control, the BAF did not provide detail to effectively describe actions take and responsibility for those actions. Many of the actions did not have timescales.

Although the trust had a governance system and processes in place, these were not always effective or robust in identifying risks and concerns across the trust. The trusts risk management policy June 2023 did not identify a specific score for any risk to be escalated to the executive oversight register but did have definitions for risk tolerance (risk appetite) for different areas. It stated that “The Trust supports staff throughout the organisation to manage risk as close to the front line of patient care as possible.”

Specifically, it also stated that the oversight register allowed the Executive Team to have oversight of particular risks where:

- Risk owners have communicated the need for additional support.
- Risks which exceed the Risk Appetite Tolerance.
- The risk indicates a significant/increased risk; or
- The risk has the potential to significantly impact a strategic objective.
- Risks held on the Executive Oversight Register continue to be managed at their current level with input and support from the Executive Team where appropriate.

We reviewed service risk registers and the executive oversight risk register. It was unclear how risk escalation was being followed as the executive oversight risk register had entries that were not included at service level.

Examples of this included, the surgery risk register had no reference to cardio thoracic risks although there were 3 entries in executive oversight risk register. Ophthalmology risks were also not on the service risk register but on executive oversight risk register. There was lack of robust ward to board governance. The executive oversight risk register was not reflective of service level risk and did not identify all of the issues regarding patient safety we found on inspection. This included the management of medicines, record keeping and assessing and responding to risk.

In terms of pharmacy staffing, on review of the executive oversight register we identified risk 1250 which related to clinical pharmacy staffing levels within the trust which the trust identified as significantly lower than those of other

Our findings

Shelford trusts. On review of this we found it had first been put on this register in 2008, some 15 years earlier, there were 19 associated actions during this timeframe and there were significant gaps in reducing and mitigating risk. The initial risk was 25 with current rating of 20 with target of 10. One of the actions stated was to conduct an appraisal of ward supply of medicines due date 31/08/2016 but was actually completed in Dec 2018'. Following inspection, the trust stated that this action related to medicines management and was incorrectly added to risk 1250 in 2016. This error was identified in 2018 and the action was therefore closed. This was highlighted in our inspections of core services where we found trust wide issues in relation to medicine management and was included in our letter of concern. As a result of CQC highlighting this issue to the trust, an action plan to address the concerns was developed and provided to us.

Some of the core service risk registers were not robust or reviewed in a timely way. The medicine service risk register only had 6 risks, with some entries on this register since 2016. Within children and young people services we were unable to identify from this risk register when risks had been added and review dates were not always recorded. The risk register was also not always clear as to the status of current risk. For example, the lack of psychology provision had been added to the register before 2016 with an initial risk rating of 15. The latest review of this risk was an allied health professional review in June 2023, but did not state whether the risk continued or identified any actions to mitigate risk despite the risk score being lowered to 6. We also found risks were not always escalated appropriately. Following our inspection, the trust provided an updated risk register stating some columns in the register had been omitted by human error at the time of our request and all risks had an 'open' status.

When we reviewed the surgical risk register that had been provided as part of the core service inspection in June 2023, we found no evidence of cardiothoracic risks on the risk register. Following our focussed inspection in September 2023, we spoke with the cardiothoracic management team and asked specifically why the issue of unsigned letters which had been highlighted in March 2023 was not on the risk register. The management team described it should have been on the risk register but may not be now as it may have been downgraded.

During our well-led inspection, we received a copy of the executive oversight register (corporate risk register) for June 2023. We found three risks on there, relating to cardiothoracic services which included: -

- Staffing shortages in the transplant department which was put on the register in July 2021 with an initial score of 25 and a current score of 20.

- The royal college of surgeons review which was put on the register in October 2021 with an initial score of 25 and a current score of 20.

- Cardiothoracic ITU capacity which was put on the register in June 2023 with an initial score of 20 and a current score of 20.

However, we found none of these risks on the surgical core service risk register and were unclear of the mechanisms or governance routes used to escalate these risks to the executive oversight register. We were not assured these risks were managed as close to frontline services as possible or there was sufficient managerial oversight either locally or at executive level to ensure sufficient actions and management of these risks. Following the inspection, we asked for the cardiothoracic risk register and this was not provided. During the factual accuracy period, the trust provided the cardiothoracic surgery risk register which included the risks on the executive oversight register

Our findings

The policy identified that "Clinical Board Management Teams are responsible for ensuring the implementation of the Risk Management Policy within their Clinical Boards including establishing appropriate risk management governance as described in this policy to support the continual management of risks and risk registers." When we spoke with the management team, they acknowledged there was a lot of work they needed to undertake to ensure there were robust governance systems in place.

Despite the trust's governance processes, we were not assured the trusts internal governance was sufficiently robust to identify key patient safety concerns and monitor progress to ensure improvements were made to the care patients received. When concerns have been identified we found that these were not acted upon in a timely, open, and transparent way with some risks requiring intervention from CQC to ensure actions were taken. These included medicine management, documentation, including their electronic information management system resulting in unsent correspondence, and issues with having assurance regarding the skills and experience of a doctor. These issues are described in more detail below. We also did not see the risks we had heard about across some services clearly identified and did not see how accountability was assigned to each risk for development of or completion of action plans and risk mitigation.

As part of our requests for further information as part of this inspection we asked for a list of clinical service reviews for any speciality over the past 2 years. The trust provided information regarding reviews of clinical services which included ophthalmology, cardiothoracic, neurosciences and cancer services. All reviews had associated action plans however we found that these were quite superficial, not robust, lacked appropriate timescales for completion and monitoring. Whilst many of these reviews had taken place over 12 months before we could not see evidence of progress against the recommendations. Therefore, it was unclear how the trust could demonstrate how these plans had driven improvement in these services.

Mortality

At the trust mortality rates were within the expected range for HSMR (Hospital Standardised Mortality Ration) including weekends and for SHMI (Summary Hospital level Mortality Indicator). For SHMI diagnosis groups, those with Urinary Tract Infections were lower than expected.

Hospital Standardised Mortality Ratio (HSMR)

For the 12-month period from Apr 21 - Mar 22, HSMR was as expected with a value of 97.84 (compared to 100 for England) and 1,570 deaths compared to an expected 1,605 deaths. Weekend HSMR was within expected range for this time period.

Summary Hospital-level Mortality Indicator (SHMI)

For the 12-month period from Jul 21 - Jun 22, SHMI was within expected range with a value of 0.91 (compared to 1.0 for England) and 2,275 deaths compared to an expected 2,485 deaths.

Learning from deaths

The trust had a policy and procedure in relation to learning from deaths and to ensure that mortality was monitored, reviewed and, where necessary, investigated. Deaths of patients with a learning disability were notified appropriately and families and carers were given the opportunity to be involved in the investigation process. The Trust's performance with learning from deaths was reported through clinical board mortality leads, their governance committees up to the

quality committee.

We undertook six mortality reviews as part of our inspection. All cases reviewed demonstrated an appropriate level of investigation and, in most cases, evidence of lessons being identified and learned being implemented.

Incidents and incident reporting

Compared to peer trusts identified from NHS Model Hospital based on trust size, similar attributes, and context, the trust was in the lowest 25% of reporters nationally based on the number of incidents reported per 1,000 bed days between May and Oct 2022. This was discussed during inspection and the trust confirmed they were aware of this and whilst they remained in this category they had moved to the top end of this lower group.

The inspection of core services identified that not all staff we spoke with reported incidents in a consistent and standardised way. Staff we spoke with did not always receive feedback or learning from incidents. However senior leaders said all learning was sent out in emails, printed briefings, at handovers, safety huddles, team meetings, a range of trust wide forums and in the risky business newsletters. In the CQC survey we found that 98% of respondents said they knew how to report incidents or knew where to find out. However, 67% of respondents said they heard about incidents reported in their part of the organisation and the learning from them, while only 45% heard about incidents from other parts of the organisation. Staff also felt that action was not taken in response to patient safety incidents. Some issues were raised around incident reporting and not having time or being encouraged to not complete them, no action taken, investigations not happening in a timely manner, incidents not being graded appropriately, and a lack of shared outcomes with those who submitted the report. This all prevented opportunities for future learning and the embedding of a safety culture.

The trust had a serious incident reporting and management policy which detailed the appropriate information and action required for staff to follow. We reviewed six serious incident investigations during the inspection, that included both initial reports (72-hour reviews) and completed investigations. The trust reported incidents on an appropriate Risk Management System and externally via NRLS and StEIS and followed a root cause analysis (RCA) approach to incident investigation. In the sample we reviewed, we found the quality and consistency of reports was varied and, in some cases, superficial; Duty of Candour was applied appropriately. In some cases, patients next of kin were not always offered the opportunity to contribute to the terms of reference of the serious incident process. There was no consistency regarding how lessons were learnt across the trust and there were some missed opportunities to share learning.

The trust identified a number of cases at a meeting in January 2022 in cardiothoracic services which met the threshold as a serious incident (SI). However, there was a significant delay in reporting them on the Strategic executive information system (StEIS) as serious incidents and this was not done until November 2022. The trust had waited to fully investigate them before reporting them, which was not in line with NHS England's Serious incident framework 2015 which states it should be reported onto StEIS no later than two days after the incident has been identified. This also meant there were delays in meeting duty of candour for the patients and relatives involved.

Within the minutes of the trust wide mortality surveillance group in July 2022, we found one case discussed specifically for cardiothoracic surgery. This case had been discussed at the serious incident triage panel as the patient's operation had been cancelled twice due to the lack of an intensive care bed and no theatre capacity. The operation did take place three weeks later and the department highlighted the delays may have contributed to the patient's death. However, a serious incident had not been declared with the rationale documented in the minutes of the meeting as "It was agreed at SI panel this was not an SI as sadly it was not uncommon to have a lack of ITU beds and/or theatre space." It was

unclear from the minutes whether a thorough review of this case had occurred, to enable identification of opportunities for learning and to reduce the chance of reoccurrence in the future. Known reasons of organisational pressures and challenges do not exempt the reporting of serious incidents, and this is not in line with a positive safety culture that is committed to learning and mitigating risks to the lowest points.

On review of incident information, we found a serious incident had been declared in October 2022 in relation to Ophthalmology. It was found that there was a lost to follow up (patients did not receive timely follow up care for their health condition) theme of 2,000 patients who had not received follow up appointments in the recommended timescale. Of these, six patients had suffered irreversible harm. On further review of incidents, we found a continuing theme of lost to follow up patients in Ophthalmology, throughout 2022 and 2023 where there were incidents detailing significant delays in patients receiving follow up care. This meant we were not assured the service had sufficiently identified learning, shared learning outcomes, or put in place robust actions to prevent reoccurrence of the incident.

Financial governance

The historic financial performance of the Trust was supportive of sustainable care and the Trust had operated at a surplus historically. However, the underlying financial position of the Trust had shown deterioration due to challenging efficiency requirements and was currently estimated to be c.£68m. The Trust was currently forecasting to achieve a break-even position in 23/24, with the gap being bridged by non-recurrent items.

In 2022/23 the Trust delivered a surplus of £4.1m, which was behind the initial planned £10m surplus. However, in January 2023 this planned surplus was amended to £3.7m with the agreement of the North East and North Cumbria Integrated Care Board. For 2023/24, the Trust had submitted a financial plan to breakeven. Initially the 2023/24 plan was a significant, but the Trust have worked closely with the ICB and the wider system to reduce this to breakeven. A key challenge for the Trust in 2023/24 is to fully deliver the cost improvement programme (CIP) which requires £57.1m of efficiencies to be delivered. The Trust slightly underachieved on the CIP for 2022/23.

Management of risk, issues, and performance

Leaders and teams did not always use systems to manage performance effectively. Although some risks were identified and escalated, identified actions were not always implemented in a timely way to reduce the impact. There was a lack of operational oversight at all levels to effectively manage and reduce risks to patients. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The board received information through integrated performance reports which provided updates against the four-hour emergency standard, ambulance handover delays, twelve-hour trolley waits, referral to treatment including 104 week waits and cancer performance. This was presented to the trust board via the Quality Committee. These reports highlighted some challenges with performance across the trust. It was also unclear how performance was tracked through these reports in terms of how trajectories would be met and monitored.

Within urgent and emergency care, the service performed well against regional and national comparisons for ambulance handovers and transfers into the department. On the three days of inspection 96.4% of ambulance handovers were completed within 30 minutes against an England average of 81.4%; 2.9% were completed within 30-60 minutes against an England average of 12.6%, and 0.7% completed over 60 minutes against an England average of 6.0%. From April to June 2023, 19% of patients waited in the department for over six hours. Patients waiting to see the psychiatric liaison team regularly had excessively long waits. In the same period 52.4% of admitted patients waited less

than four hours in the department; this did not meet the national standard. The percentage of patients admitted waiting 4-12 hours from decision to admit to admission was 10.4%. On the days of inspection, 78.5% of patients spent less than four hours in the department. Although this was better than the England average (71%) for the same days this did not meet the national standard of 95% but did meet the interim 76% national standard.

The Acute Interim Risk Model as of 30 May 2023 showed the Elective Risk for the trust at Decile 6. Decile zero is lowest risk and Decile 10 highest risk. The trust was in the second highest decile for level of risk for patients waiting over 18 weeks for treatment. The Trust was in the fourth highest performing decile for performance against the RTT Incompletes 18 Week Standard in May 2023. In March 2023 71.5% of patients at the trust were treated within 18 weeks, compared to the England average of 65.8%.

In March 2023 there were 21 patients waiting over 104 weeks at this trust, 90% were complex spinal patients. There were also 159 patients waiting over 78 weeks+, despite the NHS target to eliminate these by April 2023. The majority of patients were waiting for dermatology appointments or were complex spinal patients.

Waiting times for some patients with cancer were mixed, and inconsistent when compared to the England average. Cancer waiting times indicators were in line with regional and national averages for 2 week urgent referral and 62 day target. But the trust was in the lowest 25% of trusts nationally for patients treated within 31 days of a decision to treat in March 2023. We reviewed two week wait target data and saw in March 2023, 85% of patients were seen within two weeks, which was in the middle 50% of trusts nationally. This compared with 87% regionally and 84% nationally. The trust achieved the 28 Day Faster Diagnosis Standard in March 2023, with performance of 82.7% against the 75% standard. This was above the national average of 74.2% and the regional average of 79.7%. In March 2023, 86% of patients were treated within 31 days of a decision to treat, compared with 92% regionally and nationally. In the 62 day target data we saw in March 2023, 59% of patients were seen within 62 days of an urgent GP referral, which was in the middle 50% nationally. This compared with 64 % regionally and 63% nationally.

Within July's performance report to the board, it identified that at the beginning of May 2023, the trust was moved into segment 2 within the NHS Oversight Framework ratings (previously segment 1). This decision was taken in light of some specific issues including the primary driver of the ongoing prevalence of elective waiting times over 65 weeks and cancer waiting time performance. The segments indicate the scale and general nature of support needs for an organisation, from no specific support needs in segment 1 to a requirement for mandated intensive support in segment 4.

At all leadership levels in the trust including the board there was a lack of operational focus, oversight, and action to mitigate the risks to patients receiving care in frontline services. There was a number of patient safety concerns CQC had found during the last 12 months through our engagement, monitoring, and inspection processes. In November 2022 CQC undertook a focused unannounced inspection which looked specifically at the quality and safety of care provided to patients with a mental health need, a learning disability or autism. We carried out inspection activity in five of the acute services provided by the trust because we had concerns about the quality of services provided to people with a mental health need, a learning disability or autism.

Following our inspection of the trust's services in December 2022, we formally wrote to the trust to share our concerns about our inspection findings. We asked the trust to take immediate action to improve the quality and safety of services. The trust provided details of the immediate steps taken to ensure patient safety. In response to our findings, we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008. The Warning Notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in relation to patients with a mental health need, a learning disability or autism.

Our findings

During our 2023 inspection we identified a number of issues and risk across the services we visited. These included the following concerns as detailed.

Services we inspected did not follow their own systems and processes to ensure that medicines were stored, administered, and recorded safely, this included the safe storage and oversight of prescribing documentation. Concerns included poor stock control in relation to safe storage and general management of all medicines. For example, across most of the services we inspected there were out of date medicines, and we could not be assured medicines received had been stored in line with manufacturers guidelines with the potential of reduced efficacy. Management of controlled drugs was also an issue, in controlled drug registers there were missing witness signatures, missing doses and missing patient details. There was inconsistent fridge monitoring and recording of temperatures, with high temperatures whilst recorded were not acted upon for several days in some areas.

Following a letter of concern sent to the trust in relation to this issue the trust provided a retrospective three month audit. This audit demonstrated 97% compliance with resuscitation checks, 90% fridge thermometer check compliance and 90% compliance with controlled drug checks.

The trust used electronic recording systems when recording patient vital signs, managing the deteriorating patients, and nursing and medical care records. Staff competency using the electronic recording system varied across the wards we visited, and staff openly told us they had received limited training on the system before it was introduced. We saw only four hours of training included as part of the trust's own induction for some new staff. Staff were required to complete multiple electronic records to comply with the current systems. As a result, we saw care plans which were not in place for fundamental aspects of care and for key clinical devices such as catheters and peripheral lines. Records were not personalised as the system was not being used to its potential as the care plan section within the electronic system was not currently used in most of the services. We met with senior leaders within the trust between our core service inspection and well inspection to discuss the electronic patient record system. We raised that we found during our inspection there were issues with the documentation of escalation for potential sepsis within the electronic records. Senior clinical leaders advised that this was an active decision based on the human factors approach.

As part of our data requests, we reviewed compliance of deteriorating patient response based on national CQUIN Targets. This demonstrated an annual compliance of 63%. This meant the trust could not be assured there was timely escalation of all deteriorating patients, and they could not be fully assured that records were complete, accurate and up to date.

The full waiting area in the emergency department was not visible from the reception and triage areas. We observed there was no formal arrangement for staff to observe this area or complete regular checks on patients to identify any deterioration in their condition. In addition, there was no formal protocol or process in place to support staff in the actions they need to take to observe patients placed in this area after initial triage. This meant there was potential for patients to come to harm and any deterioration to go unrecognised especially when the department was busy, and patients were experiencing long waits. We raised this with the trust as we had found during the inspection concerns with a deteriorating patient. As such the trust implemented a process for the waiting room, their own monitoring of this process identified patients who had deteriorated whilst waiting. This had not been identified by leaders in the department or senior leaders prior to CQC identifying this as a concern.

As a result of these issues, we sent the trust a letter of concern which detailed our concerns. Following this the trust provided an action plan which we followed up as part of our well led inspection. We found that not all actions had been implemented or embedded as detailed in this plan. This included some aspects of medicine management and record keeping.

Our findings

After our onsite visit CQC received information of concern from a whistleblower in relation to a backlog of 'must sign' letters following clinic appointments, patient treatments and operations and inpatient stays within the cardiothoracic department. We wrote to the trust on 05 September 2023, using our section 64 powers to request specified information and documentation on this, and we wanted to confirm if this was an issue and the scale of the concern. We were also concerned that this had the potential to lead to delays in patient's receiving appropriate care that would meet their clinical needs, if relevant healthcare practitioners or the patient were not aware of any changes to their condition or treatment.

In their response the trust confirmed this was a known issue in the cardiothoracic department and they had been working to address this since March 2023. The size of the backlog of these letters were detailed as a total of 2,399 dating back to 2019 included in this was 1,196 unsigned letters for 2023.

On receipt of the information, CQC further wrote to the trust and sent a letter of intent (section 31) indicating possible urgent enforcement action as we were concerned patients will or may be exposed to the risk of harm. This letter had two specific parts concerns within the cardiothoracic department and trust wide concerns. Particularly for this service we were concerned that: -

- Whilst there had been management oversight and meetings since March 2023, there was still a significant issue in unsigned documentation some 6 months later.
- There was no current service or trust wide standard operating procedure and this was not due to be validated until end of September 2023.
- Furthermore, the trust identified that monitoring would form part of the clinical board's overall assurance improvement action updates. Production of a data extract report to support monitoring and oversight was only due to commence weekly from Monday 18 September.
- The trust provided no evidence of an action plan being developed in March 2023, or that the management team had robust systems to monitor this in the last 6 months.
- Despite being aware for 6 months, the trust had failed to make sufficient progress to reduce the risks to patients.

The trust responded to the letter of intent and provided information that showed this was a trust wide issue and there was a backlog of 25,315 letters dating back to 2018 across all clinical boards. With the response the trust provided an action plan with trajectories and assigned responsibilities to address this issue. The trust also volunteered to provide weekly updates to CQC, we agreed this was necessary to understand the ongoing risks, and this information should be provided so CQC can be assured that timely action by the trust continued to be taken. At the time of writing the report this monitoring is continuing until CQC deems it is no longer necessary.

Within the trusts response it also highlighted there had been nine serious incidents reported since April 2021 relating to discharge errors. One of the serious incidents had been reported by the trust in August 2022, which identified that there were delays in sending discharge letters and had been highlighted to the trust by the North of England commissioning support service (NECS). Several GP practices had reported receiving delayed correspondence over a 31-day period, there was 7,200 letters that had been sent at the same time significantly increasing workloads at the practices.

Our findings

Also, within the trust's response they provided an audit report. There was a statement within this report "This matter has been registered as a risk on the Trust's risk register (Risk ID 3819 opened 26th August 2020)". The report also stated that "IT are working on a number of development solutions, however there is no target date for when this is expected to be complete. The risk register also noted two incidents that were raised regarding letters not being issued to patients."

On review of this we found this risk had first been put on the risk register in August 2020, some 3 years earlier, there were 2 associated actions during this timeframe with due dates of 2023. There were significant gaps in assurance for the reduction and mitigation of this risk; it was unclear if actions had been taken prior to the internal audit report of 2023, despite the risk being known about since 2020.

Despite the serious incidents, staff in frontline services being aware of unsigned letters and the backlog being identified in Cardiothoracic services, we found the trust did not have robust operational oversight and had not taken sufficient action to identify the scale of this issue across the trust. There was a missed opportunity from the serious incident in August 2022 to identify if this was a bigger issue and to put in remedial actions to prevent this happening again. Discharge letters were identified as part of our concerns when we wrote to the trust about unsigned correspondence. The trust had only taken robust actions when this concern was highlighted by CQC, and their own governance arrangements and operational management had failed to identify this patient safety concern.

Some clinical concerns were raised with CQC about training, skills and experience of surgeons undertaking certain types of procedures by a number of staff. We wrote to the trust on 05 September 2023, to ask if the trust had investigated these concerns and to provide an action plan on areas that required improvement. The trust provided a draft action plan on 15 September 2023, we found the action plan detailed the recommendations, actions required and the responsibilities and gave no detail of the timelines for completion. When we inspected on 28 September 2023, we identified concerns relating to the implementation of the recommendations and spoke with two executive leaders on site to gain further assurances about training, skills, and experience of surgeons. We also reviewed personnel files of surgeons. However, we remained concerned that the actions required to address the recommendations had not been fully implemented and the trust had not gained appropriate assurances. We spoke with the Chief Executive and wrote to the trust on 29 September 2023 to ask the trust to review the recommendations and provide assurances that surgeons had the skills, knowledge, and training to undertake the procedures. This was another example where CQC have had to write to the trust to get the required actions to reduce the risks to patients. At the time of writing this report, we will continue to review and monitor information to ensure the trust is taking timely and appropriate action and will do this through our monitoring of the trust.

Due to the serious concerns identified within the cardio thoracic unit at the trust we completed a focussed unannounced inspection in September 2023. Details of our findings are available in a supplementary inspection report.

Information Management

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could not always easily access the electronic patient record system and care records. Staff were required to complete multiple electronic records in order to comply with the current systems. Staff expressed frustration due to the basic training given by the trust and the expectation to complete all records. We saw records were duplicated across

some areas. We saw inconsistencies and variation across wards, hospital sites and services where staff documented within different parts of the electronic records. This meant staff who moved between wards or services, or bank and agency staff would have difficulty finding relevant information about patient's needs and the care they needed to deliver.

Staff were not always able to use systems to their full potential. The care plan section within the electronic system was not currently used in most of the services we inspected. For example, paediatric teams did not have access to some risk assessments such as moving and handling. The system did not trigger care plans from its risk assessments and therefore staff had to make notes about plans of care in the annotations section. This meant relevant health and safety concerns about patients were not always included in people's care and treatment plans and staff did not have documented plans to follow.

We found internet dropouts in some of the services we visited and delays in reaching IT support when needed. This included surgical services.

Within pharmacy services, the trust used electronic patient record and prescribing systems but the potential to use data from these to support medicines optimisation had not yet been fully realised. Similarly, medicines audits were largely manual and time consuming. The trust recognised the value of developing business intelligence reporting to track medicines optimisation activity across the trust, but delivery was limited by a lack of IT capacity. However, the first Digital Pharmacy Strategy meeting had taken place (Q1 2023), to help drive this programme forward.

As described above, there were problems and significant backlogs with unsigned and unsent consultant letters. The trust confirmed that this was in relation to their electronic and information management systems.

Engagement

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

At the time of inspection, the trust did not have a finalised Patient and Public Engagement Strategy. However, they had commissioned a review to scope a five year patient experience strategic approach. The trust engaged with a range of patient groups to collect feedback about the experience of using trust services. These included focus and involvement groups. The main trust wide group was APEX (Advising on the Patient Experience). APEX was a group of volunteers who meet monthly to provide a patient perspective on various issues such as research proposals, QI (Quality Improvement) projects or service changes. In addition, the trust had the YPAGNE (Young Peoples Advisory Group North East) Group and Young Peoples Forum.

The trust worked with local charity groups to capture the views of people who accessed these groups. These included Deaflink to better understand the barriers faced by deaf patients. Disability North to support the development of Disability Awareness eLearning, and Newcastle Carers to engage with local carers on their experiences as a Carer when their loved ones are in hospital. The trust also had an Equality, Diversity & Human Rights Working Group attended by local charities who shared feedback from the local communities they worked with to drive forward improvements.

The trust had effective staff networks for all protected characteristics as defined in WRES. There were network and equality champions who had been involved with the co production of trust's equality, diversity and inclusion strategy and policy. Staff networks were also engaged with this. There were executive sponsors for the staff networks.

Our findings

Within surgery, colorectal nurse specialists had developed a new bowel cancer support group for patients across the region. These commenced in May 2023 and offered patients an opportunity to learn about some of the advances in colorectal cancer. There were open days held by stoma care nurses offering advice regarding appliances and general care for both patients and staff.

With Children and young people services, they held a youth forum for patients, or their siblings aged 14-24 with a focus on Trust improvements and research. There was a young person's advisory group with 62 members aged between 11-19 engaging with research and quality improvement projects such as the review and development of the paediatric food menu offered by the trust.

The trust also submitted details of a number of engagement sessions for staff to attend across the board including clinical board workshops, sisters' updates and general question and answer drop-in sessions. We saw celebrating success boards across all areas and thank you cards showing appreciation to staff.

The trust participated in various patient and staff surveys:

Adult Inpatient Survey 2021, findings of this were discussed at the Patient Experience Monitoring Group and assurance was received that the trust performance was high with 12 areas in survey performance 'Much better', 'Better' or 'Somewhat better' than other trusts.

Urgent and Emergency Care Survey 2022, this was undertaken in November 2022 with the CQC benchmark results expected in July 2023. The preliminary findings from the survey have been produced by The Picker Institute and are currently with the trust for review.

NEQOS (North East Quality Observatory Service) Cancer Patient Experience Survey 2022, of the 61 questions in the survey this trust was above the expected upper range compared to other trusts that took part for 19 questions, and no questions were below the expected lower range. All 61 questions were comparable to 2021 survey results. Two questions had a statistically significant improvement compared to 2021, and no questions had a statistically significant decrease.

National Care at the End of Life Audit (2022/23), the trust performed above the national average in all the domains of the audit.

Local patient surveys were completed by the trust. These projects were more targeted on the issues relevant to specific patient areas and the patient experience team offered support with survey methodology and design along with data entry, analysis and report writing. Examples from some of the services inspected included, medicine COPD (Chronic Obstructive Pulmonary Disease) early supported discharge patient satisfaction and patient satisfaction of COPD home management. Within surgery surveys included pre-assessment clinics in relation to communication, information, use of medication and general feedback, pre and post operative patient satisfaction in the new Day Treatment Centre (DTC), and Saturday clinic patient feedback. As a result of these surveys, a number of improvements were made, for example signage, parking, patient flow, and heating in the DTC. Other local surveys underway at the time of inspection were immunology and allergy patient feedback, patient buddy system in total pancreatectomy and auto islet surgery, alcohol care team and the falls and syncope service.

Our findings

Senior leaders described positive relationships with some partner organisations, especially the relevant Local Authority and Integrated Care Board (ICB). There was a well-established council of governors who reported that working relationships with the board are constructive and there are good opportunities for engagement and holding the non-executive directors to account. The executive and non-executive directors acknowledged that they need to continue to ensure that the governors are fully involved in developments within the trust and wider healthcare system.

The senior leadership team reported close working relationships with Healthwatch and the local independent consumer champions for health and social care.

The trust had policies and procedures in place to support patients in line with the accessible information standards. These include access to interpreter and translation services, British sign language signers, using larger fonts for letters for visually impaired service users. The trust had applied "Browse Aloud" to its external web pages to enable the audio capabilities for people with visual impairments and also for language translation.

Learning, continuous improvement and innovation

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

The trust had an established continuous quality improvement (QI) framework, with an associated training and development programme. The Newcastle Improvement approach, incorporating the Model for Improvement was used to help improve outcomes for patients and develop staff experience. QI training programmes included a selection of teams and coaches linked to Trusts strategic and patient safety and quality priorities. Most staff and senior leaders across the organisation demonstrated knowledge of improvement methods and the skills to use them.

There were examples of QI projects within the trust and its impact on patient care and experience including:

- Day case assessment for liver transplantation which saved estimated 170 bed days for 88 patients with financial and carbon savings.

- Improved recognition of deterioration & sepsis screening project with identified benefits including, increased patient safety & harm-free care, improved nursing compliance and better documentation of escalation.

- Bladder and Bowel Assessment Project which resulted in,100% of patients prescribed containment products have been fully assessed and are clinically indicated, 96 staff members trained and 37% reduction in prescribing of products.

There were also examples of quality improvement initiatives in the services we inspected, including:

The trust had installed equipment to reduce the environmental impact of the use of nitrous oxide gas for pain relief in the maternity services. The equipment has also reduce the exposure risk of nitrous oxide to staff. This also supported delivery of the trust's aim to be Net Zero by 2030 for controllable emissions. The trust was similarly piloting two novel solutions for effectively managing pain whilst reducing the anaesthetic carbon footprint in endoscopy.

Surgical services submitted examples of continuous improvement including the complex POLYP MDM, Health – Call which was a non-electronic system to improve patient pre assessment in endoscopy, and a green endoscopy working group to reduce carbon footprint.

Our findings

In 2022 the enhanced recovery team won the HSJ (Health Service Journal) performance recovery award. The trust formed an innovative collaborative partnership with a third partner provider, to develop the colorectal enhanced recovery program which resulted in reduction to cancer care backlogs and the trusts length of stay performance to pre-pandemic baseline.

The cardiothoracic care group were involved in various research and innovation projects to develop the service and services nationally. As part of a global research study, the service was performing procedures to remove scar tissue after a heart attack by using a new hybrid technique to close the scar using keyhole technology to improve heart function and distance patients could walk. This was to be introduced into clinical practice if lasting benefits to patients were proven.

The NECTAR service has pioneered a variety of innovative practices that included the creation of specific practitioner roles and pathways for the transportation of a variety of acutely unwell adults and children.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Inadequate ↓↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Ambulance	Inadequate	Requires Improvement	Not rated	Requires Improvement	Inadequate	Inadequate
Community	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Inadequate ↓↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Freeman Hospital	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Royal Victoria Infirmary	Requires Improvement ↓ Jan 2024	Requires Improvement Jan 2024	Good Jan 2024	Requires Improvement Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Dental Hospital	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall trust	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Inadequate ↓↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024

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

Rating for Freeman Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Services for children and young people	Requires Improvement ↓ Jan 2024	Good ↓ Jan 2024	Outstanding →← Jan 2024	Outstanding →← Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Critical care	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
End of life care	Good May 2019	Outstanding May 2019	Outstanding May 2019	Outstanding May 2019	Good May 2019	Outstanding May 2019
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Overall	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024

Rating for Royal Victoria Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good →← Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024
Services for children and young people	Requires Improvement →← Jan 2024	Good ↓ Jan 2024	Good ↓ Jan 2024	Outstanding →← Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Critical care	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
End of life care	Good May 2019	Outstanding May 2019	Outstanding May 2019	Outstanding May 2019	Good May 2019	Outstanding May 2019
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Requires Improvement ↓ Jan 2024	Requires Improvement ↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Urgent and emergency services	Requires Improvement ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Good ↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Maternity	Requires Improvement →← Jan 2024	Not rated	Not rated	Not rated	Requires Improvement ↓ Jan 2024	Requires Improvement →← Jan 2024
Overall	Requires Improvement ↓ Jan 2024	Requires Improvement Jan 2024	Good Jan 2024	Requires Improvement Jan 2024	Requires Improvement ↓↓ Jan 2024	Requires Improvement ↓↓ Jan 2024

Rating for Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate Jan 2024	Requires Improvement Jan 2024	Not rated	Requires Improvement Jan 2024	Inadequate Jan 2024	Inadequate Jan 2024
Overall	Inadequate	Requires Improvement	Not rated	Requires Improvement	Inadequate	Inadequate

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health services for children and young people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community end of life care	Good May 2019	Good May 2019	Outstanding May 2019	Outstanding May 2019	Good May 2019	Outstanding May 2019
Community dental services	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall	Good	Good	Good	Good	Good	Good

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

Patient transport services

Inadequate

Is the service safe?

Inadequate

This service had not been previously inspected. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key areas to all staff and but failed to ensure everyone completed it.

All staff initially received mandatory training but did not keep up to date with their mandatory training. The trust target for completion of mandatory training was 95%; information provided following inspection showed the overall current compliance rate for all staff was 85%.

Managers were able to monitor mandatory training compliance and to alert staff when they needed to update their training, but we did not see any actions taken to ensure staff compliance met the trust target.

The mandatory training was comprehensive. Staff were able to access mandatory training through a combination of online courses and face-to-face modules. Modules included dementia awareness, health and safety and welfare, equality, diversity and human rights, fire safety, moving and handling, conflict resolution, infection prevention and control, and Mental Capacity Act training.

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

During inspection staff told us that they felt that the mandatory training package was suitable for their role but struggled to access support from the clinical educator due to flexible shift patterns.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had the opportunity to attend training on how to recognise and report abuse.

Not all staff had completed training specific for their role on how to recognise and report abuse. We saw that only 87% of all staff had completed the required level of adult and children safeguarding training for their role as recommended in the intercollegiate guidance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under The Equality Act 2010. Staff completed 'Preventing Radicalisation – Prevent Awareness training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff spoken with were confident they would recognise safeguarding issues and would report as appropriate.

Patient transport services

Staff followed safe procedures for children being conveyed and had child appropriate seating, and harnesses. Parents or carers accompanied children when being transported.

Cleanliness, infection control and hygiene

The service could not demonstrate that they controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment, vehicles, and the premises visibly clean.

We saw no processes in place to monitor staff compliance with infection prevention and control (IPC) measures. Audits of environment cleanliness, equipment cleanliness and adherence to hand hygiene and the principles of bare below elbow (BBE) were not undertaken.

We saw that equipment cleaning records were completed but there were no dates recorded on the checklists, so it was not possible to see when the records had been completed.

We saw that equipment was visibly clean, but the service did not label equipment to show when it was last cleaned.

The cleaning of the vehicles was the responsibility of the subcontracted ambulance staff and that they undertook daily cleaning of the vehicles. We were told during inspection that managers did not audit daily vehicle cleaning but relied on verbal assurances from the subcontracted company. Following inspection, we requested daily vehicle cleaning records but only records of monthly cleaning was provided, therefore, we were not assured that daily cleaning had been undertaken nor that managers of the service maintained sufficient oversight of the vehicles.

During inspection there was no opportunity to observe patient contact, but all staff could articulate what personal, protective equipment (PPE) they would use, and we saw sufficient stock was available.

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

Environment and equipment

The design, maintenance and use of facilities and premises, kept people safe but the service could not demonstrate how they maintained oversight nor that vehicles and equipment were safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment but did not date the checks, so we were not assured that these were up to date.

Senior staff told us that they did not document when they performed spot checks of the environment and equipment, therefore we did not have assurances when or if these had been undertaken.

The main theme from incident reporting was equipment failure which would support that there was a lack of oversight and assurances that equipment was being adequately maintained. Following the inspection, we saw that 14 incidents were reported due to vehicle or equipment issues between January 2023 to June 2023.

The design of the environment followed national guidance.

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

Patient transport services

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and but could not always respond quickly upon patients at risk of deterioration.

Following inspection, we requested five examples of pre-transport risk assessments and were provided with five pre-departure checks. All pre-departure checks had a risk assessment score recorded but with no accompanying detail to instruct how that score was reached. We were subsequently told that all risks, including a ABCDE risk assessment were discussed on a conference call between referring hospitals and the transfer team to discuss risks.

We were told by staff that due to the trolleys not being height adjustable that it would not always be possible to perform cardiopulmonary resuscitation (CPR) if required on a transfer.

Following inspection, we reviewed one incident where there were insufficient seats for all passengers and one passenger was allowed to travel standing up whilst the vehicle moved at high speed and with blue lights. This was against national guidance and placed the passenger and others within the vehicle at risk of harm.

We reviewed completed patient record forms used on transport. We did not see evidence of a nationally recognised assessment system such as the National Early Warning System (NEWS), we saw that patients were monitored using standard critical care observation charts

All staff could articulate how they completed and updated risk assessments for each patient and managed risks identified.

Staff knew about and dealt with any specific risk issues. We saw that there were pathways for the different categories of patients.

Staffing

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

The service had enough medical, nursing and support staff to keep patients safe.

The service had low vacancy rates of 11% overall for all combined staff groups.

The service had low turnover rates of 6% overall for all staff groups.

The service had low sickness rates of 1% for all staff groups.

The service did not use agency staff due to the specialised nature of the roles but utilised staff who had previously worked for the service to fill any gaps in the rota. All returning staff had a new induction and were given the opportunity for refresher training if required.

Patient transport services

The paediatric consultants were also on call for the paediatric intensive care unit in the out of hours period and if they were needed for transfer then they would have to arrange cover themselves or escalate it to the paediatric anaesthetist on call who may be required elsewhere.

Records

Staff kept records of patients' care and treatment, but the records were not comprehensive due to key information not being recorded.

Patient notes were not always comprehensive as key information was found to be missing in all records that we reviewed such as assessment of pain and the recording of consent.

Staff could access patient records easily.

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

Records were stored securely.

Medicines

The service failed to demonstrate how they used systems and processes to safely store medicines and did not always prescribe, administer and record medicines appropriately.

Following inspection, we requested the service's medicines policy but was only provided with the overall trust medicines policy which did not reference the service nor consider the nature of the regulated activity undertaken.

Staff failed to store medicines correctly, we saw that fridge temperatures had been documented as out of range multiple times but there was no evidence of escalation and no actions taken to ensure that medicines were stored at the correct temperature.

We saw no evidence of medicine stock audits or other records. We found examples of medicines that were out of date which did not provide assurance that medicines were routinely checked.

Staff failed to store medicines securely, the medicines were stored in a shared building and was possible to enter the medicines storage room without requiring swipe card or PIN access. We raised this with senior staff during the inspection visit and were told that it had been previously highlighted as an issue, but no actions had been taken.

Senior management told us that staff did not have access to controlled drugs, during inspection we were told by staff and they gave examples of when they would obtain controlled drugs through the discharging trust and if used would be recorded in the patient record or disposed of as not needed. We were told that there was no system in place to maintain oversight of this process which meant that managers did not have assurance that this was safe.

Following inspection, we requested the patient group directive (PGD) training compliance which allowed for non prescribing staff to administer certain medicines without prescription. We saw that only 41% of eligible staff had fully completed the training. We also requested a copy of the PGD signature record, but this was not provided.

Patient transport services

During inspection, we requested copies of patient record forms that showed when medicines had been prescribed and administered. We were informed that medicine prescription or administration could not be recorded using the existing record system and was uploaded onto the patient's main medical record which meant it could not be provided for review. This meant it was not possible to ascertain if medicines were recorded accurately, kept up to date, prescribed and administered safely.

Incidents

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

Staff knew what incidents to report and how to report them. The service reported 56 incidents between June 2022 and June 2023. The main theme identified was issues with equipment and vehicle breakdown.

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

The service had no never events.

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

Staff understood the duty of candour; however, we were told that there had been no incidents in the preceding 12 months that required a duty of candour disclosure.

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

Staff met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. We were told that if appropriate patients and their families would be involved in these investigations.

Managers debriefed and supported staff after any serious incident. We were given examples of immediate debriefs and debriefs after a period of time to enable staff to reflect on the incident.

Managers did not share learning with their staff about never events that happened elsewhere. We were given no examples of shared learning.

Is the service effective?

Requires Improvement

This service had not been previously inspected. We rated it as requires improvement.

Patient transport services

Evidence-based care and treatment

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

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

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

At referral, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Pain relief

Staff did not demonstrate how they assessed and monitored patients regularly to see if they were in pain, nor that they gave pain relief in a timely way. We did not see how they supported those unable to communicate using suitable assessment tools and nor that they gave additional pain relief to ease pain.

We saw no examples of how staff assessed patients' pain using a recognised tool and nor how they gave pain relief in line with individual needs and best practice.

Following inspection, we requested patient records which would demonstrate that patients received pain relief soon after it was identified they needed it, or they requested it, but no records were provided.

During inspection, we requested patient records which would demonstrate that staff prescribed, administered, and recorded pain relief accurately but none were provided.

Response times

The service monitored and met agreed response times so that they could facilitate good outcomes for patients, but they did not demonstrate how they used the findings to make improvements.

The service had a key performance indicator (KPI) for all urgent transfers of mobilising within 60 minutes from the time that a decision had been made to undertake the patient journey. We saw that this target was consistently met in the 12 months preceding inspection.

Whilst the service was meeting KPIs for response time, we saw no evidence of how that information was being monitored nor it being used to drive improvement.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

Managers and staff did not carry out a comprehensive programme of repeated local audits to check improvement over time.

Managers and staff did not have any local audit results to improve patients' outcomes.

Managers did not have information from local audits to improve care and treatment.

Patient transport services

The service told us that they participated in relevant national clinical audits regarding paediatric response times but did not produce any data to demonstrate this and did not articulate how they used this to improve care. We did not see any examples nor were we given any information regarding the auditing of paediatric non acute, adult acute and non acute transfers.

We saw no evidence that improvement was checked and monitored.

Competent staff

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

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

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

Managers supported staff to develop through yearly, constructive appraisals of their work. All active staff had either an appraisal within the last 12 months or had one scheduled.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

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

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. We were given examples of how they supported staff through supervision, additional training, and supernumerary shifts.

There was one clinical educator for the service, staff reported issues during inspection regarding their availability to support the learning and development needs of staff.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

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

All staff reported good multidisciplinary team working.

Patient transport services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent but did not consistently record it. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

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

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

All staff undertaking paediatric transfers understood Gillick Competence and Fraser Guidelines.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff told us that they gained consent from patients for their care and treatment in line with legislation and guidance but we saw no evidence of it being recorded in the 10 records that we reviewed.

Is the service caring?

Insufficient evidence to rate 

This service had not been previously inspected. We were unable to rate caring due to no opportunity to observe patient care.

Compassionate care

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

Staff were discreet and responsive when caring for patients.

Staff followed policy to keep patient care and treatment confidential.

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

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

Patient transport services

Emotional support

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

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

Staff knew how to support patients who became distressed in an open environment and helped them maintain their privacy and dignity.

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

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

Understanding and involvement of patients and those close to them

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

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

Staff talked to patients in a way they could understand, using communication aids where necessary.

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

Is the service responsive?

Requires Improvement

This service had not been previously inspected. We rated it as requires improvement.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. We saw examples of when the service undertook non commissioned work to benefit patients and the wider service such as the transferring of patients to ensure improved access and flow.

Facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

The service was not always inclusive and did not consistently take account of patients' individual needs and preferences.

Patient transport services

Staff understood and but did not apply the policy on meeting the information and communication needs of patients with a disability or sensory loss. We did not see any information regarding supporting patients with additional communication needs.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff were unable to articulate where they could find alternative formats.

We saw that staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service but it was not clear if this was when they needed it or if it was in line with national standards, and whether they received the right care in a timely way.

The service aimed for all acute paediatric transfers to commence within 60 minutes of referral and the service collected data to demonstrate that this target was consistently achieved in over 95%of all transfers in the previous 12 months. Performance activity for acute paediatric transfers only accounted for 12% of all transport activity undertaken. Following inspection, we requested further performance data regarding paediatric non acute transfers and adult acute and non-acute transfers for the previous 12 months but we were only provided with journey numbers with no qualitative assessment or performance target stated.

Staff supported patients when they were transferred between services.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

During inspection we were given examples of the service's management failing to follow the trust's freedom to speak up policy regarding staff raising concerns or complaints. The policy stated that any concerns or complaints raised by staff should not be investigated by their line manager, but we were given examples of this not happening.

The service reported that there had been no complaints received in the preceding 12 months at the time of inspection.

Patients, relatives, and carers knew how to complain or raise concerns but there was no complaint information in languages other than English and no alternative formats.

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

Managers told us how they would investigate complaints and identify themes.

Staff knew how to acknowledge complaints and told us that patients would receive feedback from managers after the investigation into their complaint.

Managers would share feedback from complaints with staff and would use any learning to improve the service.

Patient transport services

Is the service well-led?

Inadequate

This service had not been previously inspected. We rated it as inadequate.

Leadership

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

All senior leaders were able to describe their role and how their skills and abilities enabled them to run the service.

All senior leaders could articulate the priorities and issues that the service faced and could describe how they wanted the service to improve.

Some staff reported that there was support at all levels to develop their skills and take on senior roles. We were given examples of clear succession planning which led to all grades being able to progress professionally.

Not all staff reported that senior leaders were a visible presence within the department due to flexible working patterns nor that they were always approachable. We were given examples of staff not feeling confident to escalate issues to all senior leaders for fear of negative reactions.

Vision and Strategy

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

All senior leaders could articulate the vision and strategy for the service which included further expansion to include different geographical areas of operation and for the increase into different areas for commissioned work.

Not all staff could describe what the vision and strategy was for the service, nor could they articulate how their role contributed to the strategy. Some staff felt that the service had developed too quickly and without sufficient consultation with staff.

Culture

Not all staff felt respected, supported and valued. The service did not consistently provide an open culture where patients, their families and staff could raise concerns without fear. The service provided opportunities for career development.

Results from the 'what matters to me' staff survey in 2023 reported that some staff had felt humiliated, bullied and that some managers were confrontational and intimidating. Senior managers were aware of the issues raised in the staff survey, but we did not see any evidence to support that that these issues were being addressed.

Some staff told us that they didn't feel valued and as such were seeking alternative employment. Not all staff, from across all grades and roles felt confident to raise concerns or to report incidents as they felt that they would not be listened to and that they were worried about repercussions.

We were given examples of individual members of staff being encouraged and supported to develop within their careers. Some staff told us that managers were always prepared to help with development.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We saw examples within the service where there were no processes in place to ensure effective governance. We found significant omissions within medicines management, infection prevention and control and within environment and equipment. We also saw a lack of effective governance with partner organisations regarding vehicle supply and maintenance.

We saw no evidence of regular governance meetings held for the service. Following inspection, we requested copies of governance meeting minutes from the last three meetings held. We were provided with one morbidity and mortality meeting, one senior clinical forum and one meeting from the wider paediatric group which had no reference to governance of the service.

Staff at all levels were clear about their role and accountability but we saw an inconsistent approach from staff regarding the completion of their accountabilities. We saw that staff were non-compliant with mandatory and safeguarding training but there was no evidence of any acknowledgement of this issue nor any work in place to ensure compliance.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance. They identified some risks and issues but did not consistently escalate relevant risks and issues nor did they identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We were not assured that there were effective systems to manage the service. We were given examples such as medicine security that had been raised previously but had not been actioned by the time of inspection.

We were given examples of issues with vehicles and subsequent incidents that had been reported but whilst senior leaders were aware of the issue, no actions had been taken to address this.

We requested details of internal audits that would inform senior leaders of issues or risks within the service and allow for effective management of performance. We were told by senior leaders that no internal audits were undertaken which meant that risks or issues may not be identified.

Patient transport services

We were told of a specific risk regarding overnight consultant cover where the paediatric consultant was also on call for the paediatric intensive care unit in the out of hours (OOH) period. If needed for transfer, then they would have to arrange cover themselves or escalate it to the paediatric anaesthetist on call who may be required elsewhere. We were informed that it was on the risk register and was regularly discussed but no actions had been taken. We did note that the consultants for adult transfers did not have any OOH on call liability.

All senior leaders told us that they were sighted on the risk register. They told us about risks being allocated, reviewed and with mitigation being in place. We were also told that higher risks had been escalated to the executive oversight risk register. Following inspection, we requested a copy of the executive oversight risk register and the service specific risk register. We were provided with the executive oversight risk register but no reference to the service was evident and the service specific risk register had not been provided. The trust confirmed although there were two risks related to NECTAR, they were included in the risk register for children and young people services

Senior leaders and staff were able to give examples of when they had to cope with unexpected events. Following inspection, we saw the business continuity plan which articulated methods for managing unforeseen circumstances.

Information Management

The service did not evidence that they collected reliable data. We saw no evidence that staff consistently use data to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We did not see any examples of data being analysed to improve performance, make decisions, or make improvements. There were no audits provided that demonstrated how the service used data.

We saw no examples of information being left unsecured.

The service ensured that systems were integrated to facilitate transfer of data with external organisation.

Engagement

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

Senior leaders were able to articulate how they had improved engagement with staff, and we saw evidence within the service that demonstrated that engagement was ongoing. We saw that there were examples of regular staff engagement in the form of monthly staff meetings, clinical forums, clinical supervision, and ongoing staff surveys.

We saw examples of engagement with patients and the wider community including participation in school and community events.

Learning, continuous improvement and innovation

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

The service has pioneered a variety of innovative practices that included the creation of specific practitioner roles and pathways for the transportation of a variety of acutely unwell adults and children.

Patient transport services

We were told by staff how they are constantly developing services to support stakeholders, which identified the main themes of improving patient care and patient experience and improving patient flow through hospitals.

Freeman Hospital

Freeman Road
High Heaton
Newcastle Upon Tyne
NE7 7DN
Tel: 01912336161
www.newcastle-hospitals.org.uk

Description of this hospital

The Freeman Hospital provides a full range of acute services including specialist services such as cardiothoracic and transplant services. This hospital does not have an urgent and emergency care department.

Surgery

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

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

Training was offered as either face to face or through an electronic learning portal. Staff told us they were offered time to complete the course when they could.

Nursing and medical staff received and generally kept up to date with their mandatory training. We reviewed training compliance figures across all the wards we visited and saw that the compliance rates were slightly below the trusts 95% target, although we also saw that staff awaiting training had been provided with a date to complete it. We requested the mandatory training data for the surgical health group overall and saw overall mandatory training compliance was slightly below the trust target at 90% for June 2023.

The mandatory training was comprehensive; and meet the needs of patients and staff. Staff told us they were able to access all aspects of mandatory training and were fully supported by senior ward staff to undertake both face to face and electronic learning.

However, we reviewed Aseptic Non-Touch Technique (ANTT) training rates and saw that they were consistently low across the surgical wards we visited. Overall trust compliance rates were 64% which was significantly below the trust target. Senior managers described the low compliance rates as disappointing as there had recently been an increased focus in regard to improving the overall rates.

Clinical staff completed some training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The trust told us they had introduced the regional ICS endorsed Learning Disabilities Diamond Standards mandatory training for all clinical and patient facing staff in March 2023. This training includes some aspects of autism training but has been enhanced with additional autism awareness education sessions from April 2023. The Trust is piloting the roll out of the Oliver McGowan Training for Learning Disabilities and Autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance figures were collated through a recently introduced compliance dashboard in which senior ward staff were able to view live training compliance rates. Senior ward staff spoke positively about the new electronic recording hub and we saw the system being utilised on each ward we visited.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Surgery

We reviewed the mandatory training compliance figures and saw that 93% of staff within the health group had completed level 2 adults safeguarding training and 91% had completed level 2 children's safeguarding training. These figures fell slightly below the trusts target of 95%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff knew who to contact and where safeguarding policies were for support. Staff were able to articulate examples of recent safeguarding alerts made and understood those patients who were most vulnerable and required safeguarding input. They used online forms to refer any safeguarding notifications or queries to the local authority multi-agency safeguarding teams. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern and discuss with the social work team who were based within the trust. Staff described multi-disciplinary team working to ensure patients were protected. Staff could also add any safeguarding issues to the electronic recording system.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed the most recent safeguarding alerts submitted by the trust and saw that patients were referred to the local authority safeguarding team as appropriate. Staff told us they received feedback following submission of these alerts where possible.

Cleanliness, infection control and hygiene

The ward environment was visibly clean; however, the service did not always control infection risk well. Staff used equipment to protect patients, themselves and others from infection.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We also saw completed cleaning schedules in ward areas.

We reviewed the trusts infection prevention and control audits and saw that compliance was high across the wards we visited.

Audit results were finalised at the end of the month and were shared on a monthly basis and as part of assurance measures, were discussed monthly in one-to-one meetings between Matrons and Associate Directors of Nursing. We saw high hand washing audit compliance rates across the wards we visited, including one ward which was 100%. We requested recent PLACE audit data and saw aspects of cleanliness on that ward, resulted in actions taken to improve hygiene.

Staff did not dispose of clinical waste safely. We also saw across both hospital sites that clinical waste storage areas were not always secure. This posed a risk that both patients and visitors to the hospital may gain entry into unauthorised areas, resulting in an increased risk of contracting an infection. We again brought this to the immediate attention of senior ward staff to ensure areas were maintained safely.

Sanitiser was available at the entrance of all wards we visited, and we saw these were regularly replenished.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE). We observed most staff using gloves and aprons appropriately.

We reviewed portable equipment with ‘I am clean stickers’ which were generally in date.

We saw in March 2023 data shows the trust is also in the bottom 25% of trusts nationally for the rate of infections per 100k bed days, for MSSA, E.coli, Klebsiella, P. Aeruginosa and C.difficile infections.

Surgery

For MRSA infection rate the trust is in the top 25% performing trusts nationally.

Senior ward staff told us that monthly infection, prevention and control (IPC) audits, incorporating hand hygiene audits were carried out as part of the Clinical Assurance Tool (CAT) via an electronic recording system, by each ward on a monthly basis and shared with staff through meetings and emails.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment was not always suitable and equipment used was not always serviced and checked.

The service did not always have suitable facilities to meet the needs of patients' families. No wards we visited had environmental provision for patients with dementia or delirium. In addition, we did not see any equipment provided such as brightly coloured drinking cups and plates in use on the wards we visited. We saw this was a concern highlighted as part of the recent PLACE audit results.

We reviewed portable electrical equipment across all wards we visited and saw several items of equipment which had not been tested in accordance with the trusts own testing policy or had expired.

On ward 25 we saw expired servicing stickers on a mattress pump and found expired sterile supplies. On ward 7 we found blood fluid warming bags which were out of date and several types of sterile dressings. Also, on ward 7 we saw the TPN fridge thermometer had been broken over a period of 16 days and had been escalated for repair but was still broken at the time of inspection.

COSHH chemicals were not always stored safely or in line with the trusts own policy. For example, at the Freeman hospital we saw cleaning store cupboards unlocked on wards 5, 7, 19 and 25. All stores had acticlor tablets visible and ready to dilute. This posed a risk to vulnerable patients who may gain access into these areas and digest accidentally.

We also saw several clinical areas unlocked, for example treatment rooms which stored clinical supplies such as needles and IV fluids. This was a risk due to the type of vulnerable patients nursed on wards within the service.

We also reviewed resuscitation trolley equipment checks on all wards we visited and saw inconsistent equipment checks on some wards. For example, ward 7 and 19 with gaps shown across several days.

We visited several wards with out of date or blank information boards and panels. On other wards we saw that information that was displayed did not always match what staff told us. Staff told us this was due to staff shortages and the movement of staff throughout the day.

We found no medical gas signs on the storeroom doors of all wards we visited. These rooms stored some entonox and oxygen inappropriately on the floor behind the door. Storeroom doors were all unlocked which meant medical gases were accessible to anyone on the ward. We saw poor storage of oxygen cylinders at freeman on wards 25, and 19.

Sluice room doors were also unlocked in some areas. For example, wards 5 and 7.

Therefore, we were not assured that equipment across the wards we visited were stored, serviced and managed in accordance with trust policy to ensure patients were kept safe.

However, the service had sufficient suitable equipment to help them to safely care for patients. All staff told us they had sufficient equipment to safely care for patients.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimised risks. However, escalation scores were consistently completed.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score (NEWS2). We reviewed 13 patients' records and found that all had a completed NEWS2 score recorded within the electronic database system. All staff told us that an escalated NEWS2 score would automatically trigger a medical review. However, this involved a manual process by nursing staff to ensure the NEWS2 was escalated. This posed a risk to patients that escalation of the deteriorating patient may be delayed, resulting in potential patient harm.

We requested data relation to the most recent NEWS audits and saw only a statement provided by the trust to state current NEWS2 compliance rates as of the 1st of July 2023 were 85% for surgical services.

The Trust was currently working on the deteriorating patient and sepsis digital compliance dashboard tool, which were due to go live the end of July 2023.

Staff completed a series of safety assessments at the point of admission. We reviewed the trusts own policy in relation to completion of these assessments and saw that the requirement was to complete at the point of admission, followed by a review seven days later.

We saw several wards had developed their own process for ensuring these assessments were completed or reviewed, as the electronic recording system did not prompt staff to complete them as a priority. Senior ward staff allocated specific days to complete specific assessments, however all staff told us completion was affected by the general pressures of the ward. Staff told us they completed these assessments for each patient and included pressure ulcer risk assessments and venous thromboembolism assessments where appropriate.

We saw completion of safety assessments was better at the Freeman hospital than the RVI. We requested VTE compliance scores overall for the surgical speciality, but this was not provided.

These safety assessments were also not personalised to the patient and did not clearly define how risks would be managed. We saw some evidence of risk management by staff adding narrative into the free text nursing update / handover section, but this was not consistently completed as there was no standardised template to complete this section. Following our first inspection visit, the trust told us they had implemented templates for admission, shift handover and discharge. Senior ward staff told us they had oversight of these assessments and demonstrated the safety assessment dashboards.

However, these dashboards did not show all assessments such as VTE and as such we saw these assessments were missing from some of the records we reviewed. We saw this again at our second inspection visit'

Surgery

The electronic patient record system is used within the trust's theatre environment for anaesthesia, theatre and recovery. Recovery staff record all patient vital signs in the Electronic Patient Record. These are currently inputted manually into the system with an automated solution planned for the future. None of the wards we visited had a recognised pain scoring tool and although the electronic recording system had capacity to record pain, staff were not using it.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff told us that risk was always discussed at handover. However, although some wards used s-bar to standardise key patient handovers, this was not common practice across all wards we visited.

We saw bedrails were in situ on most of the wards we visited across both sites. A Falls Risk Assessment should be completed on admission, weekly or if condition changes. A Falls Care Bundle opens on the electronic patient record if a patient triggers any part of risk assessment. Question one in the Falls Care Bundle is 'Bedrails in Place'. This is a yes or no answer and is documented in the individual patient record. It is expected that the member of staff who answers this question has used the risk assessment to inform their decision before using bedrails or not. A Bedrails Risk Assessment Record of Decision is reference text on eRecord. We requested risk assessments for these but were told by all staff there were no risk assessments completed. Therefore, we were not assured that risk and safety management processes were robust and did not always protect patients from possible harm.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and proactively sought to fill staff vacancies.

On some wards we visited the actual nurse staffing at times was below planned establishment. There was evidence supplied to demonstrate that when this occurred it was closely monitored and mitigated where possible. Senior ward staff however told us that a recent recruitment drive had been successful in the recruitment of registered general nursing staff. Most of the wards we visited were therefore fully recruited on paper and newly registered nurses were either waiting for essential recruitment checks to be processed or were approaching their actual start date, at the time of inspection. Staff saw this as hugely positive and a boost to the staff's morale.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior lead nurses held daily beds management meetings across all divisions. This included oversight of staffing numbers, access and flow with cross-divisional matrons reviewing pressures across each site. We observed a beds management meeting which was held twice a day and was attended by senior ward staff from each division. They discussed expected admissions and discharges, wards with particular challenges such as high acuity patients and increased admission numbers. We observed proactive discussion between the staff who prioritised the demand across the various health groups and considered appropriate staffing levels.

Managers limited their use of agency staff and requested staff familiar with the service. For example, internal bank staff. Senior ward staff told us unfilled shifts were offered to bank staff and if these remained unfilled after two days they would go out to agency. We observed this during the bed management meeting. We requested induction checklists for bank staff who had recently worked on the wards we visited; however, ward staff told us that bank staff brought their own induction checklist for senior staff sign off.

Fill rates trust wide for registered nurses on days are on 89% and on night shift have an average fill rate of 89%.

We saw the use of red flags which were utilised as an alert to show particular staffing pressures on the electronic reporting system. We saw these flags in use during our inspection. Staff told us senior managers tried to provide additional staff when experiencing these particular pressures. However, it was not always possible. Ward staff told us that they did not always report unsafe staffing figures, due to ward pressures and time limitation. However, we reviewed the trusts most recent nursing and midwifery staffing report and saw that datix submissions related to staffing incidents, averaged 20 per month trust wide. The majority relating to unfilled shifts, staff sickness and high acuity and dependency of patients.

As of March 2023 (latest data), overall, the trust had a sickness rate of 6% in line with sector average. Sickness levels overall for the surgical speciality had improved over the last year. Sickness rates for all separate staff groups have also improved over the last year.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

In the last twelve months reviewed the proportion of consultants and junior doctors reported to be working at the trust were higher than the England averages. We saw the percentage of consultants at this trust were 49% when compared to 43% as the England average and we saw the percentage of Registrar doctors at this trust were 42% when compared to 38% as the England average. In the same reporting period, we saw the percentage of junior doctors at this trust were 7% when compared to 9% as the England average and we saw the percentage of middle career doctors at this trust were 2% when compared to 10% as the England average.

Both junior and middle career doctors at both hospital sites, told us that they felt the workload was unmanageable at times and expressed concerns as to how ‘stretched’ they felt. Staff described particular pressures whilst working nightshift and told us there were too many wards to cover. The trust recognised difficulties regarding the rostering of junior doctors and the ongoing pressures. We requested the current Junior Doctor fill rate per core service, but the data could not be interpreted in this format.

Medical staff at the Freeman Hospital expressed particular concerns regarding the safe clinical management of medical patients residing on surgical wards. However, there is a rota of out of hours (OOH) medical staffing at the Freeman Hospital that provides medical escalation out of hours. This includes the F1 and SHO rotas for staff working on site. In addition, there is an on-site Registrar to support any escalating medical challenges. If further escalation is required, then there is an on-call Consultant available. We reviewed a consistently high number of exception reports submitted for medical staff working in excess of their contractual hours. Medical staff we spoke with told us this staffing and workload pressures had been escalated consistently for several months with no relief or support provided. We reviewed a high number of exception reports prior to inspection which corroborated this. We requested assurance from the trust regarding the challenges junior and middle grade doctors were experiencing. The trust submitted information outlining actions taken including rota changes and the introduction of teaching fellows. The trust also outlined plans to make further improvements from August 2023.

We requested medical sickness rates for the surgical division, but the data could not be interpreted in this format.

Surgery

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always kept up to date. Records were available to all staff providing care but not always stored securely.

The service was moving towards a paper lite model and predominantly used electronic recording systems when recording vital signs, nursing and medical observations records. The trusts DNACPR system has been digital since October 2019 and its functionality was enhanced in November 2022. One aspect of this process remains paper-based, as this is currently required b associated third party providers and requires the trust a DNACPR paper form for patients on discharge from hospital. We saw theatre staff used predominately paper-based documents for all aspects of recording as they had not yet moved across to the electronic systems. Staff competency of using the electronic recording system varied across the wards we visited and staff openly told us they had received limited training on the system before it was introduced. This was a tailored training programme at induction, with the duration determined by the complexity of the systems to be used and feedback from staff. For some staff this was 4 hours in duration. For the vast majority of nursing staff, this was 7.5 hours, and for some administrative staff, this was shorter. The training at induction was supplemented by on-line how-to guides and further courses were available by request via IT training.

The ability to navigate the electronic system varied according to the time they had used it and staff were open in relation to their own competencies using the system.

We reviewed the electronic records of seven patients and saw they were all incomplete. Nurses were able to add free text updates for each shift covering some aspects of the care and treatment that had been given and this box then prompted nursing staff to complete care plans for the key words identified such as catheter care, mobility and wound care. We saw in 100% of the records we reviewed, that no care plans were being used following prompting by the system. This posed a risk that patients would not receive care and treatment in line with national guidance and best practice. This also meant that nursing intervention could not be accurately measured to ensure the care provided was appropriate and beneficial for the patients. We spoke with several matrons and asked how they ensured they monitored effective intervention of nursing care. Matrons told us they did not have accurate oversight due to the failings of the electronic recording system.

Nursing staff told us that they were too many records to complete on the electronic systems and navigation was confusing and time consuming. Whilst reviewing one patients records, we measured the time from log on to retrieval of vital signs and fluid balance to be 45 minutes. The senior member of ward staff navigating the system for inspectors needed to ring for IT assistance to access the records that we requested. These records were safety assessments which should be readily accessible to all staff. We observed 15 minutes wait to contact IT with a further ten minutes to gain instruction. Staff told us they simply did not have the time or staff resources to navigate through patient's records. Following our first site visit, the trust told us they had implemented handover templates to ensure key information was recorded for each patient at the end of each shift. However, we reviewed three nursing records and saw handover templates were used as a basic prompt for staff to record some aspects of nursing care, but it was not comprehensive and did not in any way replace a nursing treatment and intervention plan. This is not in line with the royal college of nursing guidance in relation to patient records and care planning.

Nursing staff attempted to mitigate the lack of accessible key information, by developing a safety handover and a printed nursing handover document. This information was presented to all staff at the beginning of each shift to ensure staff understood the key risks for each patient. However, these documents were developed using nurses' own skills and knowledge and we saw the documents were inconsistently applied across all wards we visited.

Patient notes were not always comprehensive or up to date. The trust did not always ensure that the electronic system capabilities were fully used to promote patients' safety. For example, aspects of care to ensure safety around areas such

as falls risks, dementia and learning disabilities needs were not flagged on the electronic white board. The system had the capability to do this, but the trust had not opted to use the functionality. However, some functions were enabled. Examples of this include, highlighting when observations are due, NEWS2 score, high or low blood glucose, acute kidney injury, infection risk and DNACPR. The EPR also has electronic flagging and clinical alert functionality than can be added to by any member of the clinical team.

Care plans which were initiated by the system were not developed or completed. For example, we reviewed the care of a patients on wards 6 and 7 at the Freeman hospital with complex co-morbidities including incontinence and pressure area damage. We saw no care plans for any of the diagnosed conditions. The lack of care planning was evident across all wards we visited. In the absence of effective care planning there posed a risk that patients would receive incomplete care and treatment and the success of any care provided could not be measured accurately.

We also saw on all wards we visited, isolation icons applied against some patients on the electronic white boards, however the patients shown to require isolation were not isolated as the information displayed was incorrect. All staff we spoke with told us that this was a system error which had not been corrected since the pandemic.

We saw confidential patient records were left unattended on most of the wards we visited. We saw laptops left unlocked and bags of patient confidential waste in doorways on most of the wards we visited.

We saw the trust had recently introduced an electronic safety dashboard which enable senior ward staff to see which safety assessments had not been completed. These dashboards did not show all assessments such as VTE and as such saw VTE assessments were missing from some of the records we reviewed. We saw this again at our second inspection visit'. Most of the senior ward staff told us that the electronic recording system did not offer real time monitoring due to some system glitches which were ongoing at the time of inspection. Several staff described the system as 'not fit for purpose' and we saw members of the digital support team struggle to navigate certain aspects of the system.

We reviewed three patient records, all of whom had a diagnosis of dementia. Despite their being a note on the nursing handover to show the patient had a diagnosis of dementia there was no further support outlined within the system, such as communication tools, visual and nutritional aids.

We reviewed four surgical safety checklists on ward 25 at The Freeman hospital and saw that none of them had been signed off to show all aspects of the pause and check processes were carried out. This indicated that the appropriate checks in accordance with WHO guidance was not completed. This meant that patients were not appropriately protected from the potential of harm due to the absence of mandatory record keeping. Therefore, we were not assured that individual care records including clinical data, written, stored and managed, kept people safe.

Medicines

Staff did not always use systems and processes to safely, administer, record and store medicines.

The trust prescribed medicines using an electronic prescribing system. On surgical wards we found these were logged out after use with restricted access in place ensuring prescriptions could not be accessed by the incorrect staff.

We reviewed medicine storage arrangements on the wards we visited and saw at the Freeman hospital, controlled drugs were not managed in line with the providers own policy. On one ward we found record keeping for patients own controlled drugs was not documented in line with usual practice.

We saw oxygen was incorrectly stored across most of the wards we visited.

Surgery

We reviewed fridge temperature monitoring across the wards we visited and saw general fridge temperature records were not recorded consistently. Where fridge temperatures were found to be out of temperature range, no actions were taken. In addition, no room temperature monitoring was in place and therefore we were not assured that medicines were fit for purpose, due to the potential negative effects of extreme temperatures, on some of the medicines.

Staff followed current national practice to check patients had the correct medicines. Although the trust had an electronic prescribing system in place the trust were unable to provide real time medicines reconciliation figures therefore, we could not be assured that the trust had the required level of oversight to report on their key performance indicators of medicines reconciliation, being completed within 24 hours.

On ward 5 a new pharmacy team had been implemented as part of a pilot to initiate on ward dispensing to reduce discharge turnaround times and medicine waste expenditure. Post pilot data provided demonstrated extensive medicine cost savings as well as a marked reduction in discharge turnaround times. Due to the positive outcome of the pilot this was to be rolled out to 5 wards over two phases by January 2024.

We requested medication audit results, carried out across the trust but we received only anti-biotics interventions audits for some wards and therefore we were unable to interpret any general findings.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support. However, managers did not always ensure swift action was taken following incidents or consistently share the learning following incidents.

Staff knew what incidents to report but did not always act upon them. The service reported four surgery related never events between June 2022 and May 2022. Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers. The never events varied in theme and were unconnected. The incident types included retained swab, retained surgical sponge, retained guide wires and femoral artery puncture.

Managers did not always investigate incidents thoroughly. We saw insufficient pace when sharing the learning, resulting in potential subsequent harm to patients**.** We saw at the time of inspection that the post incident investigation action plans were incomplete for all four never events that we reviewed. We also saw that two never events involving retained guide wires occurred within four weeks of each other. We requested data from the trust to evidence learning following these never events from the trust, but this was not provided. We also spoke with theatre staff in regard to lessons learnt following these never events but none of the staff we spoke with, were aware of the incidents. We returned to the trust to carry out a further visit and staff were then able to describe actions taken by the trust at both hospital sites.

Following inspection, we also received updated post incident investigation action plans and saw that most of the actions were complete.

We reviewed the trusts policy in relation to incident reporting which included a pathway outlining the process, however timescales for completion of the full investigation were not defined.

Surgery

Most junior ward staff we asked could not give us recent examples of any shared learning from incidents. They could not list the top three incident-related risks on their ward or department beyond broad categories such as falls. However, senior theatre and ward staff at both sites had received information regarding the most recent incidents and told us these were discussed at staff meetings and safety huddles.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they reported patient incidents as quickly as they could, but this was affected by wars pressures. Most staff told us they received feedback following incidents and these were discussed with senior ward staff.

Some staff were confident to report staffing concerns, but others said staffing concerns using the electronic incident reporting system were rarely resolved, and they had stopped using the system. Some medical staff also told us it was pointless reporting incidents and concerns because nobody listened anymore.

We saw notice boards in staff areas displaying bulletins, but these did not include evidence of learning from never events. Many of the notice boards we reviewed displayed historic information and in some cases, this dated back six months or more.

Therefore, we are not assured that patients are protected from the potential of harm due to the lack of pace when both investigating incidents and sharing the learning following incidents.

Is the service effective?

Requires Improvement 

The service did not always provide care and treatment based on national guidance and evidence-based practice. Patients were not always consented appropriately. Managers did not always check to make sure staff followed guidance. However, staff protected the rights of patients subject to the Mental Health Act 1983.

Staff told us that policies were regularly reviewed and updated in accordance with national guidance and best practice.

We reviewed the trusts own intranet system and saw staff had access to policies, procedures and general guidance pertaining to clinical and operational matters. Staff knew where to access policies and guidance on the intranet and we experienced nursing and medical staff were able to articulate clinical practice with evidence-based research and best practice.

However, staff did not always follow up-to-date policies to plan or deliver high quality care according to best practice and national guidance.

Staff described the electronic care planning system as ‘time consuming and unhelpful’ and in many examples acted as a barrier for delivering clear effective care implementation.

We spoke with ward matrons and asked in the absence of care plans, how they would ensure appropriate care was being delivered for all patients in accordance with evidence-based practice or national guidance, but we were told they could not ensure this. Matrons told us that they had many experienced and skilled nursing staff across all wards. However, they acknowledged that the influx of newly qualified nursing staff created challenges when trying to provide ongoing mentorship, support and general training.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed three patients' records, all of whom were recorded as being confused and may lack capacity. We saw capacity assessments were completed and we saw some best interest decision making records.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients requiring additional hydration and nutritional intervention were monitored through fluid balance charts and nutritional intake records. As with other patient records, recovery staff used paper records and consistently recorded fluid intake and output. These stopped once the patient reached the ward and electronic records were completed instead. Fluid balance intake was recorded on both paper and electronic systems depending on which wards has access to the electronic systems. We reviewed nine fluid balance records and saw a variation in the timeliness of completion. However, all patients who required fluid balance were in receipt of fluid balance monitoring.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw MUST scores were used for all patients and explained those at risk such as patients with frailty had dietician input.

Specialist support from staff such as dietitians and speech and language therapists were available for those patients who required them. We saw evidence of dietician involvement in the records that we reviewed. We saw good practice on ward 5 at The Freeman hospital with staff ensuring patients with low MUST scores were referred quickly to dietician services to improve nutritional input.

However, we saw only one ward at the Freeman had enlisted the services of volunteers to provide additional nutritional and hydration support to patients on the wards that we visited.

We requested the trusts most recent fasting audits, but the data was historic and not within the last twelve months.

However, feedback we received from patients during the inspection regarding food was negative. All patients we spoke with told us that the food could be better, and options were often bland and uninteresting. Recent patients surveys also highlighted the quality of food as a concern. There were plans in place to improve the quality of food and a number of nutritional priorities were identified. The Trust launched the refreshed Food and Drink Strategy 2022 – 2027 in 2023 - “Our commitment to providing healthy food and drink in a sustainable way to meet the nutrition and hydration needs of all.”

This strategy includes a Delivery Plan and monitoring of the 3 strategic priorities through a Nutrition Strategy Steering Group.

Surgery

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, staff did not always support those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff prescribed, administered and recorded pain relief accurately. We reviewed medication administrations charts across both hospital sites we visited and saw analgesia was prescribed and administered appropriately.

However, staff did not assess patients' pain using a recognised tool, although pain relief was given in line with individual needs and best practice on the wards that we reviewed. Following inspection, the trust told us there was an option to record a pain score within the electronic patient record.

We saw patients receiving care following surgery were assessed in recovery, using a pain score. Numerical scores were recorded on the paper documents that we reviewed. However, these scores were not continued once the patients transferred to the wards. We asked ward staff on each ward we visited what pain scoring tool was being used and all staff told us there was none in use. Ward staff told us that they would ask patients to describe their pain but there was no tool to support patients who were unable to communicate or for those with specific needs such as dementia or learning difficulties. Some staff told us that the electronic recording system could be used to record pain but none of the staff we spoke with knew how to do this.

Ward staff told us they could refer patients to a specialist pain team and we saw evidence of involvement within the records we reviewed.

Patients we spoke with told us they received analgesia when required, however they understood when there were delays due to busy periods on the wards.

Patient outcomes

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

The latest National Emergency Laparotomy Audit data was published on 9th February 2023. This uses data from December 2020 to November 2021 inclusive with patient report and RAG tables published November 2022, not February 2022. In the National Emergency Laparotomy Audit at the Freeman Hospital had a case ascertainment rate of 80.8% which exceeded the national average of 78.8%.

In the National Emergency Laparotomy Audit Royal Victoria Infirmary had a case ascertainment rate of 98.9% which exceeded the national standard of 78.8%. It met the standard for 7 out of 9 indicators in the audit.

In the 2021 national bowel cancer audit, the trust had a 'good' data completeness of 97.3%. The trust within the expected range for the four indicators in the audit.

In the National Prostate Cancer audit, the trust reported 75% of men had complete information to determine disease status. This did not meet the national standard of 100%. The trust performed with the expected range for all three indicators in the audit.

Surgery

In the National Joint Registry audit, the site had a case ascertainment 100%, which exceed the national standard of 95%. The site reported that 6.8% of patients consented to have personal details included (hips, knees, ankles and elbows). This was much worse than other hospital sites and did not meet the national standard of 95%. The site was within the expected range for the remaining four indicators in the audit.

The trust met the standard or was within the expected range for four out of five of the indicators in the 2021 National Vascular Registry Audit. The trust reported a crude median time from symptom to surgery [Carotid Endarterectomy] of 15 days. This was higher than the national standard of 14 days and higher the national aggregate of 12 days.

We saw the trust had implemented action plans for each of the audits where recommendations were required. Review of these action plans was ongoing and had been assigned a risk rating score in order of priority.

Outcomes for patients were mixed, and inconsistent when compared to the England average.

The Model Hospital data flagged 36 indicators relating to surgical specialties as concerning with most indicators related to length of stay and readmission rates. Anaesthetics and perioperative medicine had the most indicators or concern, followed by spinal services and urology.

For all specialties overall at trust and hospital level and also for elective and non-elective patients, the trust had longer average stays than the national average between January 2022 and December 2022. The speciality with the most notable differences compared to the England average were ear nose and throat, vascular and urology.

Managers and staff carried out some audits to check improvement over time. We requested the trusts recent audit data in relation to pain and preoperative fasting and saw no specific audits had been completed, although the fractured neck of femur audit had recently been carried out, with embedded pain specific information under collation at the time of inspection.

PROMS data was limited at the time of inspection. PROMs are a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. These areas are nationally selected procedures. We reviewed the reduced data available for the period 2021/22 and saw results were mixed. It is acknowledged nationally that questionnaires may have been impacted when compared to earlier years.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance. Staff induction was not always recorded and link nurse training had not always been renewed.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke with several staff working in newly appointed senior nursing roles. Many of whom had been in their current role for less than 12 months but were supported by matrons and colleagues working at a similar grade. Senior ward staff told us that the numbers of newly qualified staff was challenging due to the level of support however saw the recruitment as positive overall. All staff underwent trust induction training. We saw some digital training was provided, however all staff we spoke with told us it was insufficient preparation for the use of the system. The trust induction also included advanced care planning which included the use of emergency health care plans and DNACPR training.

Surgery

Managers gave all new staff a full induction tailored to their role before they started work. We saw preceptorship and mentoring was tailored to the staff specific role to ensure training was appropriate. Bank staff arrived to the wards with their bank induction document, to ensure consistency of completion.

We asked to review bank staff induction checklists, to ensure staff working on these wards were provided with a basic overview of the operational aspects of the ward such as patient escalation processes. However, senior ward staff told us they did not always have sight of these as no copies were kept on the wards we visited.

Managers did not always make sure staff received specialist training for their role. The provider previously provided named staff with additional training in specialist areas (link nurses). This enabled those staff to share key learning and act as a 'go to' person to provided advice and information in these specific areas. Senior ward staff told us that told us that link nurses had been in place across wall wards and departments prior to the pandemic but due to recruitment difficulties most of the wards we visited had not reinstated these staff roles. Only one of the wards we visited had named link nurses covering training such as tissue viability, dementia, and falls.

We saw however that qualified nursing staff were provided with x4 study days per year.

The clinical educators supported the learning and development needs of staff. Senior ward staff told us that newly qualified nurses were provided with ongoing support through their preceptorship period. All staff we spoke with told us that the support received was invaluable. We also saw clinical educators had supported all staff in areas such as pressure ulcer management, safety assessments and falls management.

Managers worked flexibly to ensure staff received information from governance meetings, safety briefings, MDT meetings and trust updates. Managers told us meeting notes were emailed to all staff or shared at ward handovers. Social media platforms were also used creatively to reach out and ensure information sharing.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Trust wide staff appraisal data was submitted by the provider for the health group. We saw that the overall appraisal compliance figures for surgery in May 2023, was lower than the trust target of 90%. Most wards we reviewed during our inspection demonstrated a high compliance figure for clinical staff appraisals.

Some managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. New roles had recently been developed and introduced such as risk leaders and additional nurse educators.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Ward staff told us that managers ensured time was made available where possible to complete training and share courses which were available throughout the trust.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers described the support they offered to staff and actions taken when improvements were required.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We reviewed ward rounds which were conducted several times and saw patient information was exchanged using the electronic recording system.

However, this information was not detailed and did not always include discussion in regard to risk. We spoke with medical staff and their understanding of the electronic nursing records including safety nursing assessments. Several medical staff told us they did not review the nursing assessments and reviewed a separate section of the electronic recording system.

We saw consultants and allied health professionals arriving to the wards at various points of the day, which impacted on the senior sister or nurse in charge having to repeat essential handover information. Senior ward staff told us this created operational difficulties due to the different ways of working and inconsistencies within the ward rounds and information exchange.

Senior ward staff told us they had developed 'work arounds', as the electronic recording system did not provide a prepopulated information print out to enable consistent information sharing across all members of the multi-disciplinary team. We saw ward staff provide printed handovers, based on the knowledge and skills of the nursing staff overlooking the care of patients. This posed a risk that some key information may be missed off due to human error and failure to recall certain key points.

We attend a board round and saw that they were well attend, with all members of the clinical team in attendance.

We also attended a multi-disciplinary meeting for a complex patient requiring intervention and treatment from a multitude of teams within the hospital. Again, we saw this was well attended and there was comprehensive discussion from all who attended. However, senior staff in attendance delegated the role of the co-ordination of the MDT actions to the ward sister, despite a request from the sister for some support due to the challenges of the ward. We observed a reluctance by senior staff to undertake some responsibility to support more junior colleagues.

Some wards were supported by discharge co-ordinators and all ward staff we spoke with told us that they were invaluable. However, many of the wards did not have these additional staff which impacted on timely discharge planning. However, we spoke with ward clerks who liaised with families, social workers, and care home managers, and booked district nurse and GP practice nurse appointments to ensure patient discharges went as smoothly as possible.

Pharmacy support was not consistent with some wards advising they were well supported whilst others received no support at all.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. All managers we spoke with told us that trying to bring staff together due to staffing shortages was challenging but tried to ensure meeting minutes were read by all staff where possible.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. However, escalation processes were potentially delayed for some patients.

Ward staff told us consultants led daily ward rounds on all wards and we observed this during our inspection. Staff also told us patients were reviewed daily by consultants depending on their particular health group or speciality. However, medical staff expressed concern that the review of deteriorating medical patients residing on surgical wards at the Freeman hospital was not timely. We requested to review the medical on call rota, but staff told us they were not provided with this information and all calls were made through switchboard. Medical staff explained that their call

would then relay to the consultant at the RVI who would then discuss with the registrar at the Freeman before then talking to the medic. There was no support from critical care in reach. This created potential delays for specifically unwell patients with complex medical needs. Medical staff also told us that there had been examples when these delays had resulted in patient harm. We requested data in relation to these delays and saw four incidents had been logged.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Phlebotomy services run 7 days per week from 07:00-13:00 due to reduced demand in the afternoons however, junior medical staff told us this created additional pressures for them, particularly at weekends.

Health promotion

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

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

Epilepsy specialist nurses provide a monthly seizure education session with the aim of this session to explain about first/ single seizures, epilepsy or any reason why the patient might have attended the first seizure clinic. The educational session covered safety, avoiding triggers including limiting alcohol consumption, avoiding recreational drugs, ensuring good sleep health, the importance of discussing any mental health problems with their GP and ensuring they are well hydrated and eating a balanced diet.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Wards we visited had lots of information available for patients on leaflet racks. We also saw a patient education day had recently been established once a quarter where patients and a friend or partner could come along and meet the team for an afternoon. Similar information was also available such as typical symptoms to look out for, side effects and tips to try and keep patients being admitted to hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always complete consent protocols appropriately, in accordance with provider policy.

We found some improvements in practice since the focussed inspection was carried out in November 2022.We saw that each ward had a 'care for me, with me' folder in place that provided staff with guidance on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff we spoke with, were aware of these folders and were familiar with the trusts plans for staff to become confident in completion of capacity assessments and deprivation of liberty safeguards. All staff we spoke to were aware they could contact the MCA lead for advice. Staff also knew how to contact the safeguarding adult's team for advice regarding MCA and DoLs.

However, staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. A recent audit demonstrated 62% of capacity assessments had documents completed. However, it was identified that a more in-depth review of clinical notes was required.

Mental capacity act level one e-learning had been completed by 84% of staff in July 2023. This was a significant improvement to 32% in April 2023. A package for level two training was being developed. We heard mixed views from staff we spoke to regarding the level of confidence and whose responsibility it was to complete capacity assessments. For example, on one ward nurses were new to competing these assessments whilst on other nurses told us they had more experience of completion.

Surgery

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patient records. We saw that patients were not always consented appropriately. At The Freeman hospital on wards 25, 5 and 7, some own patients copy of the consent form had not been provided. We reviewed four separate patients records and saw both the patients consent form copy and the hospital copies were still held together. This posed a risk that patients may not have been fully advised when obtaining consent for surgical procedures.

During our inspection in November 2022, we found examples where staff had not established whether patients lacked mental capacity to make decisions about their care and treatment, however, indicated care was being provided 'in their best interests'. During this inspection we saw some examples of best interest making and appropriate capacity assessment completion, but this was not always consistent.

There was a Mental Capacity Act policy in place, however this was not updated to reflect the training requirements and responsibilities of staff in completion of mental capacity assessments. For example, it referred to optional mental capacity act training for areas where this was felt necessary.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity.

Staff followed policy to try to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and medical staff holding sensitive conversations respectfully.

Side rooms were available on all of the wards we visited and were utilised where possible, for those patients particularly in need, such as end of life or those requiring isolation.

Patients said staff treated them well and with kindness. "The staff all simply amazing. They have done so much for me, and I can't express enough how they have changed my life'.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw communication with the hospital chaplains and general privacy provided to enable patients to undertake prayer and spiritual reflection.

Feedback provided to the enhanced recovery team included 'Incredible staff, professional but very approachable caring and always good humoured. I was treated with respect and felt part of the process (rather than just being treated) my husband was treated well too, a lot of attention goes to the patient but family need support too and this was given'.

Surgery

The service had not participated in a recent national patient survey, however locally feedback was sought from a number of internal surveys. The last annual inpatient survey held in 2021 showed that the trust scored about the same when compared with similar trusts. Compared to the previous survey the trust showed a statistically significant increase for information provided to patients leaving hospital.

We reviewed the trusts latest friends and family survey summary dated May 2022 to My 2023 but it was incomplete and did not include all of the surgical wards.

We reviewed recent internal patient feedback sources and saw that generally feedback regarding surgical services was positive. This included feedback to the enhanced recovery programme team, pre and post operative assessment clinics, Saturday clinics and the new day treatment centre.

Emotional support

Staff provided emotional support to patients to minimise their distress. However, there were no personalised care plans for any patients, including those with specific emotional needs.

We reviewed three patients who required additional support due to a diagnosis of dementia. In all three patient records that we reviewed we did not see any care plans to support the emotional needs of these patients. An icon on the electronic whiteboard was also absent to inform staff of the additional needs of these patients.

Staff told us that additional care was always provided, for example, additional observations known as high observations, but none of the records we reviewed demonstrated personalised care planning for specific needs or emotional support. We saw no care planning in regard to emotional support for any of the patients we reviewed at both hospital sites.

We reviewed spiritual documentation and although there were no specific areas in which to define spiritual needs and wishes we saw a section could be completed when recording religious beliefs. However, we saw none of these sections completed regarding spirituality in the electronic recording system.

Staff recognised that time providing emotional care including enhanced interaction was limited. All staff we spoke with found the lack of staff to be a significant barrier to delivering quality emotional support. However, all staff were motivated to provide this care whenever they could and we saw staff working together to ensure patients received the optimum level of care with the staffing resources that they had.

Patients or their relatives could be referred for access to counselling and psychological support if required.

Understanding and involvement of patients and those close to them

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

Staff made sure patients understood their care and treatment. We observed the communication and interaction between patients and clinicians at both hospitals we visited. We observed clear dialogue and conversations which enabled patients to ask questions regarding their surgery and treatment. We also observed ward rounds in which patients were proactively involved in their care journeys and were provided with comprehensive updates and next step planning.

One patient at the Freeman hospital told us that staff were found to be, ‘really good, caring and compassionate’.

Surgery

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff interaction with families and patients' carers and saw information was provided in a way that was easily understood.

Patients gave positive feedback about the service. However, we saw within the last patient survey report, that patients felt that staff did not always provide communication around expectations following surgery. Patients said that further communication was needed so that they know what to expect before and after surgery.

Feedback provided to the enhanced recovery team included 'The continuity of seeing the enhanced recovery nurse preop and during my hospital stay was really helpful the excellent ward staff obviously work shift and rotas so seeing the same person each day and feeling that she knew and understood me was really helpful she was motivating and encouraging and able to offer reassurance'.

Is the service responsive?

Requires Improvement ↓↓

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

Service delivery to meet the needs of local people

The service aimed to plan and provided care in a way that met the needs of local people and the communities served. However, the demand for bed availability presented ongoing challenges.

Managers planned and organised services, so they met the needs of the local population. The service relieved pressure on other departments when they could treat patients in a day. We reviewed the beds management process and saw patients who were safe to be transferred were moved regularly to accommodate elective surgical patients. We also saw several of the wards we visited were of a dual function offering beds for both surgical and medical patients. The demands on the beds however meant some patients operations were cancelled on the same day, however the numbers were small. We requested data showing the number of surgical procedures which had been cancelled on the same day within the last 12 months and saw 1525 operations were cancelled. Of these 64 related to a lack of beds.

We requested bed occupancy rates for the surgical speciality, but this data could not be interpreted in the format it was submitted.

We saw the trust worked proactively with neighbouring hospitals to reduce backlogs across several specialities. Additional MRI and EEG capacity has been insourced to reduce delay in pathways and a review of consultant job plans has taken place to maximise theatre use. Trauma and orthopaedics planned to continue using the independent sector for spinal, hip, knee, foot and ankle surgery. In addition to utilising waiting list initiatives and insourcing to increase capacity

Beyond the Trust main sites there are collaborations in place with ten other NHS Trusts across 235 pathways. There are also arrangements in place with independent sector providers, with agreed activity levels which are being met. Many of the patients waiting are too complex to go to independent Sector and therefore remain on NuTH waiting lists.

Surgery

All specialties have access to the Digital Mutual Aid System (DMAS) to upload who are suitable to be transferred to other providers in a timely manner.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last six months and none told us they had.

The service had some systems to help care for patients in need of additional support or specialist intervention. We saw specialist teams such as pain, mental health, social work and dietary service staff involved in the care and treatment of the patients we reviewed. However, there were some delays in responding at times. In particular, the mental health team. The electronic system however did not support staff to refer to these services as it did not have the functionality to raise an automatic referral. Manual contact was required to access supporting services, which added to the existing workload of staff. There was also no manual flag to alert specialist teams when a patient had been admitted that was known to them prior. This again required a manual process by ward staff.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff we spoke with told us they used information passports for patients with learning disabilities. The use of this passport however was inconsistent and we saw some passports were in place, but we were not assured that these were routinely reviewed or commenced. We attended an MDT at the Freeman hospital, for a patient admitted in May 2023 with complex needs including learning disabilities. This patient had a grade 3 pressure sore, required dialysis, follows a renal diet, experienced challenging behaviour and had complex social needs. We saw there were no active care plans for any of these needs and the learning disability passport completed in September 2022 had not been revised. We reviewed the passport and saw it did not meet any of the patient's current needs. This patient had specific dietary needs and requests but none of them were documented within the passport. Inspectors spoke with some members of the MDT to ask who took responsibility to ensure passports were kept up to date, but it was unclear who was accountable.

Wards were not always designed to meet the needs of patients living with dementia. We did not see any evidence of adaptation for patients with a dementia such as appropriately coloured bays or specifically designed signage. Several senior ward staff told us they would include discussion around the needs of specific patients with dementia as part of the safety huddle, but we did not see records relating to specialist intervention or support. Senior ward staff told us that plans to ensure areas were designed to meet the needs of patients with dementia were part of the refurbishment plans for those wards affected.

The service had information leaflets available in languages spoken by the patients and local community. All staff we spoke with told us they were able to request a variety of leaflets in various languages, however we did not see these freely available on the wards that we visited. Two patients we spoke with could understand English but had been offered access to information in their first language if they needed it.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could access language support when required and we saw access numbers available to all staff on the wards that we visited.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw menu choices were available offering kosher, vegan and gluten free options. Staff told us they could also make bespoke requests for individuals should there be a specific need.

Access and flow

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

We reviewed trust wide data in relation to 18-week referral to treatment times and saw trust was in the second highest decile for level of risk for patients waiting over 18 weeks for treatment. In March 2023 71.5% of patients at the trust were treated within 18 weeks, compared to the England average of 65.8%.

In regard to 52-week referral to treatment time we saw trust was in the second highest decile for level of risk for patients waiting over 52 weeks for treatment. In March 2023, 6% of patients at the trust were treated over 52 weeks compared to 8.5% nationally.

There were 3,626 patients still waiting over 52 weeks in March 2023, 101 more patients than were waiting over 52 weeks in March 2022.

We saw waiting times for the surgical division were mixed across the various specialties. Cancer waiting times indicators were in line with regional and national averages for 2-week urgent referral and 62-day target. But the trust was in the lowest 25% of trusts nationally for patients treated within 31 days of a decision to treat in March 2023. The greatest improvement was seen in breast cancer 62 week wait data.

We also reviewed 2 week wait target data and saw in March 2023, 85% of patients were seen within 2 weeks, which was in the middle 50% of trusts nationally. This compared with 87% regionally and 84% nationally.

In relation to 31-day target data, the trust was in the lowest 25% of trusts nationally for patients treated within 31 days of a decision to treat. In March 2023, 86% of patients were treated within 31 days of a decision to treat, compared with 92% regionally and nationally.

In the 62-day target data we saw in March 2023, 59% of patients were seen within 62 days of an urgent GP referral, which was in the middle 50% nationally. This compared with 65% regionally and 63% nationally.

We reviewed the data specifically for the surgical speciality and compared performance against similar sized regional and national trusts, looking at key specialist areas.

We also saw ophthalmology and plastics were in the bottom five of all trusts for 52 weeks waits for treatment.

The trust reported long waiter times for hepato pancreato biliary surgery, however there were no projected 78 week waits by the end of March 2023. We saw extra clinics had been implemented to address the ongoing waits.

We requested data from the trust to show average length of stay for both elective and non-elective surgery, but the data could not be interpreted in the format it was submitted. However, we saw trust wide the trust does have a higher

proportion of longer stay patients over 21 days than comparators (10.5% compared with 8% national average. However, the average length of delay for patients who stay in hospital for 7 days or longer is better than regional and national averages, at 5.8 days delay after being clinically ready for discharge. Compared with 7 days for regional peer average and 8.4 days national average.

Since October 2022, the proportion of bed occupancy patients that were clinically ready to discharge has been better than the regional and national averages.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service displayed information about how to raise a concern in some patient areas. We saw some PALS information displayed on wards we visited but this was not consistent. Wards we visited did not have friends and family test feedback boxes and display boards were out of date and did not show current feedback. However, patients, relatives and carers knew how to complain or raise concerns. A patient we asked said they would feel confident asking ward staff how to raise a complaint or concern.

The trust supplied a log of complaints for the surgical health care group that showed 28 complaints had been received from patients and relatives, in the last twelve months. complaints and identified themes on behalf of other wards to retain an independent view, investigation, and any identified themes. The provider was able to identify the top three categories of complaints for the surgical specialty which were communication, clinical treatment and patient care. The Trust timescale for issuing a written response is 60 working days from commencement of the formal investigation. Responses that had taken longer than 60 days were monitored and at the time of the inspection there were 14 complaints overdue in the Surgical speciality.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. However, the complaints spreadsheet provided to us did not show what actions had been taken or any changes made as a result of complaints. We saw examples of concerns raised by patients in staff communication files on some of the wards we visited.

Staff could give examples of how they used patient feedback to improve daily practice. This included access for ward staff to interpreter equipment to help patients whose first language was not English and for patients who used sign language.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Senior leaders were not always visible and staff did not always know who their leaders were.

Clinical specialities across the trust were defined as divisional health boards. These boards were introduced on the 1st of April 2023 and were led by a Clinical Board Chair and Director of Operations, however clinical board priorities were in place which included staffing and workforce, Flow including theatres, governance structure, quality and safety, innovation and transformation, efficiency.

In addition, these clinical priorities we saw key pillars were defined to support each of the clinical boards. These included quality and safety, performance, finance and work force. The pillars represented the journey of transformation and formed part of the Newcastle model of organisational development for the trust.

Senior leaders we spoke with understood the new direction and were able to define the priorities of the clinical boards. Ward managers were less knowledgeable about the priorities but understood the reason for the changes overall and saw the changes as positive.

Ward staff were not able to explain the new leadership arrangements or who senior leaders were for their clinical board. However, these positions were new to the organisation and it was acknowledged information was still being shared across the trust at the time of inspection. A number of new appointments had been made at the time of inspection, including a new head of nursing, clinical board directors and chairs.

Staff told us historically they had not seen they did not see senior members of the previous health divisions and attendance on the wards was rare. Most of the ward staff we spoke with were unable to name their clinical directors.

All staff we spoke with spoke highly of their local leaders but felt there was a disconnect at more senior levels. Only one member of staff told us senior leaders had engaged with them and had acknowledged the operational challenges experienced by staff. Staff gave many examples of escalated concerns and issues which had not resulted in change despite staff voicing their concerns over a prolonged period of time. For example, junior and middle grade doctors experiencing excessive workload pressures and digital system frustrations experienced by local clinical managers.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy. However, the vision and strategy was not underpinned by detailed, realistic objectives and plans for high quality and sustainable delivery.

We reviewed the trust Strategy 2019-24 which detailed the vision for achieving local excellence and global reach through compassionate and innovative healthcare, education and research. The vision, values and ambitions and strategic framework were agreed by the Board of Directors in the summer of 2019 following a period of discussion and engagement with a wide range of staff and stakeholders. The vision expressed the collective aspirational and purpose and summarised the desire to achieve the highest standards in service delivery, improve health for local people and capitalise on world class expertise and research capacity. We saw the strategy also outlined the values of the organisation which were, ‘We care and are kind, we have high standards, we are inclusive, we are innovative, we are proud’. The Board of Directors and Council of Governors held the responsibility to ensure the strategy was delivered.

Surgery

The trust aspired to be an outstanding organisation now and support regional and national colleagues. The trust told us they were committed to being a full civic partner contributing to the health and wellbeing of the city and to be an anchor organisation in the Northeast and Cumbria. Key areas for recovery included orthopaedics, urology and oral surgery. Increasing theatre and cancer treatment capacity was also outlined. A number of objectives including the retention of staff and the recruitment of new staff were also listed.

We saw operational plans were also developed for each of the subgroups within the new clinical boards. The trust had set a time frame of five years from September 2019 for an updated strategy with a planned update on an annual basis.

We requested the annual update reports following the development of the strategy and saw delivery goals were set for the 2023/2024 period. We saw a timeline to ensure trust strategy objectives were refreshed however, they were not aligned ICP integrated strategies, and we did not see any wider trust engagement or stakeholder engagement at the time of inspection. These were highlighted as actions within the trust strategy; however, these were not completed or in progress at the time of inspection.

We saw the overview and summary outline for the surgical transformation programme including the improved theatre optimisation plans. We reviewed the timeline for implementation, but this did not include detail for completion, or the steps required to ensure the project deadlines were achieved or were achievable.

Culture

Staff did not always feel respected, supported and valued. The service did not always promote equality and diversity in daily work and provide opportunities to speak openly in relation to concerns or risk. However clinical staff were focused on the needs of patients receiving care and continued to drive positivity, despite the ongoing operational challenges.

Staff morale and wellbeing varied across the wards we visited, and staff told us their morale at times was quite poor due to the staffing challenges. Staff openly spoke of periods of exhaustion and frustration with operational demands, however the drive to work collaboratively as a local positive team was palpable. All clinical staff told us they were proud to work in the region and represent the trust, but also spoke of increasing frustration at the introduction of new systems and models with the ongoing necessity to seek basic staffing numbers. Staff spoke about the general increasing frailty of patients requiring care and treatment balanced against the high levels of staff who had left the service.

Staff generally felt well supported by their local managers and matrons and several staff told us that they felt managers were doing ‘all that they can to support them’, ‘great’ and ‘supportive’ and ‘always there when you need them’.

However, some staff felt that leadership styles were inconsistent, which affected the culture within certain areas. Some staff told us they felt their senior staff were not approachable and did not listen when they tried to escalate persistent issues or concerns. Several staff told us they no longer submitted incident reports regarding low staffing levels or near miss harm incidents, as they was simply insufficient feedback or change from senior managers to motivate them to submit the reports.

Some staff told us they had escalated concerns in relation to specific staff conduct issues or fears of possible patient safety risks and felt as if they were being ignored by senior managers.

In order to gain a wider view of staff morale we developed and collated a staff survey as part of this inspection, to enable all current staff to feedback regarding their experience of working within the trust. We received a total of 2,360 respondents trust wide with 164 respondents from the surgical speciality. 44% of staff working at the RVI and 33%

working at the Freeman hospital. We saw 66% of respondents were clinical staff and 71% of staff had worked in their roles for at least 3 years. Findings showed that 40% of respondents disagreed that communication between senior management and staff was effective. Over half of respondents (74) disagreed that senior managers act on feedback and 61 respondents disagreed that they felt safe to report concern without fear of what will happen. However, we saw 97 respondents felt comfortable raising bullying and harassment or discrimination concerns and 110 respondents agreed that they felt confident raising patient safety concerns or other concerns within the organisation. However, 37 respondents had experienced harassment, bullying or abuse from colleague at work with 7 of them stating it had happened more than 10 times. We also reviewed survey results received in regard to managers and saw 28 had experienced this behaviour.

Analysis of the free-text comments we received, revealed a workforce who felt disconnected from leaders who did not understand, acknowledge, or address issues that staff 'on the ground' faced. Comments spoke to a culture of favoritism and bullying, where problematic behaviour went unchallenged, and concerns went unheard. Staff did not always speak-up because they felt "nothing changes", or from fear of repercussions. Staff spoke of the huge pressure they faced and the negative impacts it had on them, and on patients who they felt were at increased risk of harm as a result.

Leadership was an important theme for respondents who often described a culture of top-down communication, of feeling unheard, and of disconnection at the Trust. Respondents felt information was cascaded down from management, rather than in dialogue with them. They did not feel there were many opportunities for feedback.

Staff told us many senior leaders and managers were not visible to them on a daily basis, further reducing feedback opportunities. For many respondents, issues around communication and visibility compounded feelings of disconnection between management and clinical staff especially.

Some staff referred to the recent restructure and some felt this had been positive, while others felt it had exacerbated existing issues and felt frustrated at the lack of consultation.

Governance

Governance processes were not fully embedded at the time of inspection, due to the newly created health board structures. Staff were not always clear about their roles and accountabilities due to the ongoing operational changes.

Senior leaders outlined the key objectives for the clinical governance framework. They told us these fell into four domains which were patient safety, clinical effectiveness, patient experience and quality improvement. These domains were newly created as part of the health board modelling across the trust.

The structure was then broken down at local level (wards and medics) and the clinical care group (departmental level) to show what each area was required to have in place to meet the governance objectives.

We saw at ward level each area should have patient safety, clinical effectiveness ad patient experience processes. Shared learning and quality improvement including risk management processes sat within the department areas. Senior managers told us that some of these meetings were yet to be carried out due to the newly created structures.

Local staff had developed individual methods of cascading information in the interim. These methods varied between wards and included bulletins for staff, staff meetings or sharing of information through handovers. Matrons and sisters told us that there were regular meetings to review performance, incidents, risk assessment compliance and shared learning. Ward sisters and matrons told us that these was not always recorded, however.

Surgery

Clinical boards held responsibility for the assurance dashboards and trends including complaints, serious incidents and general incident review, risk registers, new procedures and interventions and escalation of barriers and concerns.

The trust told us that information from the board was then cascaded through the clinical board quality assurance meetings at clinical board level to departmental level in consultant meetings, junior doctor's meetings, sister's meetings and admin meeting. Transplantation within the organisation sits across 3 Clinical Boards: Cardiothoracic, Urology, General surgery and Theatres. The Institute of Transplantation (IOT) has a cross board governance and business meeting with all key stakeholders and clinical leads. The meeting brings together governance across the IOT and ensures transplantation is championed within the Clinical Board structure. Information would then be passed down to local level meetings for each for each of the defined objectives. Again, we saw some of these meetings had not yet been carried out as appointments were made at senior leadership levels. In the interim we were not assured of any consistent methods or approaches for feeding key information up and down through the service. We did not see a clear process for sharing key themes regarding risks, performance and learning whilst processes were being embedded.

The ambitions for the trust were to ensure that all areas have similar directorate governance structures in place in regard to planned clinical governance meetings. All areas to identify good practice in addition to areas for improvement and to provide an opportunity for standardisation and shared learning across the boards.

The trust also held model hospital reviews and we saw analysis across breast and general surgery.

The trust acknowledged that these plans were in their infancy and plans were being commenced at the time of inspection.

Management of risk, issues and performance

Leaders and teams used some systems to manage performance. However, they did not always identify and escalate relevant risks or issues which identified actions to reduce their impact and there remained an ongoing risk to patients.

Senior leaders within the health group told us that elective recovery was their biggest challenge and we saw plans to address this within the surgical health board strategy. The current focus was to efficiently manage the delivering of services whilst reducing long waits and backlogs. Managers told us this involved all staff working collaboratively together to meet the complex needs of patients and working proactively with other regions to reduce specific pressures across the trust.

We reviewed the surgical services risk register and saw there were 13 risks identified, 11 of which were ongoing risks at the time of inspection. Each risk had been given a risk score depending on the level of risk. Risks ranged from a lack of a designated IF unit, delays in the development of the new surveillance pathways in BCS, surgical on call intensity at the RVI and backlog of DOSA benign cases in HPB.

However, it was not clear what actions were undertaken when the register was reviewed as there were no dates shown against each action or point of review. It was also not detailed as to whom was accountable to progress each action. Therefore, we saw some actions had been ongoing for prolonged periods of time, for example the failure to recall endoscopy patients within the required timescales. This risk which was initially rated high at 20 was identified in 2021 and was again due to reviewed in August 2023. Digital shortcomings resulting in a lack of care planning and governance oversight was not included. F1 and junior doctor workload pressures and the never events were also not included as risks.

We also saw risks identified on the surgical risk register were not included as part of the corporate risk register. For example, we saw within the surgical risk register that cardiothoracic concerns and historic system issues affecting colorectal patients who were lost to follow up were not included as risks.

The cardiothoracic concerns related to a historic cluster of incidents resulting in potential patient harm. Concerns within cardiothoracic were known prior to the inspection and were further highlighted during the inspection. Due to these ongoing concerns within this department, we carried out a further focused visit and completed a separate report. Please refer to this report for further information.

We also saw risks noted within the corporate risk register were not then transferred into the surgical risk register. The provider told us risk registers were reviewed every month with risk escalated through to board level. We reviewed the integrated board report for May 2023; however, we were not assured that risk was prioritised as the minutes were not sufficiently detailed to ensure robust discussions were held in regard to clinical risk. We requested clinical governance meeting minutes from the provider, but they were not provided. Therefore, we were not assured that all aspects of clinical governance were routinely discussed to include audits, mortality and morbidly learning, serious incident learning, incident and duration and medication concerns. Leaders told us new board structures and corresponding meetings were still to be established and embedded.

However, we reviewed the endoscopy user group meeting minutes dated March 2023 and saw aspects of clinical governance were discussed.

We spoke with senior managers regarding concerns we saw during the inspection in regard to the management of medicines. Managers were not aware of the current practice undertaken by some staff, as recent internal audits undertaken had not identified these issues. We spoke with pharmacy staff in regard to the recent audit findings within theatres, however they were unsure when audits were last completed in regard to medication.

Leaders were also disappointed to learn that we had found concerns when reviewing the surgical safety checklists. We saw within the safe September performance report that the frequency of WHO audits had been doubled but results were not available at the time of inspection. We asked senior managers about the learning following the recent numbers of never events within the health group and were told that there had been three never events to date, but the majority of them had not caused patient harm. Managers told us all incidents are discussed at team meetings and lessons learnt discussed to prevent happening again, however information across the wards we visited were out of date.

The trust told us that each month each clinical board and ward receive a ‘harm free care Dashboard’ which provides an overview of the month and years patient falls, their severity and injury, pressure ulcers their category and location, HCAIs, outbreaks, clinical assurance checks, deterioration compliance and the Take 5 antibiotic audit. Information was compared month on month over 24 months trends and variances visualised. Matrons and Ward Leaders are asked to share this with their teams and information is shared on the wards public facing ‘How we are Doing’ board. However again we saw historic information displayed.

The service did not always perform routine comprehensive clinical audits to monitor the quality of care being implemented or the effectiveness of care being delivered, for continuous improvement. This meant the service could not identify risks and improve outcomes for service users. We saw gaps in audits undertaken which were not flagged or actioned for further improvement.

Ward matrons told us there was no oversight of care implementation plans in accordance with best practice or national guidance. The absence of care plans for patients was not seen as a risk by the trust.

Surgery

CQC received information of concern from a whistleblower in relation to a backlog of 'must sign' letters following clinic appointments, patient treatments and operations and inpatient stays. We wrote to the trust on 05 September 2023, using our section 64 powers to request specified information and documentation on this, and we wanted to confirm if this was an issue and the scale of the concern. We were also concerned that this had the potential to lead to delays in patient's receiving appropriate care that would meet their clinical needs, if relevant healthcare practitioners or the patient were not aware of any changes to their condition or treatment.

In their response the trust confirmed this was a known issue in the cardiothoracic department and they had been working to address this since March 2023. Please refer to the cardiothoracic report for further details.

Again, we found no evidence of this risk on the risk register. Following our focussed inspection in September 2023, we spoke with the cardiothoracic management team and asked specifically why this wasn't on the risk register. The management team described it should have been on the risk register but may not be now as it may have been downgraded.

We were therefore unclear of the mechanisms or governance routes used to escalate these risks to the executive oversight register. We were not assured these risks were managed as close to frontline services as possible or there was sufficient managerial oversight either locally or at executive level to ensure sufficient actions and management of these risks.

The trust acknowledge that cancer performance targets were not where they wanted them to be but told us screening backlogs were possibly impacting on recent referral numbers.

Managers also acknowledged challenges within the lower gastric intestine performance figures and outlined difficulties due to the number of specialities the pathways cross.

The speciality had recently developed a new complaints process that had been ratified at both a management meeting and with the patient experience team.

The trust had recently implemented some additional oversight, in practice the trust has a real time deteriorating patient list. The Deterioration List is visible to all Clinical/Medical staff, Trust Deterioration Nurse Specialist and Critical Care Outreach Teams. The Deterioration Nurse Specialists use this to monitor surveillance daily alongside the critical care outreach teams who monitor this throughout their shifts, to review and respond to patient deterioration across wards, providing support to staff out with the critical care environment. This allows the Trust to proactively track, prevent and manage deterioration augmenting the ward escalation process.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure. Data or notifications were not always submitted to external organisations as required.

We found some of the trust's systems and processes for recording inconsistent, for example the lack of electronic recording systems in theatres. Consequently, ward staff spent time transferring paper-based information into the electronic recording systems which posed a risk of lost information during the transfer process. We saw staff confidence using the electronic systems varied from ward to ward. All staff we asked to guide us through the electronic systems told us there were sections of the systems they had not accessed before. We saw the training provided to staff in order to use

the digital platforms was only four hours. This is a tailored training programme at induction, with the duration determined by the complexity of the systems to be used and feedback from staff. For some staff this is 4 hours in duration. For the vast majority of nursing staff, this is 7.5 hours, and for some administrative staff, this is shorter. The training at induction is supplemented by on-line how-to guides and further courses are available by request via IT training.

Staff told us that some of the data within the electronic recording system was not accurate. This included the calculations in which to determine MUST scoring. We also saw inaccuracies within the electronic whiteboard system in relation to potential isolation of patients. records. We saw internet dropouts on some of the wards we visited and delays in reaching IT support when needed.

We found some electronic systems where not being used to their full potential. For example, no electronic referrals were evident to specialist staff such as palliative or pain teams. However, both the palliative care and pain team electronic referrals are available within the system.

We also saw care plans suggested by the platform were not created by staff and there was no flag to highlight that these essential care plans were missing. Staff spoke of their frustrations trying to navigate the system and felt much more could be done to improve it.

We saw the trust had recently introduced an electronic safety dashboard which enables senior ward staff to see which safety assessments had not been completed. However, at the time of the inspection this dashboard did not include VTE monitoring. We were told at a meeting with the Digital Health Team, plans were already underway to enhance the dashboard and expand the metrics included. We also saw that incidents which should have been reported through the National Reporting and Leaning data base were not reported in a timely manner. This had been raised to the trust prior to the inspection and was ongoing at the time of report.

Engagement

Leaders and staff engaged with some patients, staff, equality groups, the public and local organisations to plan and manage services.

We saw the last staff survey had been completed in October to December 2021, with results published in 2022. For this survey the response rate for the trust was 48.5%, slightly above national median scores. The trust performed in line with the benchmark group median for most sections of the survey. ‘We work flexibly’ and ‘We are a team’ were below the median scores nationally.

Staff responded less positively to questions around working flexibly and being able to achieve work/life balance. Also, less positive around questions related to line management and dealing with disagreements in teams effectively.

Staff responded more positively than comparators about teams working well together to achieve objectives and understanding each other’s roles.

We requested staff survey data specific to the surgical health board, but we received only summary headlines in relation to the findings. The trust also submitted an action plan to support this summary, but it was brief and did not include all key areas of concern raised in the survey findings. For example, investigating staff feeling short staffed and how staff are supported with personal development.

The trust also submitted details of a number of engagement sessions for staff to attend across the board including clinical board workshops, sisters' updates and general question and answer drop-in sessions.

We saw an endoscopy specific staff survey was completed in December 2022. Responses were generally positive in regard to working conditions, morale and culture. However, we saw only a 30% return rate.

Within our CQC staff survey, results showed 83% of surgical speciality staff felt that communication between staff and managers was not effective. We also reviewed survey findings in regard to staff receiving effective support and feeling valued to do their jobs. We saw 79 respondents felt they did not feel supported or valued.

Senior medical staff told us they acknowledged the challenges with morale in some areas due to staffing pressures. Recent recruitment campaigns had gone some way in addressing some of the staff concerns.

We saw colorectal nurse specialists had developed a new bowel cancer support group for patients across the region. These commenced in May 2023 and offered patients an opportunity to learn about some of the advances in colorectal cancer.

We also saw open days held by stoma care nurses offering advice regarding appliances and general care for both patients and staff.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The speciality submitted examples of continuous improvement including the complex POLYP MDM, Health – Call which was a non-electronic system to improve patient pre assessment in endoscopy, and 'Green' endoscopy working group to reduce carbon footprint.

In 2022 the enhanced recovery team won the HSJ performance recovery award. The trust formed an innovative collaborative partnership with a third partner provider, to develop the colorectal enhanced recovery program which resulted in reduction to cancer care backlogs and the trusts length of stay performance to pre-pandemic baseline.

The service had created bespoke tools for to increase patients' ability to monitor their health from home. The international normalised ratio (INR) home monitoring programme was an electronic database which monitored results of patients managing blood thinning medications at home to reduce repeat visits and hospitalisation, staff were available to obtain advice 7 days a week.

The trust had pioneered and introduced robotic assisted major lung resections (small incisions in the chest to perform surgery) which had resulted in reduced pain scores, faster recovery time, early discharge, and reports of improved quality of physical, social and mental wellbeing for the patients.

Three new robots have recently been introduced at the hospital which are intended to greatly improve capacity. These robots were waiting for sign off at the time of inspection.

The trust were looking to work with a local regional trust to develop a collaborative on call for obstetrics and gynaecological services.

Services for children and young people

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

The service provided mandatory training in key skills to all staff. Staff had not completed all mandatory training in line with the trust's compliance target.

Nursing staff did not always receive and keep up to date with their mandatory training. Mandatory training completed was 75.5% for nursing staff which did not meet the 95% trust target compliance.

Medical staff did not always receive and keep up to date with their mandatory training. Mandatory training completed was 85.4% for medical roles which did not meet the 95% trust target compliance.

The mandatory training met the needs of children, young people, and staff. Mandatory topics included fire safety, health and safety, equality and diversity, infection prevention and control, information governance, moving and handling, safeguarding and basic life support.

Matrons worked with line managers and HR managers to identify training areas of low compliance of nursing staff completing training. The director of operations and clinical directors for their clinical boards identified areas where medical staff compliance levels require improvement. Some mandated training was also covered in specialty mandatory study days at intervals across the year. Mandatory training was also discussed in one to ones with staff, and as part of the appraisal process.

Staff we spoke with told us they were not always given protected time to complete training.

Staff did not always complete training on recognising and responding to children and young people with learning disabilities and autism which became mandatory from 1 July 2022 under the Health and Social Care Act 2022. Staff told us they had not received training specifically in learning disability or autism awareness, but that there was a e-learning disability and mental health awareness course.

The trust told us they had introduced Learning Disabilities Diamond Standards mandatory training for all clinical and patient facing staff in March 2023 and had introduced autism awareness education sessions in April 2023, however Autism awareness was still not part of the mandatory training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff had not completed all safeguarding training in line with the trust's compliance target.

Services for children and young people

Staff received training specific for their role on how to recognise and report abuse. Nursing staff we spoke with told us they had received training and completed levels 2 and 3. Medical staff received training specific for their role on how to recognise and report abuse. Clinical staff that we spoke with told us that they all had completed Level 3 safeguarding children.

Paediatric staff were 78.7%% compliant with level 2 safeguarding training and 62.6% compliant with level 3 safeguarding training which was below the trusts target of 95%.

Matrons, managers, or head of service leads, met with both line managers and HR managers to highlight areas where compliance was lower with a focus on improvement. The safeguarding and clinical educator team identified solutions to barriers to compliance such as providing dedicated training sessions, or additional pay for staff to access on-line training in their own time.

Staff were aware of female genital mutilation (FGM) and Child sexual exploitation and told us these subjects were covered in their safeguarding training.

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. Learning from specific cases of safeguarding was discussed and disseminated throughout the departments.

There was a designated safeguarding team. Staff told us they could escalate concerns to them and seek advice from them if they had any concerns. The safeguarding team consisted of a named nurse, doctor and nurse advisors who were available Monday to Friday. Out of hours support were provided by the social care team. Each ward that we visited had a named link nurse for safeguarding who provided training and support to each of the teams. Staff we spoke with knew the name of safeguarding children leads on their wards.

We observed medical and nursing staff routinely discuss safeguarding concerns or children who were subject to a child protection plan at daily team safety briefing meetings and multi-disciplinary meetings (MDT) on each of the wards we visited.

Staff knew how to escalate safeguarding concerns and told us the procedure they would follow to make a safeguarding referral. Staff gave an example when they had suspected abuse and how they had referred to and worked with external agencies to keep the child safe.

Staff showed us a pocket-sized guide to safeguarding information card which had the details of each staff and team to be contacted in the event of a safeguarding incident or concern including out of hours and community.

Patient electronic records showed that appropriate safeguarding concerns were identified, recorded and referrals documented.

Staff had clear guidance to follow in the event of child abduction.

Access to all the wards and units we visited was restricted and only accessible by authorised swipe card. Staff checked and challenged people entering the wards.

Staff told us that if children were under child protection plans, they were made aware of any family members that were permitted on the ward. This was reviewed regularly, and the staff liaised with the local authority. We saw evidence that this was discussed and documented at MDT meetings.

Services for children and young people

Cleanliness, infection control and hygiene

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

Wards visited were visibly clean, tidy, and free from dust. There were suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

The service performed well for cleanliness with 97%-100% compliance rates for hand hygiene and personal protective equipment (PPE) between April and June 2023. At the entrance to the wards hand sanitisers were available and hand washing facilities with hand hygiene posters provided guidance to hand washing.

We observed staff following infection control principles including the use of PPE and take regular hand washing opportunities.

Staff told us side rooms and ward areas were cohorted to keep children with immune-compromised and infectious conditions separate. We saw patients who required isolation nursed in side rooms with the doors closed, additional PPE outside and appropriate signage in place.

Environment and equipment

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

We received whistleblowing in regard to equipment failures. Information reviewed during the inspection showed that staff did not always carry out safety checks of specialist equipment. We observed that across the wards/units that electrical equipment portable appliance testing (PAT) dates were overdue. We requested the service's register for the servicing of equipment. This showed 77 items of equipment that required servicing between 1 and 2 years ago. We did not observe any examples of equipment failing whilst on inspection.

We observed staff checking the equipment on the resuscitation trolley and records were completed. Tamper proof tags were used correctly in line with local policy.

We saw that wards and units were brightly decorated and some of the areas were personalised to the child.

The Children's heart unit had an indoor and outdoor play area for the children.

Each ward that we visited had notice boards visible to patients and families. They included information about staff teams, staff uniforms, 'thank you' cards, staffing levels (planned versus actual), and how are they were doing specific to each area. This was presented in easy to understand and read format.

PICU cubicles were able to be air pressurised for certain procedures such as Extracorporeal Membrane Oxygenation (ECMO), a technique of providing prolonged cardiac and respiratory support, and emergency stabilisation.

Children, young people, and their families could reach call bells and staff responded quickly when called.

The service did not always have suitable facilities to meet the needs of children and young people's families. On Ward 23, the Children's Heart unit, we saw lots of equipment, such as specialist chairs and beds, being stored at the sides of

the corridors, and domestic staff arranging this to ensure it caused minimal obstruction to corridors. Staff told us the remit of the Ward had outgrown the size of the space they had but they did their best with the space they had. However, there were accessible toilets for people and nappy changing facilities for parents with children within the department.

The service had enough suitable equipment to help them to safely care for children and young people. We checked a range of consumables items including syringes and dressings. All were within their expiry date. All sharp boxes that we looked at were signed, dated, and stored appropriately.

Staff disposed of clinical waste safely. We saw different coloured waste bins and sharp boxes for different types of waste such as general waste, clinical waste swabs and dressings. However, we did see clinical waste was often stored in areas that were left unlocked.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff did not always identify and quickly act upon children and young people at risk of deterioration.

Staff used a recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service currently used a paediatric early warning score (PEWS) to assess, detect and respond to any child deterioration.

The trust had a sepsis policy in place that was in date and in line with best practice guidelines. Staff were trained in sepsis awareness. The trust provided training materials in a variety of ways to increase staff awareness of sepsis including bespoke training and recognition days, video links and paediatric sepsis podcasts from The Royal College of Paediatrics and Child Health. There was a specific inpatient paediatric sepsis/deterioration screening and action tool to be used when staff were treating children with a suspected infection or abnormal observations without a clear cause, this included risk factors, red flags, timeliness of clinical review and treatment in line with paediatric sepsis 6.

However, we saw an incident that occurred during an inpatient stay for sepsis. Staff had taken patient observations triggering two amber PEWS scores 2 hours apart with no further review until the next morning resulting in the patient's deterioration. PEWS scores should be recorded every 4 hours as a minimum in line with trust policy. We requested PEWS audits for wards visited but the trust did not provide these.

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were completed for every child young person on admission and were reviewed regularly.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep children and young people safe.

Staff completed safety briefings for each ward, these included key safety information such as infection control, intentional rounding, assessments, safeguarding, DNACPR status, medication, staffing, incidents and complaints and patient flow.

Staff completed World Health Organisation (WHO) surgical safety checklist a checklist to prompt professionals to check aspects of surgical safety, in paper format prior to a patient's surgical procedure.

Services for children and young people

Nurse staffing

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

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

Leaders supported ward manager decisions to adjust and/or reduce the number of available beds according to the needs of children and young people and availability of staff. The risk register identified nurse staffing shortfalls on Ward 26 (PICU), this was reviewed regularly and had control measure in place to reduce the likelihood of risk including the closure of beds if required.

The number of nurses and healthcare assistants (HCA's) matched the planned numbers.

The service had 11.4% turnover rate in June 2023 which had reduced from 9.5% in July 2023.

Staff used red flags on the electronic reporting system as an alert to show staffing pressures. Staff told us senior managers tried to provide additional staff when experiencing these pressures. Ward staff told us that they did not always report unsafe staffing figures, due to ward pressures and time limitation. We reviewed the trusts incidents and saw that datix submissions related to staffing incidents, averaged 0.5 per month in paediatrics.

The use of bank and agency staff was limited and when required staff familiar with the service were requested.

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

Medical staffing

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

The service had enough medical staff to keep children and young people safe.

We requested the planned and actual medical staffing figures for wards visited, these were provided for departments as a whole as opposed to by ward.

The service had 18.2% turnover rate in July 2023 which had decreased from 29.5% in August 2022.

The service had 0.75% FTE medical staff absence rates between July 2022 and June 2023.

The service had reducing vacancy rates for medical staff.

The service had high rates of bank and locum staff use.

Managers could access locums when they needed additional medical staff.

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

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

Medical staff told us they did not have concerns with staffing, were able to support junior doctors and felt there was a positive culture within the medical staff team.

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

The risk register identified anaesthetist cover for the congenital paediatric service was a risk. This had been recently reviewed and the risk lowered. There were actions in place to reduce the potential impact of low staffing numbers including locum cover and adult support.

Records

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

Staff recorded patient information. We reviewed 4 sets of records which all accurately captured patient information.

Staff could not always access all the information required about patients easily. Staff told us that moving and handling assessments were available through the adult records system, but not all paediatric staff had access to this. Moving and handling risk assessments were available to all clinical staff through the electronic patient record system. A training need had been identified as some paediatric teams were not aware of this.

Staff did not complete plans of care for all patients as the records system didn't generate these. Staff completed risk assessments for patients which would then determine whether a care plan needed to be developed but would not automatically generate this.

For two records we saw, skin integrity risk assessments had been completed it was difficult to identify from patient records where the skin damage had occurred of if there were multiple areas of skin damage as personalised plans of care had not been generated. However, staff were aware of children with skin damage, completed regular risk assessment and had made appropriate referrals where necessary.

Staff were working around the gap in records by making their own notes in patient records, adding information to the handover, and reverting to paper records where possible. This meant there was a risk that information could be lost.

When children and young people transferred to a new team, staff provided a full handover and there were no delays in staff accessing their records.

Records were stored securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Services for children and young people

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their carers about their medicines.

Medicines were stored securely in appropriate facilities. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked in line with the providers policy. Controlled drugs were kept in separate locked cupboards and appropriate checks recorded. We saw records for electronic fridge temperatures, and all were within acceptable limits. All medicines we checked were within their expiry date. Oxygen cylinders were stored and secured appropriately and within expiry date.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

The service followed a 'reducing restrictive interventions' policy for adults and children and young people which was in date and developed in line with NICE guidance. This ensured children's behaviour was not controlled by excessive and inappropriate use of medicines, advice was sought from the psychiatric liaison service and safeguarding team and that consideration was given to capacity and safeguarding issues.

On Ward 23 staff had created an emergency drug calculator and grab bag. The emergency drug calculator was created for children using their weight to determine what dose of different emergency medications would be required and minimised the potential for human error during difficult scenarios. Staff had then created a grab bag of these emergency medications so that they were easily accessible in a time critical situation. The bag was stored in the medication room and included in the medication checks.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. However, although managers investigated incidents, they did not always share lessons learned with the whole team and the wider service. When things went wrong, patients did not always receive an apology.

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

Ward sisters told us they were asked to present complex cases and learning at meetings, rotationally to share learning across wards.

There was a specific incident investigation team known as CGARD who investigated serious incidents and never events.

There was evidence that incidents were investigated, learning recognised and shared across the trust to make improvements. In incidents of pressure damage, learning and recommendations were identified. We saw no repeated theme of how pressure ulcers were acquired.

Staff did not always receive feedback from investigation of incidents. Staff told us that they did not always receive outcomes and learning to incidents in a timely way and gave an example when they had met with a family to discuss an incident and were unaware that the outcome had been shared with the family.

Data provided showed that DOC was not always provided in full for all incidents graded moderate or severe in line with their statutory duty. Staff we spoke to understood DoC and demonstrated an open and transparent approach.

Services for children and young people

Is the service effective?

Good ↓

Our rating of effective went down. We rated it as good.

Evidence-based care and treatment

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

Staff had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were evidence based on national guidance including National Institute for Health and Care Excellence (NICE) guidance, Royal College of Nursing (RCN) and other professional guidelines such as National Burn Care Standards, Paediatric Intensive Care Society and the British Association of Perinatal Medicine.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We saw in records that the was appropriately completed.

Staff referred children and young people to Child and Adolescent Mental Health (CAMHS) when deemed appropriate. We saw evidence in records of the appropriate timely referrals.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We observed handover meeting and staff discussed all aspects of the wellbeing of children and young people and their families.

Nutrition and hydration

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

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed.

Staff documented specific dietary requirements clearly such as allergies and cultural diets. The service developed bespoke menus to meet their needs and kosher and halal food was prepared as appropriate.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Wards used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. It is a simple five-step tool to identify if a child's condition has any nutritional implications, what the child's nutritional intake is plus their weight and height.

Based on the results from the first three steps, the overall risk of malnutrition is calculated, and a care plan developed as appropriate.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it. A team of dietitians and speech and language therapy (SALT) worked with patients and their families across the wards.

The community eating team visited children to carry out debriefs with children and young people with eating disorders following their discharge.

Pain relief

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

Staff assessed children and young people's pain using the Face, Legs, Activity, Cry, Consolability (FLACC) scale, a recognised tool, and gave pain relief in line with individual needs and best practice.

Children and young people received pain relief soon after requesting it.

Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

We requested the most recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) audits relating to Children and young people. The last audit was published in June 2023. The trust did not provide this data.

Managers and staff used the results to improve children and young people's outcomes. On Ward 23, staff had developed policies in collaboration with medical staff and in line with best practice guidance, to reflect and support practices in their speciality. These included a chest drain policy, anti-coagulation policy and high-risk feeding policy for new-borns with single ventricle. Staff recognised children with single ventricle were developing Necrotizing Enterocolitis associated with Congenital Heart conditions (NEC), since implementing the new policy the ward had had a significant reduction in the number of children that developed NEC.

Managers and staff carried out a programme of repeated audits to check improvement over time. These included the Clinical Assurance Toolkit (CAT), a suite of audits to oversee core standards on wards, and The Newcastle Reporting Hub, which used the electronic record system to monitor staff compliance with assessment tools and gave staff an oversight of how their ward were performing comparatively to other wards.

Services for children and young people

Managers did not consistently use information from audits to improve care and treatment. Processes were not embedded to share audit findings to staff despite this being provided regularly to ward managers, sisters, and matrons. Staff we spoke to had varying knowledge of audit findings.Improvement was not always monitored and checked. Findings from the CAT tool showed repeated partial compliance or deterioration in scores to non-compliant between April and June.

Competent staff

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

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

There were a number of newly qualified nursing staff in post who were developing their skills and knowledge, with support from the Trust. However, this meant at times there was not always enough staff with experience, to meet the needs of children, young people, and their families.

Managers gave all new staff a full induction tailored to their role before they started work. The Trust offered comprehensive preceptorship programmes providing support and guidance to newly registered practitioners.

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

Staff had the opportunity to discuss training needs and development opportunities with their line manager and were supported with their skills and knowledge. The Trainee Nurse Associate role had been introduced, a programme to upskill Band 2 and 3 Healthcare Assistant (HCA) staff through a 2-year programme of learning and placements to be able to progress to a Band 4 Nursing Associate position. Staff told us this had made it financially viable for them to invest in their education and development.

Managers made sure staff received any specialist training for their role. The clinical education team were made up of nurses from different specialities and were responsible for supporting students and newly qualified staff and ensuring staff stayed up to date with their competencies and best practice. All ward staff we spoke with spoke highly of the clinical education team and managers felt able to contact the team if they identified a training need for their staff group. Clinicians trained in ECMO had to renew their status yearly. There was a ECMO specialist nurse and consultant staff that supported staff training in ECMO.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers worked with clinical educators to identify staff training requirements and put on additional training days for competencies, they currently had a group of staff that had not been trained in withdrawal of care and were organising the training day for this.

Managers identified poor staff performance promptly and supported staff to improve with different teaching methods, reflections, and action plans. Staff underwent a full probation to demonstrate their competencies.

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

Multidisciplinary working

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

Services for children and young people

We observed daily multidisciplinary meetings across the wards/units. Staff discussed each of the children or young person to plan, monitor and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for children, young people, and their families. We observed a multidisciplinary team approach which included consultants, nurses, nursery nurses, play therapists, physiotherapists, occupational therapists, and teachers delivered the care and treatment provision to each child and young person.

Staff that we spoke with give us examples of co-ordinated planning and delivery of care, and communication between teams was excellent, focusing on the needs of the child and their family. For example, when the MDT made the decision, in collaboration with the family, to withdraw care from a very poorly child, the team supported the family through the process and explained the stages for palliative care. One of the outcomes included the donation of the child's organs to help other sick children.

Staff appropriately referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Children and young people are reviewed by consultants depending on the care pathway. The Children's Heart Unit operated seven days a week 365 days a year. Staff told us that they had to be flexible and be able to assemble day or night due to availability of organs becoming available.

Staff could call for support from doctors and other disciplines diagnostic tests and pathology 24 hours a day, seven days a week. Consultants were available out of hours and supported the junior doctor rota in the paediatric intensive care unit, covering night shift when necessary.

Nursery nurses and play specialists were available seven days a week.

Physiotherapy and occupational therapy services were offered to children on specialist wards seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Each ward/unit had an array of information to promote healthy eating, infection control and sexual health.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw that when a child or young person was admitted a full assessment was completed on admission and if needed referrals to dietitians or speech or language therapy were requested.

The service displayed QR codes to health promotion materials such as local running routes, emotional well-being resources, psychology information and mindfulness exercises.

Services for children and young people

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. The trust had a mental capacity policy with a section specifically referenced to children and young people. We reviewed 10 records all had the appropriate mental health risk assessments to assess if a child or young person had capacity to make decisions about their care.

We saw evidence that when children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture, and traditions. This was appropriately recorded.

Relatives and loved ones of children and young people told us they consented to treatment based on all the information available and felt fully informed. Staff clearly recorded consent in the children and young people's records. Parents that we spoke to told us that they had been given a copy of the consent.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff we spoke with understood the Gillick competencies and Fraser guidelines and gave examples of how they would be applied in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care. Gillick competency helps staff assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Staff that we spoke with knew and understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Clinical staff did not always complete training on the Mental Capacity Act, medical staff were 75.8% compliant with training and nursing staff were 89. 2% achieve the trust’s target of 95%.

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

Is the service caring?

Outstanding ☆ ➔➔

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

Compassionate care

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

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way.

Services for children and young people

Children, young people, and their families said staff treated them well and with kindness.

Staff followed policy to keep care and treatment confidential.

Results from the NHS Children and Young People's Patient Experience Survey showed the trust scored better than other trusts when asked if the staff looking after them were friendly.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. The service had a chaplaincy team that provided pastoral, spiritual, and religious belief support which were available 24 hours for patients, relatives, and staff.

Emotional support

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

Staff gave children, young people and their families help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The trust provided a specialist service known as the CHIPS team who supported staff, children and families physical, emotional, social and spiritual elements of their wellbeing of and ensured care, support and choices continued at the end of life.

Staff on Ward 23 worked with the local hospices and PICU to ensure children and young people with life limiting conditions were given a preferred place of death. We saw an example where the intensivist, a board-certified physician who provides special care for critically ill patients, had withdrawn care in a private outside area in line with the child and families wishes.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on them, and their families, wellbeing. Ward 23 signposted to and worked with relevant charities to provide emotional, financial, physical and wellbeing support to families of children with heart conditions.

Ward 23 ensured children and young people and their families to take a holistic approach to taking care of their well-being and shared top tips to remind them to do things such as, "know it's ok to ask for help," and "take 10 minutes out for yourself to unwind."

Staff supported loved ones of children and young people in how to have difficult conversations by using techniques such as drawing and repetition over time.

The service had compiled stories from other patients that used Ward 23 to provide children and their families with hope that their challenges could be overcome.

Staff ran a sibling support group each week to support the well-being of siblings and relieve pressure on parents. The group gave chances to chat, served food and hosted activities.

The service delivered a roster of therapeutic activities for children and young people to support their well-being such as therapy pets, physiotherapy groups, music therapy and the Clown Doctors. The Clown Doctors delivered therapeutic play to children on Ward 23 to minimise distress and anxiety.

Services for children and young people

Understanding and involvement of patients and those close to them

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

Staff made sure children, young people and their families understood their care and treatment.

The service had created and displayed posters to help parents understand their children's care and observations such as PEWS scores. Posters gave information in accessible formats to help parents understand information such as why, when and how observations of their child would be taken.

Relatives and loved ones told us they were fully informed in their child's care; they were kept informed and up to date on what was happening.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary.

Children, young people, and their families could give feedback on the service and their treatment and staff supported them to do this. The service displayed friends and family posters and we saw feedback boxes on all areas we visited.

Staff actively sought feedback from children, young people and their families when planning to make improvements to the service.

In Ward 23, staff had sought feedback regarding the play area and how this could be improved for the needs of patients using the ward and as a result the outdoor area had been expanded.

Staff supported children, young people and their families to make advanced decisions about their care. The CHIPS team provided expert palliative support for babies, children and young people with life-threatening conditions and their families.

Staff on Ward 23 told us how they worked closely with the CHIPS to provide comfortable palliative care and supported families with difficult decisions such as choosing a preferred place of death.

Relatives and loved ones told us that staff supported them to make informed decisions about their child's care.

Results from the NHS Children and Young People's Patient Experience Survey 2020 showed the trust scored much better than other trusts when children 8-15 and parents were asked if they were involved in decisions made about their care and treatment.

Is the service responsive?

Outstanding ☆ →←

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

Services for children and young people

Service delivery to meet the needs of local people.

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

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

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

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support for children and young people with mental health problems and learning disabilities. We saw examples of referrals made and advice sought when required.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

Managers monitored and took action to minimise missed appointments. Managers ensured that children, young people and their families who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat children and young people in a day.

The service had created bespoke tools for to increase patients' ability to monitor their health from home. The international normalised ratio (INR) home monitoring programme was an electronic database which monitored results of patients managing blood thinning medications at home to reduce repeat visits and hospitalisation, staff were available to obtain advice 7 days a week.

Liaison nurses had created the Congenital Heart Assessment Tool (CHAT2) in collaboration with medical staff, for children and young people that left the ward. Staff trained parents in recognising signs of change or deterioration in their child and being able to rate this red, amber or green using the tool. CHAT2 gave clear pathways of action and escalation.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people, and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. On Ward 23 staff became familiar with children with long term cardiology conditions and on the ward for extended periods of time, such as those with a Berlin Heart ventricular assist device (VAD). Staff worked with families and children to learn their physical and holistic needs to provide individualised care.

Wards were designed to meet the needs of children, young people and their families. Wards had cleanable sensory rooms and interactive play areas that were suitable for different ages and ability of children and young people.

Services for children and young people

Staff used transition plans to support young people moving on to adult services. There was a transitional policy for children that were moving into adult services and staff we spoke with were knowledgeable about this.

Staff supported children and young people living with complex health care needs by using 'This is me' documents and passports.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. The service had information leaflets available in languages spoken by the children, young people, their families, and local community. Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. The service was fitted with a hearing loop and had pictorial signage throughout.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

The service worked with charities to make the hospital accessible to families and loved ones of children and young people. Scott House supported families of ill children being treated at the Freeman Hospital by giving them a communal 'home from home' close to the hospital.

The service had a transport service to support families and loved ones in being as close to their child as possible. The NECTAR service, a standalone commissioned service that provided intensive care for children from the point of referral to the handover of care at the receiving unit. NECTAR also transported children home for palliative care.

The service had purchased a Transmedic Organ Care System (OCS) for preservation of donor hearts which was beneficial in donor retrievals from longer distances and redo or complex operations. The Trust had received fundings for a further 5 systems.

The service had amenities such as a cash machine, post box, shops and cafes to make it easier for people spending long periods of time in the hospital.

The service offered specialist clinics such as an asthma clinic and cardiothoracic post-operative wound clinic which offered MDT support for complex dressings and other cardiothoracic post operative care such as chest drains to relieve pressure off system partners, reduced outpatient appointments, admissions, and length of stay.

Access and flow

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

The service had clear admission pathways for children and young person's admissions into the children's heart unit and PICU.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

Services for children and young people

Trust wide data in relation to 18-week referral to treatment times, showed the trust was in the second highest decile for level of risk for patients waiting over 18 weeks for treatment. In March 2023 71.5% of patients at the trust were treated within 18 weeks, compared to the England average of 65.8%.

Trust wide data showed 52-week referral to treatment time was in the second highest decile for level of risk for patients waiting over 52 weeks for treatment. In March 2023, 6% of patients at the trust were treated over 52 weeks compared to 8.5% nationally.

We saw trust wide the trust had a higher proportion of longer stay patients over 21 days than comparators (10.5% compared with 8% national average). However, the average length of delay for patients who stay in hospital for 7 days or longer is better than regional and national averages, at 5.8 days delay after being clinically ready for discharge. Compared with 7 days for regional peer average and 8.4 days national average. Since October 2022, the proportion of bed occupancy patients that were clinically ready to discharge has been better than the regional and national averages.

The number of paediatric patients waiting within 52 weeks for treatment was 106 patients, this meant 98.9% of children waiting were within the 52-week target compared to the national average of 94.8%. The service also performed positively with 99.2% of paediatric patients receiving treatment within 52 weeks compared to the national average of 92.2%. The percentage of paediatric patients waiting within 18 weeks for treatment was 82.9% compared with the national average of 59.2% with children treated within 18 weeks was 81.6% compared to the national 62.6%.

The service moved children and young people only when there was a clear medical reason or in their best interest. Staff did not move children and young people between wards, or begin surgical procedures unless life threatening, at night.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Staff had thorough discharge procedures including how to ensure children and parents had adequate supplies and information around. Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported children, young people and their families when they were referred or transferred between services.

The trust had funded an additional ECMO system to be kept at the GNCH to offer support to both adult and paediatric patients rather than transporting one system between the Freeman and GNCH to improve response times.

Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns.

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

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

Services for children and young people

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

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

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

Is the service well-led?

Requires Improvement ↓↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Paediatric services sat within Cardiothoracic service's which had a clear leadership structure.

The leadership structure chart was clear and comprehensive.

The matrons visited each ward every week and attended team meetings. Staff told us they knew who they were and how to contact them. Leaders supported staff to develop their skills and more senior roles.

Vision and Strategy

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

The service had a vision to be a leading national healthcare provider with a strategy to achieve this which included putting patients first, focusing on quality and safety, integrated care, research, and development underpinning their services, reputation, and sound financial management to secure ongoing development.

The trust had developed 5 values known as the 5 P's, patients, people, partnerships, pioneers, and performance.

Staff were aware of the vision and strategy.

Paediatrics worked to Cardio delivery goals and a strategy that linked to the 5 P's. The strategic goals recognised areas for improvement we found during inspection and how these would be addressed including the review of serious incidents and clinical harm investigations, roles and responsibilities of the medical leadership team and clear recruitment plans.

Services for children and young people

Culture

Staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care.

We received a number of anonymous whistle blowing concerns leading up to and during the inspection. In order to gain a wider view of staff morale we developed and collated a staff survey as part of this inspection, to enable all current staff to feedback regarding their experience of working within the trust. We received a total of 2,360 respondents trust wide with 44% of staff working at the RVI and 33% working at the Freeman hospital. We saw 66% of respondents were clinical staff and 71% of staff had worked in their roles for at least 3 years. Findings showed that 40% of respondents disagreed that communication between senior management and staff was effective. Over a third of respondents (38%) disagreed that senior managers act on feedback. More than a quarter of respondents (28%) disagreed that they felt safe to report concern without fear of what will happen. One in five (21%) disagreed that they felt comfortable raising bullying and harassment or discrimination concerns and one in five (20%) disagree that they felt confident raising patient safety concerns or other concerns within the organisation.

Analysis of the free-text comments we received, revealed a workforce who felt disconnected from leaders who did not understand, acknowledge, or address issues that staff 'on the ground' faced. Comments spoke to a culture of favouritism and bullying, where problematic behaviour went unchallenged, and concerns went unheard. Staff did not always speak-up because they felt "nothing changes", or from fear of repercussions. Staff spoke of the huge pressure they faced and the negative impacts it had on them, and on patients who they felt were at increased risk of harm as a result.

Leadership was an important theme for respondents who often described a culture of top-down communication, of feeling unheard, and of disconnection at the Trust. Respondents felt information was cascaded down from management, rather than in dialogue with them. They did not feel there were many opportunities for feedback.

Staff told us there was a hierarchical divide in culture between nursing and medical staff. All nursing staff that we spoke with told us they were sometimes spoken to with disrespect or shouted at by surgical staff. Managers told us that medical staff could often intervene with nursing interventions when unnecessary, making nurses feel devalued.

Staff also reported feeling frustrated that their concerns over staffing and potential for a patient safety incident was undermined by leadership either "not helping" or denying the circumstances. They felt that feedback around quality of care and safety were not responded to and opportunities for learning subsequently missed or, worse, "ignored". Staff we spoke told did however tell us that the culture was slowly changing in a positive way with the introduction of new consultant and surgical staff and that they had felt listened to when raising concerns about culture with management.

However, ward managers, sisters and matrons spoke highly of their teams and praised them for the work and care they provided on an ongoing basis.

The service display Freedom to Speak Up information and details of champions to contact if staff wanted to raise concerns about patient or staff safety confidentially.

Staff were offered support following emotionally difficult cases from services such as the children's palliative care team debriefs and (CHIPS) psychologist.

The trust provided resources for staff to manage their own wellbeing. Staff were able to self-refer into counselling services and were offered self-help resource leaflets for serious health related conditions such as stress, anxiety, self-harm, domestic abuse, alcohol, controlling anger, abuse and eating disorders. Managers were also able to refer to these services.

Governance

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

Children's services sat within Cardiothoracic division and therefore was managed within its governance structure within The Freeman Hospital.

Service leads identified their top three risks. These were reflected on the risk register; measures put in place to mitigate the risks and were regularly reviewed.

Staff told us they discussed quality and safety issues, audit outcomes and feedback from complaints.

The trust shared with us 2 governance meetings for April and May 2023. These showed good attendance, however rolling agenda items were not always included such as risk, and performance data was not discussed.

The trust's patient safety team completed quarterly audits of compliance against the duty of candour regulatory requirements. We reviewed the data provided to us and found that the trust delivered duty of candour in full to 1 out of 3 patients who were involved in a moderate or severe patient safety incident.

Management of risk, issues and performance

Although leaders and teams used systems to manage performance effectively, they did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

Ward level leaders had oversight of their team's risks, issues, and performance through on going ward level audits and were aware of the service's risk register. We spoke with senior managers and consultants who were aware of the individual ward risks which was based around staffing, records, and culture. However, there were 2 risks within the register that scored 15 but had not been escalated onto the corporate risk register in line with policy, this meant there was a risk senior leadership could not take action to mitigate risk.

Senior leaders met daily to discuss any staffing escalation to mitigate staffing risks and manage unexpected events. They redeployed staff across the service to meet the planned staffing levels.

Staffing pressures were escalated, and action taken to mitigate risks. Staff were redeployed across the service to meet planned levels and bed closures were considered and made when necessary to keep services safe. The service was undertaking a large recruitment campaign and staff we talked to told us about decreasing staff vacancies and adult nurses were used where appropriate in intensive and critical care environments.

Performance information was collated through the Newcastle reporting hub dashboard and shared with ward managers monthly. This included various performance indicators such as risk assessments completed and level of falls. However, there was no formal process in place managers to cascade and improve performance information with some managers

printing information and placing in staffing areas, some discussing in safety briefings and others sending emails. This meant that the availability of performance information did not always result in measurable improvement. The paediatric risk register identified 6 risks. Each risk had been given a risk score depending on the level of risk. Risks ranged from staffing pressures, to dated environment and potentially unreliable data systems. Risks were escalated through to board level and included risks identified by staff.

Risks to patients, such as hospital acquired infections (HAI), were monitored and escalating risk discussed at the Nurse Staffing and Outcomes Group with areas of concern receiving additional intervention and support which we saw.

The CAT was one of the methods used to collect information through clinical practice, patient care records and risk assessments and staff knowledge to inform ward sisters, charge nurses and matrons how their areas were performing monthly and provide clinical assurance to the Trust Board.

Managers were aware of the potential risks, and had contingencies in place, for the shortage of paediatric surgeons. Only one elective surgery was ever undertaken at any one time, during elective surgery the main surgeon would be asked to attend an emergency with their surgical registrar stabilising elective surgery. There was an employed and bank surgeon available on call. There was an emergency call for all adult and child consultants and surgical staff to be able to attend elective cases if ECMO was required.

Information Management

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

Staff could not always easily access the electronic patient record system and care records. We received whistleblowing in regard to the effectiveness of IT systems and how this was slowing down improvement within the service. Information reviewed during the inspection showed that system issues were a risk.

The service used Microsoft Access database system to collect various data such as morbidity intervention data, level of acuity, nutrition and blood products to feed into discharge summaries, mandatory reports and research and governance. Staff continued to experience issues gaining access when required and were unable to 'log-on'. This was included in the risk register and identified that the system did not interface with other monitoring equipment and was a time and labour-intensive system for staff navigate.

The community team did not have access to inpatient electronic records, staff told us they felt this "restricted the development of a really good service."

Data management systems were not always integrated and secure. The risk register identified that the two transplant databases in use had become unreliable and were prone to crashing meaning teams were often unable to access vital patient information and there was potential information could be lost.

Staff were not always able to use systems to their full potential. The trust identified a training need as some paediatric teams were not aware they were able to access moving and handling risk assessments. The system did not trigger care plans from its risk assessments and therefore staff had to make additional notes about plans of care.

Staff raised concerns with us that IT systems were slow and ineffective.

Mandatory training covered information governance for staff to complete. Staff were 85.4% compliant with information governance training which did not meet the trusts 95% compliance target.

The Newcastle reporting hub was available to all staff and allowed them to monitor their compliance and performance against other wards. This was not always disseminated consistently to staff teams.

Staff had access to policies and guidance on the trust intranet.

We reviewed incident information submitted for the last 12 months; the trust had only submitted 4 incidents to CQC under the Paediatric speciality. The trust provided incident information and staff had reported 931 incidents in the last year.

Information provided as part of the data requests post inspection visit was not provided in a format that was easy to interpret.

Engagement

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

Wards displayed staff engagement boards that included general information about ward performance in various areas.

We saw celebrating success boards across all areas and thank you cards showing appreciation to staff.

Family and friends test boxes and posters were displayed across children and young people services, this gives patients and their families the chance to give open and honest feedback about their care.

Leaders engaged with patients and families around plans to move Cardiothoracic services into the GNHC. Plans were concluded in December 2022 and discussed with patients any ideas or concerns.

The Trust held a youth forum for patients, or their siblings aged 14-24 with a focus on Trust improvements and research.

The Trust had a young person's advisory group with 62 members aged between 11-19 engaging with research and quality improvement projects such as the review and development of the paediatric food menu offered by the trust.

Learning, continuous improvement and innovation

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

The cardiothoracic care group were involved in various research and innovation projects to develop the service and services nationally. As part of a global research study, the service was performing procedures to remove scar tissue after a heart attack by using a new hybrid technique to close the scar using keyhole technology to improve heart function and distance patients could walk. This was to be introduced into clinical practice if lasting benefits to patients were proven.

Services for children and young people

The trust were one of three trusts involved in a pilot to develop a new national standardised tool for paediatric observations (SPOT System-wide Paediatric Observation Tracker). The GNCH had introduced parental concern element to their PEWS scoring system and had auditing and exploring the outcomes of collecting parental concern to feed into the pilot.

Medical care (including older people's care)

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory Training

The service did not provide all mandatory training in key skills to all staff. The service made sure staff completed mandatory training.

Nursing staff received and kept up to date with their mandatory training. Nursing staff were supported by ward sisters to ensure this training was completed. Clinical educators provided mandatory training days for qualified staff. These training days were held monthly for each staff member to attend on an annual basis. Completion of training for nursing staff at the time of inspection was 92.7%.

Medical staff received mandatory training. Medical staff did not always keep up to date with their mandatory training. At the time of inspection 77.6% of medical staff had completed their mandatory training. Medical staff told us that they were supported to have time to complete their training.

Overall, there was 89.9% compliance with mandatory training across the medical core services within the trust at the time of inspection. This was below the trust target of 95%. We identified that basic life support training rates had fallen for four months prior to inspection. These rates had increased to 73.3% across medical core services at the time of inspection. Senior staff were aware of this and identified that a new electronic system had been implemented which was more intuitive and supported a new system to allow staff to complete training before it expired.

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

Clinical staff did not complete all comprehensive training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. We saw that mental health awareness training had been included within mandatory training since November 2022. Staff told us they had completed this training and we saw that compliance had reached 93.2% for medical cores services across the trust at the time of inspection. We also saw that 98% of staff had completed dementia awareness training and 87% of staff had completed learning disability awareness training. However, we were not provided with any clarity that the training specifically included autism awareness.

Staff we spoke to were not able to clearly articulate what autism specific training they had received. The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. Mandated training is in place within the trust for learning disabilities which is endorsed by the North East and North Cumbria ICS. The trust is also piloting the roll out of the Oliver McGowan training for learning disabilities and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward sisters told us that they reviewed training compliance and supported staff to attend. Matrons told us that they reviewed mandatory training compliance on a one-to-one basis with the ward sisters.

Medical care (including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have training on how to recognise and report abuse. Staff who had training knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. We reviewed the training compliance for safeguarding adults levels two and three. We found the health group was 93% compliant with safeguarding adult level two training and 83% compliant with level three. The compliance rate for level three training was an improvement from previous months. However, we found no data to confirm that allied health professionals (AHP's) had completed level three safeguarding adults training. There was a safeguarding policy in place, but this did not specify the level of training each staff group required. This meant we were not assured that all staff had completed training appropriate to their role.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff we asked were able to give examples of circumstances and presentations that might indicate further consideration and referral for safeguarding concerns. For example, bruising or change of behaviour with family members. Nursing staff identified that they would speak to the nurse in charge regarding any safeguarding concerns and knew how to contact the trust safeguarding team for advice. We were told that the nurse in charge would be the primary point of contact for ward staff. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

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

Ward areas were clean, however, did not have suitable furnishings which were well-maintained. Throughout the hospital and on the wards we visited we saw doors and handrails that were wooden. These were often chipped and therefore could not be thoroughly cleaned, increasing the risk of spread of infection. However, all doors and handrails were part of a daily cleaning schedule to reduce any risk. The hospital used linen curtains throughout the medicine wards to support the delivery of net carbon zero and ensure sustainability. There was a process in place to wash and change curtains routinely.

The service generally performed well for cleanliness. Monthly infection prevention and control audits were carried out. Patient Led Assessments of the Care Environment (PLACE) had taken place across the hospital. The score for the 2022 survey was 94.88%. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff did not always follow infection control principles. We saw some missed opportunities for hand hygiene.

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

We reviewed infection rates for the wards and found there had been 61 Healthcare Associated Infections (HCAI's) across 15 wards during the three month period of March to May 2023. Of these 61 there were 28 identified across three wards within the Northern Centre for Cancer Care.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept did not always keep people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

Access to all wards was via secure buzzer.

Patients could reach call bells and staff responded quickly when called. However, we observed call bells with cords that were not plastic coated, were long and on occasion to the floor. We observed there to be a portable call bell with cord wrapped around the toilet rail in one toilet area on one ward. Behind the toilet was an individual shower cubicle with curtain rail - this was in an isolated area of the ward. We were not provided with any evidence of ligature risk assessment or risk reduction for the ward. This meant there was a ligature risk and potential for patient harm.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to health (COSHH) Regulations (2002). For example, on one ward we accessed a room with a box containing 150 chlorine tablets that were not secured.

Oxygen cylinders were not always stored securely by chain or in cages. For example, on one ward we entered an unlocked room containing multiple gas cylinders that were not stored securely by chain or in a cage.

The design and use of the environment did not support patient safety. On nine wards we visited we found rooms unlocked that had potential for patient harm. On one ward we were able to access an unlocked door into the electrical switch room.

There were cables and a metal mesh flooring in this room. On several other wards, we entered doors marked bathroom that were not locked. We found multiple pieces of equipment including hoists, trolleys and commodes stored in these rooms. They were not in use as bathrooms.

In some wards we found unlocked storerooms that were accessible and contained items that posed a potential risk such as sharps and monitors with cords. On one ward we found doors marked staff only that were wedged open. We found one room with the door wedged open on the main corridor, marked staff only that contained supplies of sodium chloride, glucose, unsecured oxygen cylinders, a machine marked as out of order and feeding tubes. This door was marked as an automatic fire door, however, was wedged open.

We entered another room with a staff only door propped open that was accessible by anybody and contained a mix of equipment, storage cupboard for build-up drinks that was not locked and a fridge for total parenteral nutrition (TPN) supplies. TPN is available by prescription only. This meant that confused patients were at risk of accidental harm through access to equipment and substances that could cause harm through misuse. This also meant that fluids for clinical use were at risk of being tampered with.

Staff carried out daily safety checks of specialist equipment.

The service had enough suitable equipment to help them to safely care for patients. However, decommissioned equipment was not always removed from clinical environments.

Staff did not always dispose of clinical waste safely. On two wards we found evidence of sharps bins in corridors or areas accessible by others. These sharps bins were also not dated.

Medical care (including older people's care)

Assessing and responding to patient risk

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

Staff used the nationally recognised NEWS2 tool to identify deteriorating patients. The trust also recognised the importance of clinical judgement and recognition of additional clinical signs in identification of deteriorating patients, for example, unresolved pain. The trust had included additional clinical signs within the alerting process. These additions would not alter the NEWS2 score but would support clinical decision making.

NEWS2 escalation compliance was audited monthly across each ward and reported via the trusts Harm Free Care Dashboard and individually to each ward through ward meetings. The trust target rate for compliance with NEWS2 was 90%. Compliance rates as of 1st July were 85% for medicine services.

We reviewed three sets of notes across three wards at The Freeman Hospital. We found two of these three had NEWS charts completed, one did not. There was no automatic alert on recording physiological observations to trigger a change to NEWS scores. This meant that a response was dependant on the nurse completing a deteriorating patient alert which meant there was a risk of delay to care and treatment of a deteriorating patient. On one ward we saw no NEWS2 chart in place for one patient. Scores were completed on prompting by inspection team.

Staff completed risk assessments for each patient on admission to wards using recognised tools including falls risk, Malnutrition Universal Screening Tool (MUST), Braden risk assessment (for pressure risk potential), moving and handling, lines and devices, smoking and alcohol and Covid tests.

All staff we spoke to told us that these risk assessments would be completed on admission and weekly thereafter except for Braden and lines and devices that were completed daily. All risk assessments would also be reviewed earlier if there was a change to a patient's circumstances indicating an earlier risk review, for example, a fall.

All staff told us that matrons completed weekly audits regarding completion of assessments using the trust wide clinical assurance tool. We asked for copies of the recent clinical assurance tool audits for the wards we visited. We received monthly figures as a percentage for each ward. There were no actions shared.

Staff knew about and dealt with any specific risk issues. Staff were able to articulate risk concerns with individual patients well. Staff knew how to report and escalate risks.

Staff we spoke to demonstrated their understanding of the sepsis six protocol. Staff explained how to escalate concerns and contact the critical care outreach team. However, the CQUIN audit information completed for 2022 -2023 demonstrated that for trust inpatient admissions they did not meet the operational standard of 90%. For the final quarter a score of 63% was achieved. Within the medicine core service, the trusts automated recording process for recognition, escalation and treatment for sepsis was 40% compliance at the time of inspection.

The trust provided further information from a snapshot manual audit undertaken quarterly for those patients where the automated process was not used. This showed compliance of 54%. The trust carried out further monthly audit within ward areas reviewing five patients per month. This demonstrated that 100% of these five patients had appropriate escalation plans and review within one hour in place.

Medical care (including older people's care)

There was some inconsistency regarding the completion of venous thromboembolism (VTE) risk assessments. Completion of these assessments is the responsibility of medical staff and they are not routinely carried out by nurses. They were recorded in a separate location on e-records to the other risk assessments. We were told that medical staff would carry out these risk assessments and that nurses would prompt medical staff if they were missed.

The Venous Thromboembolism (VTE) Assessment and Management Policy stated that assessments would be carried out by admitting doctors (with exceptions of specialist nurses in specific clinical areas). The policy stated they would be re-assessed within 24 hours of admission and following clinical change. The trust wide VTE audit for completion of an assessment on admission showed 96% compliance for May 2023. This meant a total of 473 patients admitted trust wide did not receive a VTE risk assessment on admission. Data was not available specific to core service at the time of inspection.

Staff told us that pressure ulcers were reviewed through intentional rounding. On identification of a pressure ulcer a referral would be made through the e-record system to the tissue viability nurse team.

Patients were assessed by this team and a plan of care agreed. This plan of care would be documented within patient notes in an activity entry rather than a formal care plan document. The tissue viability team would close the referral once a plan for care was agreed and would accept re-referrals for review if there was a change to a patient's pressure ulcer.

The review of pressure ulcers relied upon observations made by nursing staff and healthcare assistants through their regular checks. We were not able to identify detailed recording in the patient notes to evidence how staff unfamiliar with a patient's condition would recognise changes.

From 1 June 2022 to 31 May 2023, 66% of STEIS incidents reported by the trust relating to medical core services were in relation to pressure ulcers and slips/trips and falls. We saw evidence of falls risk assessments and assessments for pressure ulcer risks. Staff were able to describe and explain their knowledge of these risks, however, as there were no action plans formulated following completion of the monthly clinical assurance toolkit we were not assured regarding the process for monitoring and review of these risks.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). There was a psychiatric liaison team that worked into the hospital. Written referrals had to be made for this team to attend. Staff were aware of how to make referrals and knew when to make referrals.

Staff arranged, psychosocial assessments and risk assessments by the psychiatric liaison team for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. For example, a handover took place at each shift change and written handover sheets would be shared.

Shift changes and handovers included all necessary key information to keep patients safe. Nurses worked from the handover sheet throughout the shift to inform care. The handover sheet included indication of risk, current plans of care, information on mobility, nutrition, social needs and allergies. Nursing staff we spoke to told us that they would review e-records to get more detailed information as they needed it.

Staff also attended a multidisciplinary safety huddle each morning. This would be attended by physiotherapists and occupational therapists alongside medical and nursing staff.

Medical care (including older people's care)

Staffing

Nurse staffing

The service did not always have enough nursing and support staff with the right experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and proactively sought to fill staff vacancies.

We heard that across seven wards between the two hospital sites there were 12 staff nurse vacancies of which 11 had people appointed to awaiting to start. There were 30 healthcare assistant vacancies. Leaders had an oversight of the staffing and reviewed this across the two hospital sights. Where there had been previously high vacancy and turnover rates in one ward area there had been adaptations to the recruitment process such as involving ward staff directly in their own recruitment rather than new staff being allocated through a pool. This was aimed at retention of staff.

On the wards staffing requirements were calculated by the senior sisters using the recognised Safer Nursing Care Tool (SNCT). There was a safer care meeting twice daily to review the staffing levels for day and night shift. Any staffing shortages would be raised through this meeting and additional staff identified following escalation.

Staff explained that where possible wards would be staffed with a range of experience and grades. However, during staff focus groups we heard that often more experienced staff had chosen to leave recently, and wards were staffed with less experienced nurses.

The ward manager could adjust staffing levels daily according to the needs of patients. There was a red flag system in place to escalate staffing pressures along with a twice daily safe care review of staffing levels for each shift. There was also a ‘safer Friday’ review to ensure adequate staffing for the weekend shifts was in place.

On most wards we visited the number of nurses and healthcare assistants matched the planned numbers.

The service had reducing sickness rates and were in line with the sector average.

The service had low rates of bank and agency nurses used on the wards.

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

Medical staffing

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

The medical staff did not always match the planned number. Within medicine services the planned number of doctors across all grades was 318. There were 267 in post. For consultants, there was a fill rate of 112 out of 125 (89.6%). We were told that a team worked to ensure all shifts were filled with enough medical cover. There was a six week rolling rota and a dashboard that supported looking ahead to ensure there was always cover. Staff on the wards we visited told us there was enough medical cover.

The service had consistent vacancy rates for medical staff since 2021.

The service had consistent turnover rates for medical staff since 2021.

Medical care (including older people's care)

Sickness rates for medical staff were low.

The service had consistent rates of bank and locum staff.

Managers could not always access locums when they needed additional medical staff. The fill rate was 46.67% for locum posts.

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

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

Records

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

Patient notes were not comprehensive, and all staff could not access them easily. There was an electronic record system in place that had been implemented in 2019. We spent time reviewing patient notes with matrons, ward sisters, staff nurses and with the digital training team made up of staff with nursing backgrounds.

All groups of staff took lengthy periods of time to navigate the system and find information required to be able to understand a patient's needs. This meant there was a risk of patient care being delayed or a risk of missing important information. There was a disconnect in where ward staff were recording information and where the digital training team would expect to find information. There were inconsistencies in where ward staff documented information and where ward leaders would expect to find the information potentially leading to fragmented care.

There was no evidence of a clear record keeping process and no evidence of regular record keeping audits specific to each ward. We saw results from the most recent trust wide record keeping audit dated October 2022. Over a five day period four sets of notes from each ward were reviewed. For medicine core services we saw variations in the results for the question 'Is daily nursing handover communicated using the appropriate standardised proforma?' Five of eight wards scored 75%, two scored 50% and one scored 25% for compliance. There was an action plan in place to ensure the effective recording of details relating to patient conditions were handed over to ward colleagues using appropriate documentation. There was a timescale for reaudit in January 2024.There was no detail included regarding actions or the monitoring of this between the audit completion date and the re-audit date.

The electronic patient record system provided a combination of discrete prompts for patient care and clinical decision support (tick boxes) and free text to document clinical reasoning and rationale. We did not always see the free text areas being used to the full potential to evidence clinical reasoning. Notes were not always contemporaneous as some staff recorded an addendum below a previous entry.

However, staff were used to this practice and would look for any additional information in addendums. There were no clear care plans recorded within the care plan section on the system, which meant not all the patients' health needs were clearly documented in a plan of care to support staff to deliver safe and effective care. Templates had been introduced for use within activity recordings, these included prompts for each area of concern to be considered and were completed by staff on each shift for their own patient group. We saw evidence of completion of these on each ward we visited. This information did not transfer into a handover document resulting in nurses completing an additional handover sheet. There was a risk that key information could be missed.

Medical care (including older people's care)

During the inspection staff could not always access patient information promptly using the electronic patient information system.

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

Records were not always stored securely. We observed computers being left unattended and unlocked in the Freeman Hospital on two wards which could compromise patient confidentiality.

Medicines

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

Staff did not always follow systems and processes when prescribing, administering, recording and storing medicines.

Medicines were not always stored securely or safely. No room temperature monitoring was in place, therefore, we were not assured that medicines were stored in line with manufacturers guidance. We were also not assured that stock control systems were effective as we found seven medicines over two wards that were out of date. On one ward we found cartons of Total Parenteral Nutrition (TPN) stored in an unlocked fridge in a room marked staff only with the door wedged open. TPN is prescription only and was not stored safely or securely.

We reviewed three patient medication records and saw that medicines were prescribed appropriately however we found one example where a patient had been administered their medicines covertly (disguised in food and drink) without the completion of the necessary legal documentation.

Oxygen cylinders were not always stored securely.

Controlled drugs were managed in line with the providers policy. Data provided by the pharmacy department for completion of controlled drugs checks in the last 12 months showed all were up to date.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We spoke with pharmacy staff on ward 18 where they provided a clinical service such as medicines reconciliation and discharge planning as well as general queries. On ward 13 we were told pharmacy was contactable for advice.

Staff did not always complete medicines records accurately or keep them up to date.

During our second inspection we found staff did not store and manage all medicines and prescribing documents safely. On one ward we had not previously visited we entered a clean utility room. The door was not locked, and staff did not question our entry. We found mixed batches of medications stored in unlocked cupboards and on the floor. We saw mixed batches and different concentrations of IV fluids containing potassium. Some medications were out of their original packaging. Intravenous and oral medications were all stored together mixed with items subject to COSHH regulations (chlorhexidine and bleach tablets). Fridges were not locked, and oral chemotherapy was not locked away. Patients own medications were mixed in with ward stock items. There were empty medicine boxes mixed with stock medicines and bags of disposed medication. There was no evidence of stock checks or system for recording the storage of patients own medication. On a second ward we also found medications out of the original packaging. On this ward we reviewed the controlled drugs checks and found these to be incorrect with 10 lots of morphine missing. We were

concerned about this because we had raised concerns about medication storage in other areas of the service and trust during our first inspection. Whilst there was evidence of trustwide actions to address the concerns raised, improvement was still required in a small number of areas. We were concerned that actions had only been taken where we had previously highlighted issues with the safe and secure storage of medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted or moved between services. Although the trust had an electronic prescribing system in place the trust was unable to provide real time medicines reconciliation figures therefore, we could not be assured that the trust had the required level of oversight to report on their key performance indicators (KPI) of medicines reconciliation being completed within 24 hours

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

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents but this was not always timely, and they did not always share lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew how to report incidents but did not always recognise what to report as an incident and therefore did not always report incidents in line with trust policy. We heard from staff that patient harm should be reported but incidents where omissions had been made but there was no harm did not need to be reported.

We were not assured staff reported serious incidents clearly and in line with trust policy.

We found no evidence managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. However, we spoke to one patient who had felt there had been a lack of openness and transparency in investigating their concerns regarding care and that an appropriate apology had not been provided. We spoke to another family member who had felt that concerns about poor care had been dismissed. They were not always open and transparent and did not always give patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents within their clinical environment. A survey we carried out with staff as part of the inspection identified that of those staff completing the survey 45% stated they heard about incidents and learning from other parts of the organisation.

Staff met to discuss the feedback and look at improvements to patient care.

Staff told us they were working to make changes because of feedback. For example, we heard that there was a recognition that incidents had reduced, that the main themes had been around falls and pressure ulcers and that staff were sharing information around preventative measures and working more closely with the tissue viability team regarding pressure ulcer damage. We saw evidence of information displayed around the importance of supporting people to keep moving in hospital.

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

Medical care (including older people's care)

Managers did not always debrief and support staff after any serious incident. We heard mixed views from staff regarding debrief and support after serious incidents. Some staff told us they felt supported, however other staff during individual conversations and through focus groups told us that they felt there were no formal support mechanisms available for debrief.

Staff provided strong views that all ward-based staff and immediate line management were very supportive of each other, however, did not feel that this was replicated, or their needs fully understood from more senior management who did not work on the wards on a daily basis.

Is the service effective?

Requires Improvement ↓↓

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed the trusts own intranet system and saw that staff had access to up to policies, procedures, and guidance on the intranet. Nursing, medical and AHP staff were able to articulate rationale for their clinical practice with evidence-based practice examples. We saw examples of evidence-based practice displayed on wards such as dementia awareness and involving carers.

However, on all wards we visited we saw that nursing care plan documents were not used. Therefore, we were not assured that care was delivered in accordance with best practice. We saw evidence of tick box completion of the standard set of risk assessments that would achieve adherence with a range of National Institute for Clinical Excellence (NICE) guidance, however we did not see evidence of clinical rationale regarding all care provided.

In the absence of effective care planning there was a risk that patients would have received incomplete care and treatment and the effectiveness of any care provided could not be measured accurately.

We saw that there was an annual audit plan for reviewing the processes for the implementation of NICE guidelines. However, we did not see a copy of the completed audit for 2022/23. We reviewed the annual audit report for the directorate of medicine dated June 2021 to May 2022. We found that there were outstanding and incomplete actions on a number of national audits and NICE guidance identified. For example, there were three NICE guidelines relating to diabetes management with areas of non-compliance. It was understood that increased clinical pressures had impacted on the timely completion and development of actions. We did not see evidence that actions had since been completed, therefore, were not assured of compliance with all national guidance.

We saw display boards with sepsis awareness information guiding staff to complete sepsis screening and management in line with National guidance. Staff we spoke to were able to explain sepsis screening and management. We saw evidence of audit that identified action plans including increased education and awareness training to staff regarding the timely completion and recording of NEWS2 scores.

We reviewed the trusts own intranet system and saw that staff had access to policies, procedures, and guidance on the intranet. Nursing, medical and AHP staff were able to articulate rationale for their clinical practice with evidence-based practice examples. We saw examples of evidence-based practice displayed on wards such as dementia awareness and involving carers.

Staff did not always protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. Across the trust we found inconsistencies in staff understanding of the Mental Health Act and of their role within this. Since inspection in November 2022 there were folders on each ward containing information regarding the Mental Health Act, however, we found staff did not have detailed knowledge regarding the difference between their own role and the role of the local mental health trust that would be working alongside them with some patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff did not always record nutrition and hydration needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

During inspection we saw staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw menus that included a range of dietary choices, for example, gluten free, halal and vegetarian options. Food was checked against patient preferences before being given. Snacks were made available for patients throughout the day including snacks such as supplements, yoghurts and custards for patients with swallowing difficulties.

Staff did not always fully complete patients' fluid and nutrition charts where needed. We saw evidence of gaps in food and fluid charts. On one ward staff told us that fluid balance charts were never accurate. On four sets of notes we reviewed we found that none had fluid balance charts completed fully. For example, a patient on a fluid plan had gaps missing in fluid intake. Staff told us they assumed this was due to recording error rather than missed fluids. We could not, therefore, be assured that all patients consistently received enough food and drink to meet their needs and improve their health.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, we found that scores were not always calculated. Staff told us they were aware there had been some challenges with recording nutrition and hydration needs including completion and scoring of MUST scores. We heard that on some wards there had been an increase in non-compliance of completion of MUST scores because newer less experienced staff were not as used to the systems as the more experienced staff who had left. Not all harm free care nurses had been identified yet so support was not always available to staff. We were told this was being addressed through additional training and weekly audit using the clinical assurance tool. The trust was in the process of strengthening its harm free care leaders, which was an identified staff member on each ward who had additional training to support education around the harm free care agenda. Not all wards had this in place at the time of inspection.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. If a specialist diet was recommended there was a colour coding system in place reflected within the kitchen area and at a patient's bedside. We saw nutritional advice displayed on the wards.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw pain charts were in place and pain was checked regularly and recorded in the patients e-records. Pain was reviewed through regular intentional rounding.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

The service participated in relevant national clinical audits for example the sentinel stroke national audit programme (SSNAP), national respiratory audit programme (NRAP), national diabetes audit, managing frailty and the national early inflammatory arthritis audit.

Outcomes for patients were positive, consistent and met expectations, such as national standards. However, the managing frailty benchmarking exercise identified that the service had no dedicated acute frailty service in place.

Whilst the service did not have a dedicated acute frailty service (AFS), it was able to deliver the core parts of an AFS as demonstrated in the managing frailty benchmarking action plan we received. This action plan assured us that the Trust was aware of opportunities for improvement and was actively working on these; this includes engagement with the Frailty CQUIN 2023/24. The Trust had established a frailty steering group to have oversight of this action plan and drive continuous improvement in frailty screening and other areas as outlined in the managing frailty report. However, there was no date by which to achieve these actions.

Managers and staff carried out locally agreed routine audits using the clinical assurance tool. Managers and staff told us these results would be shared with staff and areas of concern would be a focus for improvement giving examples of completion of MUST scores and pressure care. These audits were repeated monthly to check for improvement over time.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

We did not see any clear processes for sharing and making sure staff understood information from the audits.

The service held a certificate of registration issued by the national standards body BSI for operating a quality management system compliant with requirements for the prescription, planning and delivery of radiotherapy and brachytherapy services. This was effective from January 2022 with an expiry date in January 2025. The service was accredited by Joint Advisory Group on gastrointestinal endoscopy (JAG) in June 2022 for one year.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance. Managers held supervision meetings with them to provide support and development.

Staff were not always experienced. Staff we spoke to told us that there were greater numbers of more junior lesser experienced staff working within the service as experienced staff had moved on. Staff told us that in response to this there was a drive to ensure that there were harm free care leaders identified within each ward for a range of subjects. Most wards we visited had identified staff to take on these roles where staff had a specific interest area.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to who were new to the service told us they had felt well supported by their peers and direct managers. New staff had a named mentor identified. Clinical educators told us that all newly qualified nurses completed a preceptorship and induction training. There was also an 18 month pathway to follow which was bespoke to clinical areas. There was a set of competencies for each area and specific training days set up to support staff to achieve competencies, for example, a tracheostomy day and neuro observations. Some competencies required signing off based on knowledge base or skills set for example, cannulation.

International nurses moving from overseas received an additional six week 'boot camp' training. There was a specific lead for the support of international nurse recruits. We heard examples of how the different needs of international recruits were recognised.

Managers aimed to support staff to develop through yearly, constructive appraisals of their work. The trust target of 95% was not achieved. For the medicine core service, the appraisal completion rate for May 2023 was 75%. This rate had remained stable throughout the previous year. Clinical educators supported appraisals. We heard that staff would be contacted three months prior to the appraisal due date to offer any support or discussion prior to the appraisal session.

Staff we spoke to told us they felt supported by their managers to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors told us that senior staff were always contactable for support and there were opportunities and time given to complete all mandatory training. There were also additional departmental teaching sessions that could be accessed.

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

Managers held team meetings for all staff to attend. However, there was variation in the format and style of team meetings. Some team meetings were held formally for all staff to attend whilst some wards relied on sharing information through daily MDT meetings and safety huddles, for example any learning from serious incidents.

Managers told us they identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Results for the staff survey demonstrated that 54% of people completing the survey for the core service identified they felt they had opportunity to develop in their career. 28% felt that the appraisal process supported them to set clear objectives for their work. 58% felt able to access the right learning and development opportunities when needed to.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, we observed daily MDT meetings including consultants, junior doctors, nursing staff, physiotherapists and occupational therapists. We saw evidence within these meetings of discussion regarding referrals to other professionals to support patient care such as the social work team.

However, we were told that there had been some changes to the multi-disciplinary discharge process following the implementation of the nationally recognised discharge to assess model. The discharge team told us that social workers would work with patients on pathway three – requiring 24-hour placement or complex needs. The discharge team would work with other patients, however, recognised that there were sometimes delays as they were still learning how to manage discharges. Additional investment in 2022/23 had enabled an expansion of the specialist discharge nurse team to provide 7 day responsive support and coordination, working alongside the ward MDT and the identified services to enable timely discharge. The Trust had established a Discharge Improvement Programme, with a dedicated discharge improvement lead and work was ongoing to engage ward MDT's to support their own discharge planning improvements.

We saw evidence of good MDT working on ward 9, for example the moving and handling team and the physiotherapist had worked together to find a suitable sling to support a patient with complex needs. We saw evidence of the use of a therapeutic gym on this ward and session times displayed for patients and visitors to see.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us there was a learning disability specialist team available within the trust to refer to for advice. The trust had 24-hour access to psychiatric liaison, specialist mental health support and a specialist learning disability team. The specialist learning disability team was available Monday to Friday. In most services there was a reliance on the psychiatric liaison service to provide an assessment of patients' risks and a management plan.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff knew how to make mental health referrals.

Patients had their care pathway reviewed by relevant consultants. For example, patients accommodated on non-medical wards due to medical bed shortages, were reviewed by the appropriate consultant for their care needs. The list of medical boarders was updated and reviewed daily. Each ward had contact details for the relevant consultant.

Staff we spoke to told us there was good teamwork across all disciplines. Staff liaised with the multi-disciplinary team directly. For example, referrals would be made to tissue viability nurses, learning disabilities, team, diabetes care, dieticians and the falls team.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Junior doctors were present on the wards daily and had access to more senior doctors as needed. All doctors we spoke to felt the arrangements for cover regarding patient care was sufficient to meet needs.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was a hospital at night team available during the night. Physiotherapy and occupational therapy staff operated a seven day service.

Medical care (including older people's care)

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. For example, we saw posters relating to nutrition and exercise.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff asked each patient about smoking and alcohol on admission. We saw evidence of alcohol awareness and smoking awareness displayed on wards. We saw nutritional information displays.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always clearly evidence that patient's consent had been gained. They did not support patients who lacked capacity to make their own decisions.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. A recent audit demonstrated 62% compliance with conducting assessments of capacity across the trust.

We heard mixed views from staff we spoke to regarding the level of confidence and whose responsibility it was to complete capacity assessments. For example, on one ward we were told clearly that the understanding of capacity assessments was the responsibility of all staff. On another ward we heard that doctors would take responsibility for capacity assessments and nurses would then complete Deprivation of Liberty Safeguards (DoLS) where capacity was lacking, and best interest decisions had to be made.

When a patient's capacity to consent was queried, staff did not always undertake appropriate assessments of their mental capacity to determine the need for best interest decisions to be made. Staff did not always consider patients' wishes and the views of relevant people including family members.

During our inspection in November 2022, we found examples where staff had not established whether patients lacked mental capacity to make decisions about their care and treatment, however, indicated care was being provided 'in their best interests'. On this inspection we found this phrase was used less and more consideration given to assessing a patient's capacity before using the best interest terminology which was an improvement. However, we did find there were still inconsistencies in recording mental capacity assessments, best interests' decisions and DoLS. For example, we found inconsistencies regarding the recording of capacity assessments and best interests' decisions where there was a DNACPR in place for a patient lacking capacity.

Staff did not implement Deprivation of Liberty Safeguards in line with approved documentation. We saw evidence of a patient with a DoLS recorded as being in place, but staff could not locate evidence of the Mental Capacity Act (MCA) documentation or decision-making process. Staff were unclear regarding which profession would be responsible for the completion of this. Staff told us that sometimes they might just write in the notes rather than a specific identifiable area of documentation.

We found that patients subject to DoLS had this highlighted on the banner of the electronic records, so this was easy to see. Patients with a DNACPR in place also had this highlighted on the banner.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patient records.

Medical care (including older people's care)

Patients we spoke to told us they were informed of treatment options. However, we did not see detailed records to evidence these conversations always took place. We did not see detailed rationale documented where patients were found to lack capacity. For example, on one record we reviewed we saw 'best interests and discussed with family' recorded. The trust recognised that there was a need for a visible section in the e-records for staff to evidence their decision making. The format of this had not been finalised at the time of inspection.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance specific to the Mental Health Act and Mental Capacity Act although they knew who to contact for advice.

Mental Capacity Act level one e-learning had been completed by 88% of staff in May 2023. This was a significant improvement to 32% in April 2023. A package for level two training was being developed.

There was a Mental Capacity Act policy in place, however this was not updated to reflect the training requirements and responsibilities of staff in completion of mental capacity assessments. For example, it referred to optional Mental Capacity Act training for areas where this was felt necessary.

Managers monitored the use of Deprivation of Liberty Safeguards but did not always make sure staff knew how to complete them.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. A Mental Capacity Act steering group had been in place for some time but had been strengthened following the previous inspection. The minutes from the group gave us assurance that practice was being reviewed and future action plans were discussed.

We found some improvements in practice since the focussed inspection was carried out in November 2022. We saw that each ward had a 'care for me, with me' folder in place that provided staff with guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff were aware of these folders and were familiar with the trusts plans for staff to become confident in completion of capacity assessments and Deprivation of Liberty safeguards. All staff we spoke to were aware they could contact the MCA lead for advice. Staff also knew how to contact the safeguarding adults' team for advice regarding MCA and DoLs.

Is the service caring?

Good  

Our rating of caring went down. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. We observed nursing, healthcare assistant, therapies staff and housekeeping staff interacting with many patients. We saw patients had been supported to sit up in chairs or bed

depending on their needs and wishes. Patients had been supported with self-care when needed. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw examples of patients placed on end-of-life care in side rooms for privacy and dignity. Staff told us about the hydrangea project. This provided patients on end of life care the opportunity to use a visual sign to signal their wish for quiet space and time.

Patients we spoke with said staff treated them well and with kindness. We observed all patients to have call bells available and evidence of regular comfort checks through intentional rounding.

Staff followed policy to keep patient care and treatment confidential.

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

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw evidence of a patient and family member being given support when the patient had become confused and distressed.

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

We were told nurses would provide bereavement support to families and carers immediately after a death. Ward staff had access to a range of leaflets providing practical support advice and contact numbers for external agencies. The chaplaincy team were available 24 hours a day and seven days a week. End of life and palliative care nurse specialists were available seven days a week to provide short intervention bereavement support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw an example of emotional support being given to one patient and family member.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We spoke to eight patients who all felt their care and treatment had been explained to them. Patients with discharge plans in place were aware of the plan.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw examples of 'you said, we did' boards on wards we visited.

Medical care (including older people's care)

Staff supported patients to make advanced decisions about their care, however, did not always document this clearly.

Staff supported patients to make informed decisions about their care, however, did not always document this clearly.

Patients we spoke to gave positive feedback about the service.

Is the service responsive?

Requires Improvement ↓

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

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

The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers did not always plan and organise services, so they met the changing needs of the local population. Staff told us that the patient population had become more complex following the covid -19 pandemic. Patient conditions have become more complex to assess and treat as a result of patients not being seen as early as they might have been before this period. Staff told us that patient expectations seemed higher. Staff told us that experienced nurses had left and were replaced by newer less experienced nurses. Some staff felt that these changes had not always been recognised by senior managers.

We heard one example of how services had adapted to support the needs of local people, for example, on the emergency admission suite we were told they would accept patients who self-presented with chest pains rather than send them straight on to the nearest urgent and emergency department. This was an exception that had been made to support people at the point of attending the hospital site.

The trust provided a protocol that explained only in exceptional circumstances where a patient was too unwell to leave the emergency admission suite due to a suspected medical emergency would they be reviewed. There was a triage process in place that advised contact with the relevant speciality for review through the hospital switchboard. However, there were no formal pathways in place for medical review of these patients by a designated consultant and therefore, there was no assurance that a patient would be reviewed medically in a timely way. We heard an example where there had been some difficulty in contacting an appropriate doctor for review of a patient a few days prior to inspection.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust reported 65 breaches across the trust for the month prior to inspection. These breaches were classified as where a patient requiring level two care or enhanced monitoring / assessment were not able to move to a single sex area within 4 hours of being ready to move.

Facilities and premises were appropriate for the services being delivered.

Staff could not always access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The trust was working with the local psychiatric liaison team and

the wards to improve working practices. We requested data for response times from making a referral. We were told this data was not always recorded sufficiently to be able to calculate a response time. However, based on the data available, we saw the average response time for wards was 1440 minutes (24 hours), the average response time of those with accurately recorded data across all wards on the site was 1690.76 minutes.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, there was a critical care outreach team that staff knew how to access. There was a diabetes in reach service available seven days a week.

The service relieved pressure on other departments when they could treat patients in a day. For example, the emergency assessment suite accepted referrals from health professionals such as GP's and district nurses. This provided a same day service to patients requiring more than a community service could offer with the aim of assessing and treating people the same day. This improved patient experience and reduced hospital admissions.

The service worked with local charity groups to better understand barriers faced by minority groups and to identify ways to overcome these, for example, difficulties faced by deaf patients. Feedback from local communities was also gathered on a quarterly basis through an equality, diversity and human rights working group attended by several charities representing a range of people.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They did not always coordinate care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service applied the 'Dementia Friendly Charter'. Staff received training during induction for dementia awareness. Staff compliance with dementia awareness training was 98% The service had a specialist dementia care team who were able to provide specialist assessments and treatment plans based on holistic assessments. The service used the 'forget me not scheme' to identify patients with dementia needs.

The trust had taken part in the National Audit of Dementia. Results published in August 2023 demonstrated that improvements had been made since the previous year's audit in areas including delirium screening, pain assessments and discharge planning for patients who met the criteria for the audit.

Wards were not always designed to meet the needs of patients living with dementia. We saw signage within the wards to identify bathroom and toilet areas, however, we opened some doors marked bathroom and found unused equipment stored within the rooms. For example, there were large amounts of moving and handling equipment found in a room marked bathroom on a main corridor in ward 13. Confused or unsteady patients were at risk of harm should they enter the area. We saw evidence of equipment stored in corridors. We found rooms unlocked and COSHH substances accessible. We also found evidence of thickener powder on a tea trolley and easily accessible rooms with prescription food supplements easily accessible. This posed a risk to patient safety.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff told us they were aware of hospital passports. Each ward had a 'care with me folder' in place. We saw that these folders had been implemented since the focussed inspection in November 2022. These folders had been designed to give staff guidance on working with patients with co-existing mental health needs who were detained under the Mental Health Act.

The guidance stated that patients with a learning disability or autism should come into hospital with a learning disability passport.

Prior to inspection we received two concerns regarding poor communication with other service providers on discharge of patients with complex needs and poor communication regarding dietary needs.

We reviewed the audit that was carried out monthly as part of the clinical assurance tool and found that whilst five of six wards scored 100% for patients with a confirmed learning disability having a passport in place and evidence of this being discussed one ward scored 17% for overall compliance. It was unclear regarding the calculation of these scores as wards had scores recorded for patients where there was a confirmed learning disability. However, the score for a passport being in place on this ward was 0% whilst the score for a passport being discussed was 100% and the overall compliance 17%. The data provided was confusing and did not make sense. We did not see evidence of how audit scores were reviewed or followed up. We did see that there was a plan for the learning disabilities team to carry out ongoing review and evaluation but that was not clearly detailed with specific timescales.

Prior to inspection we received two concerns regarding poor communication with other service providers on discharge of patients with complex needs and poor communication regarding dietary needs.

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw evidence of staff using interpreters during inspection.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus included a range of options to meet specific needs.

Pastoral care was available from a multi- faith chaplaincy service.

Access and flow

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

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. For example, the percentage of patients treated within 18 weeks slowly declined from 78% in May 2022 to 71.5% in March 2023. However, this was better than the England average of 65.8%. Referral to treatment times across the trust where patients were waiting more than 52 weeks had increased by 101 patients in the year from March 2022 to March 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. We were told there was a system in place to check daily which patients no longer met the criteria for right to reside, for example those with oxygen requirement and NEWS scores requiring hospital treatment.

Those patients who did not meet the criteria to reside were reviewed by ward staff and would be referred to the discharge hub if their treatment could be provided at home. If patients did not meet the criteria to reside for more than two weeks, the ‘Newcastle System Escalation Process’ would be followed.

A multi-disciplinary team meeting would be convened and if there was still no resolution for a discharge plan after a further week then a complex case discharge escalation group would meet to agree a final decision.

There were no incidences reported of staff moving patients between wards at night.

Managers monitored that patient moves between wards were kept to a minimum. We saw some evidence that the trust monitored inappropriate transfers through the incident reporting system. We saw no evidence of inappropriate moves.

Managers and staff started planning each patient's discharge as early as possible. There was a discharge team and funding was in place for a discharge service lead. This post had been in place since March 2023 with the aim to embed the discharge process and to support staff in understanding criteria to reside. Some past difficulties had been identified, for example not all staff had understood the criteria to reside.

Staff told us that there were some delays in planning discharge because paper-based referrals were required for the discharge team and the spreadsheet system used for identifying patients ready for discharge was only accessible by one member of staff at a time. We were told about the discharge improvement programme that included a new platform for electronic discharge processes to be set up. This also included a series of videos that were due to be launched in September 2023 to support staff, patients, and carers in understanding the discharge process and supporting safe discharges.

Staff planned patients' discharge taking into account those with complex mental health and social care needs.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. We heard that all non-medical wards had contact details for the appropriate medical consultant who would review their patients. The trust told us that at times of surge in numbers of medical outliers a dedicated border team would be assembled to ensure review of all patients.

Managers worked to minimise the number of medicine patients on non-medicine wards. We saw that the number of medical boarders across medicine had fallen significantly from 205 in January 2023 to 32 in June 2023.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. For example, they would speak directly to ward staff or contact the trust patient experience department. Senior ward staff would speak directly with patients and their families where concerns were raised verbally.

The service clearly displayed information about how to raise a concern in patient areas. There were posters displayed in ward environments explaining how to raise a concern.

Staff understood the policy on complaints and knew how to handle them. Senior ward staff would investigate complaints relating to their own ward. This supported ownership of any learning or actions required following complaint review.

Medical care (including older people's care)

Managers told us they investigated complaints and identified themes. We asked for a breakdown of the number of complaints for the service. We received figures without any further context to the complaints. We saw there had been one complaint over the previous year received regarding general medicine and three for elderly medicine.

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

Staff told us feedback from complaints was shared and learning was used to improve the service. We did not hear any examples of complaints where learning had taken place during our inspection.

Staff could give examples of how they used patient feedback to improve daily practice. For example, on some wards we saw that patients had expressed concern regarding the amount of food available between mealtimes and this had led to a change to increase availability of snacks throughout the day.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced.

Ward managers were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Clinical specialities across the trust were organised within clinical boards. The Clinical Boards were established on 1st April 2023 and the transition from the previous Directorate structure commenced. Director of Operations were in post and the handover period began. The Clinical Board Chair commenced in May and the Head of Nursing for Medicine was not due to start in post until October 2023.

The service was part of the Medicine and Emergency Care Clinical Board. Each ward had an identified matron with responsibility for several wards within the speciality area. Each ward had senior sisters in post as leaders within the ward environment.

The senior leadership team had a range of experience and an understanding of each other's role which allowed them to complement each other's skills. They described the current challenges to the service including workforce shortages, changing challenges from patients such as increases to violence and aggression and a need to instil value back into the team. They recognised external factors creating internal challenges such as difficulties with delayed transfers. It was recognised that this was a national issue and consideration had been given within the service to expanding the medical footprint to ensure there were always enough beds for admission. They also recognised that this pressure may become more predominant again in the winter months and that forward planning was needed to be able to respond to pressures.

Senior sisters had the right skills and abilities to run the services.

Senior sisters understood the priorities and issues the service faced. They recognised changing demands on services including patients presenting with more complex health needs, increased violent and aggressive behaviour from some patients and staffing challenges.

Staff told us that their senior leaders external to the wards were not visible. Staff told us about the recent reorganisation into boards, however, were unclear about their direct leadership beyond their immediate line management. Some staff felt that the senior management team were working well amidst the transformation to update staff and there was confidence within this team although not beyond it.

Staff told us members of the executive team were rarely seen.

Junior staff told us that senior ward staff and ward sisters were always accessible and supportive. Staff felt that they were supported by their immediate team leaders to develop. We saw evidence on each ward we visited of staff being supported to take on lead roles as harm free care leaders. We heard that staff were able to volunteer according to their specific interest area and skill set.

Vision and Strategy

The service did not share a clear vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were not clearly focused on sustainability of services or aligned to local plans within the wider health economy.

The trust had an overarching vision and strategy to be achieved over the 2019-2024 period. The trust was also in a process of embedding new clinical boards across core services. Staff we spoke to were not able to clearly describe the role of the clinical boards and how these would impact upon direct patient care.

Staff we spoke to were aware of some aspects of the trust vision and strategy such as the Flourish campaign to support staff to achieve their potential, however, staff saw this an outward facing public relations exercise and could not articulate the benefits to themselves.

The vision and strategy were developed prior to the reality of the covid -19 pandemic and therefore, was not current in reflecting the changing demands of health care post pandemic. Staff we spoke to recognised that patient needs had become more complex, patient expectations felt greater, there was an increase in violence and aggression from some patients and an increase in patients with co-existing mental health problems.

Alongside these challenges there had been an increase of experienced staff leaving or moving onto other roles which meant the wards were staffed with newer and less experienced staff. Ward staff and ward leaders that we spoke to were clear on these challenges and able to describe their own service vision to support staff in achieving a back-to-basics approach to ensure that all staff were skilled in appropriate risk assessment and care provision. We saw evidence of this through the implementation of harm free care leaders. We also heard that some senior leaders within the core service recognised the importance in finding ways to instil value back into the team.

Culture

Staff did not always feel respected, supported and valued. The service did not always promote equality and diversity in daily work and provide opportunities for career development. The service did not have an open culture where staff could raise concerns without fear. However, clinical staff were focused on the needs of patients receiving care and continued to drive positivity. The service had an open culture where patients and their families could raise concerns.

Medical care (including older people's care)

Ward staff demonstrated a culture of good care towards their patients. We saw that ward staff were focussed on the needs of their patients. We heard that patients had opportunity to raise concerns with senior ward staff and resolve any concerns at that level.

We heard that staff were proud to work for the organisation and recognised the good care they provided. We heard from staff working in direct patient facing roles on a day-to-day basis that they worked well as a team to prioritise patient needs. Staff supported each other and felt they could raise concerns safely within their immediate line management. Staff felt that ward sisters were approachable and supportive. One comment within the staff survey carried out as part of the inspection highlighted that there was a 'collective passion and drive to care for patients to the highest standards' and to 'support one another to deliver safe harm free care and achieve the best outcome for all patients.

However, we also heard that staff did not feel respected supported or valued within the wider organisation. The recent staff survey carried out identified that whilst 72% of staff who responded felt their immediate manager valued their work only 32% of staff felt they were satisfied or very satisfied that the organisation valued their work. The staff survey completed as part of the inspection identified a separation between senior management team, executive team and staff on the ground floor with comments including 'glossy weekly updates but not a lot of substance behind. It would be much better to see them walking around the wards and checking how things are going'.

We heard mixed views from staff regarding equality and diversity. We heard from two staff speaking out within the trust that they felt they had experienced discrimination due to disability or gender. We reviewed the trust staff survey results for medicine and found that of those staff completing the survey only 61.1% had answered yes to the question 'Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?'. Only 74.7% of staff completing the survey responded to say they agreed or strongly agreed that the organisation respects individual differences. However, 96.2% of staff reported they had not experienced discrimination form a manager or team leader within the past 12 months. Staff told us they did not always feel they could speak up and raise concerns safely. Staff were aware of the Freedom to speak up and whistleblowing policy, however we heard through anonymous whistleblowing concerns raised during the inspection that staff were concerned there would be negative repercussions towards themselves even if they spoke out through these channels.

During the inspection we received 69 whistleblowing concerns from staff across all areas of the trust. Eighteen of the concerns were raised anonymously and had cited reasons being that even raising concerns externally in confidence would somehow lead to repercussion in a negative way. Bullying was referred to as a concern in 17 of these concerns whilst a culture of poor leadership and staff support was referred to in 26 of these concerns. The staff survey carried out as part of the inspection identified that 38% of respondents had witnessed harassment, bullying and abuse at work from colleagues or managers but only 51% of these had reported it.

Governance

Leaders did not operate effective governance processes, throughout the service. Staff were not always clear about their roles and accountabilities and regular opportunities to meet, discuss and learn from the performance of the service were not clear.

The trust had recently re-organised into clinical boards. Staff told us they were not clear about the management structure within their own boards. The staff survey carried out as part of the inspection identified that 40% of respondents felt that communication between senior management and staff was not effective.

We heard from staff regarding varying methods of information sharing between leaders and staff carrying out daily clinical duties. These methods varied between wards and included bulletins for staff, staff meetings or sharing of information through handovers. Matrons and sisters told us that there were regular meetings to review performance, incidents, risk assessment compliance and shared learning. We asked for minutes from the charge nurses and sisters' meetings for the previous three months, however, were not provided with any.

The information we were given stated that minutes were not routinely kept for these meetings. We were provided with a list of standard agenda items for these meetings. We also asked for clinical governance meeting minutes for the past three months for the service.

We were provided with a selection of governance and risk meeting minutes from specialities in Medicine, dated from January 2023. Within this we were provided with evidence of an audit and clinical governance meeting specific to dermatology and a liver morbidity and mortality meeting. There was no evidence of consistency of meetings held in the information we were provided.

We also asked for the previous three months of care group performance meeting minutes. We were provided with minutes dated October 2021, April 2022 and January 2023. We were told that these meetings had been temporarily paused following the transition to the new clinical boards structure on the 1st of April 2023.

We were not assured of any consistent methods or approaches for feeding key information up and down through the service. We did not see a clear process for sharing key themes regarding risks, performance and learning opportunities. The staff survey completed as part of the inspection identified that less than half of respondents (45%) stated they heard about incidents and learning from other parts of the organisation. We were provided with information regarding key milestones within the transition. This information stated that clinical governance structures with clear lines of accountability were due to be devised by May 2023. Meeting structures within the board were to be devised by June 2023. We did not see evidence of these structures in place at the time of inspection.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not follow a clear process to identify actions to reduce their impact. They had plans to cope with unexpected events.

We did not see evidence of comprehensive assurance systems in place. The trust had a reporting hub and harm free care clinical board dashboards in place. Leaders reviewed these on a weekly basis. We were told anomalies or areas for concern in relation to risk would be discussed directly on the wards. Staff told us that information might be shared at handovers, however this was not recorded and there was no evidence provided to demonstrate how all staff received such information. There were no clearly identified forums for sharing information. We were not assured there was a clear process or vision moving forward for performance management, however recognised that the board was newly formed.

We were told about the services procedures for managing safety through audit and quality improvement. We were told that the incident reporting system was used to identify emerging themes that may warrant attention or intervention. We did not see evidence of discussion of emerging themes. We did see the clinical governance forward programme for 2022-2023. However, this was not an up-to-date plan. For example, the falls and fragility fractures audit programme was included. The timescale was recorded as 'report submitted October 2020'. The description stated the trust was fully

complaint with four recommendations and there were action plans in place for the other eight recommendations. We saw evidence that the trust had set out a trajectory for falls reduction and that there were actions in place such as increased education to staff, however we did not see clear action plans that identified dates for achievement, staff responsible for implementation of actions or re-audit dates.

Leaders told us about the top risks for the service. For example, staff shortages, increase of complexity of patients and increased violence and aggression. Staff we spoke to also identified these risks. However, we reviewed the service risk register and found this did not clearly align with the risks that we were told about. We saw six risks identified of which two related specifically to the emergency department. The other four risks we reviewed included winter pressures, staffing deficits, environmental issues on a community location impacting patient care and management of long covid patients.

It was not clear how risks were identified and escalated to the risk register with the latter two risks being added during 2022 and the earlier two being added in 2012 and 2013. We did not see the risks we had heard about clearly identified and did not see how accountability was assigned to each risk for development of or completion of action plans and risk mitigation. For example, staffing deficits were dated as identified in 2013, the description of the risk referred to increased absence due to covid-19 and evidenced recognition that staff retention and sickness could have been adversely affected by the pre-existing staffing deficits. We saw a 'controls in place' section which matched some staffing controls we had been told about, however there were no dates or named staff against these controls. We saw due and done dates against a number of action descriptions for this risk. For example, we saw an action to increase the number of healthcare assistants dated December 2015. We saw a done date for this of October 2018. For this specific risk there were six action descriptions ranging with dates from 2016 to 2018 and all were recorded as done in October 2018 with the exception of one dated 2015. However, the risk remained on the register, with additional concerns that would have arisen during 2020 onwards as a result of the pandemic. There was no clarity or further explanation of changing risks or named staff responsible for any ongoing review yet there was a review date of March 2023 recorded. The risks identified on the medicine risk register relating to medicine services were not reflected on the executive oversight register.

The Safer Nursing Care Tool was used to review staffing levels on wards and identify any areas of concern which would be raised to the trust board bi-annually. Staff told us about actions that might take place in the event of short-term staffing difficulties such as closure of beds, overtime for additional shifts, use of bank and agency staff, deployment of staff form other areas. Leaders considered short term changes such as higher acuity of patients at any one point in time. We saw there was a bed closure request form that could be used to consider temporary bed closures. This form directed staff to identify reasons for closures, actions taken to prevent closures and escalation plans should demand exceed capacity. We did not see any completed forms. We saw evidence of increased staffing establishments agreed following review over the years 2019/2020 with implementation of the increased establishments during 2021/2022, for example on ward 49. We heard that winter pressures would be considered in advance although we saw no clear plan. At the time of inspection, the winter pressure plan had not been agreed.

Leaders told us that the trust patient safety incident response plan was currently in development. Once complete we understood this plan would align with the trusts incident management policy. We reviewed the serious incident policy and found this set out clear guidelines regarding reporting and escalation of incidents and risks. We looked at mortality and morbidity review meeting minutes and saw that each consultant would update the database monthly with level one deaths and level two deaths would be discussed in the monthly meetings. We were told that recommendations would be made, and feedback discussed with individuals where needed. We did not see evidence of how or where feedback was provided when it was identified there was learning.

Medical care (including older people's care)

Information Management

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

We reviewed the trusts systems and processes for recording information. We found inconsistencies in these recording systems, for example there was a paper referral for the discharge service required. We found inconsistencies and variations in staff understanding of how to use the electronic recording system. For example, ward staff worked with the system daily and knew where to find information when working directly with patients, however senior staff struggled to find information and the digital health team had differing expectations of where information would be stored.

Staff told us that some of the data within the electronic recording system was not accurate. In a small number of records there was an issue with MUST score reporting via the dashboard, which had only been launched 3 weeks prior to the inspection. This was quickly rectified and explained to us by the Digital Health Team during the inspection. The MUST score recorded in the EPR was accurate and available to all clinical staff, there was not a risk to patient safety. We also saw inaccuracies within the electronic whiteboard system in relation to isolating patients. We identified that during the pandemic all patients who had to isolate for health reasons had been recorded as requiring isolation. We understood that there was now difficulty in removing these markers from the system and therefore, there was no accurate record on the display boards on each ward regarding which patients required isolation in real time.

We saw internet dropouts on some of the wards we visited and delays in reaching IT support when needed.

We found the electronic record system was not being used to its full potential. For example, care plan sections were not used, and daily activity entries relied upon for identifying the current plan of care.

The safety assessment dashboard currently includes moving and handling and falls risk assessments. At the time of the inspection the dashboard did not include additional key metrics, such as VTE assessments; we were told at a meeting with the Digital Health Team, plans were already underway to enhance the dashboard and expand the metrics included. Aspects of care related to nutrition and hydration are part of the clinical assessment and the usual handover processes.

We also saw that incidents which should have been reported through the National Reporting and Leaning data base were not reported in a timely manner. This had been raised to the trust prior to the inspection and was ongoing at the time of report.

During the inspection we heard information of concern regarding a backlog of ‘must sign’ letters following clinic appointments, patient treatments, operations and in patient stays across the trust. We were concerned that this had led to delays in patient’s receiving ongoing appropriate care if relevant healthcare practitioners had not received information detailing changes to treatment or conditions. The trust was asked to provide current information regarding the amount letters waiting to be sent out. The trust provided us with information that evidenced 1361 letters within the medicine and emergency care board required review for 2023 as they had not been signed off for processing further. In addition, there were a further 3548 letters that required reviewing for the years 2018 to 2022.

Engagement

Leaders did not always engage with staff to actively plan and manage services. Leaders and staff engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust participated in the National Patient Survey Programme and the NHS friends and family Test. Results were monitored by the patient experience monitoring group. The trust also had volunteer involvement groups who would provide patient perspectives on quality improvement projects, research proposals and service changes, for example Cancer Perspectives.

The trust engaged with a range of charity groups to support reducing barriers to groups who may have found it more difficult to access services. These included disabilities, carers and ethnic minority groups. The trust also held an equality, diversity and human rights working group quarterly. This was attended by local charity organisations and provided an opportunity for the trust to hear feedback from within the local communities.

The patient experience team visited wards on an ad hoc basis to talk with patients and hear their views on possible improvements, for example regarding cleanliness.

Staff participated in the annual staff survey. We saw one example of a ward area that had been identified following the survey as having concerns in relation to culture and staff relationships. We were told that the management team engaged with staff and invited staff to provide comments on key areas for improvement.

We gathered information from staff through a survey during the inspection. Staff who responded to this survey had the opportunity to provide comments. Staff consistently reported feeling disconnected from leaders. We heard the same reports when carrying out focus groups with staff as part of the inspection. Clinical staff in particular reported feeling physically disconnected from senior management as they were not visible to them. They felt they had no opportunities to feed into the processes that directly affected them.

A specific piece of work had taken place to engage with postgraduate doctors within the service on a quarterly basis to hear their views and to support improvements to working practices to make the service a more attractive place to work. For example, we were told that there had been a reduction of junior doctors from three to two on night shifts with extra support added from the hospital at night team nurse practitioners. This reduced the overnight burden and disruption to day shifts. We did not have any data provided regarding the review of these changes or impact to the wider service.

Senior leaders told us that clinical directors and directorate managers held forums for all consultants and senior nurses to attend. These were held with an open invitation via online meetings. We heard that a staff engagement strategy for the clinical board was due to be devised by May or June 2023.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They did not always have a good understanding of quality improvement methods and the skills to use them. Leaders did not always encourage innovation and participation in research.

We saw newsletters that were issued within the service entitled achieving clinical excellence for internal medicine at the RVI. These newsletters promoted current clinical topics for learning.

The trust had received feedback from staff that attending training sessions for additional learning was difficult due to ward and staffing pressures. In response to this we saw that visual education boards had been developed. This allowed staff to access education resources at a time convenient to them in their own ward environment. We saw boards that provided information that acted as prompts such as the ‘care for me, with me’ boards on some wards. We also saw boards that linked with events such as the learning disability awareness week.

Medical care (including older people's care)

We requested data regarding how services used lessons learned to improve services. Examples of five improvement projects trust wide were shared. We saw that they had been identified through lessons learned where there had been missed opportunities. For example, one project had arisen through recognition of two ways of recording urine output as part of fluid balance – one using the bedside electronic observation system and one using fluid balance chart in the separate electronic records.

Staff we spoke to were not able to give us detailed examples of quality improvement. However, we saw written evidence of local improvements that had taken place on wards such as development of dementia friendly activity packs and specific training sessions for students. We did not see evidence of how these initiatives were shared across wards.

Some staff told us that they had been supported with taking forward innovative ideas whilst others told us that they felt they had been dismissed and were not supported to promote quality improvement. We did see evidence of a trust wide 'Q Factor' award scheme which encouraged staff to create posters based on quality improvement and clinical effectiveness with cash prizes for the top three.

Royal Victoria Infirmary

Queen Victoria Road
Newcastle Upon Tyne
NE1 4LP
Tel: 01912336161
www.newcastle-hospitals.org.uk

Description of this hospital

The Royal Victoria Infirmary including the Great North Children's Hospital provides a full range of acute services including an urgent and emegency care department.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory Training

The service did not provide all mandatory training in key skills to all staff. The service made sure staff completed mandatory training.

Nursing staff received and kept up to date with their mandatory training. Completion of training for nursing staff at the time of inspection was 92.7%. However, nursing staff were supported by ward sisters to ensure there was time to complete this training. Clinical educators provided mandatory training days for qualified staff. These training days were held monthly for each staff member to attend on an annual basis.

Medical staff received mandatory training. Medical staff did not always keep up to date with their mandatory training. At the time of inspection 77.6% of medical staff had completed their mandatory training.

Overall, there was 89.9% compliance with mandatory training across the medical core services within the trust at the time of inspection. This was below the trust target of 95%. We identified that basic life support training rates had fallen for four months prior to inspection. These rates had increased to 73.3% across medical core services at the time of inspection. Senior staff were aware of this and identified that a new electronic system had been implemented which was more intuitive and supported a new system to allow staff to complete training before it expired. Ward sisters told us that they reviewed training compliance and supported staff to attend.

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

Clinical staff did not complete all comprehensive training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. We saw that mental health awareness training had been included within mandatory training since November 2022. Staff told us they had completed this training and we saw that compliance had reached 93.2% for medical cores services across the trust at the time of inspection. We also saw that 98% of staff had completed dementia awareness training and 87% of staff had completed learning disability awareness training. However, we were not provided with any clarity that the training specifically included autism awareness.

Staff we spoke to were not able to clearly articulate what autism specific training they had received. The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. Mandated training is in place within the trust for learning disabilities which is endorsed by the North East and North Cumbria ICS. The trust is also piloting the roll out of the Oliver McGowan training for learning disabilities and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward sisters and charge nurses told us that they reviewed training compliance and supported staff to attend. Matrons told us that they reviewed mandatory training compliance on a one-to-one basis with the ward sisters.

Medical care (including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have training on how to recognise and report abuse. Staff who had training knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. We reviewed the training compliance for safeguarding adults levels two and three. We found the medicine core service was 93% compliant with safeguarding adult level two training and 83% compliant with level three. The compliance rate for level three training was an improvement from previous months. However, we found no data to confirm that allied health professionals (AHP's) had completed level three safeguarding adults training. There was a safeguarding policy in place, but this did not specify the level of training each staff group required. This meant we were not assured that all staff had completed training appropriate to their role.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff we asked were able to give examples of circumstances and presentations that might indicate further consideration and referral for safeguarding concerns. Nursing staff identified that they would speak to the nurse in charge regarding any safeguarding concerns and knew how to contact the trust safeguarding team for advice. We were told that the nurse in charge would be the primary point of contact for ward staff. Staff told us they would alert their line manager and raise an immediate cause for concern form to make a safeguarding referral if they had concerns. We reviewed the trust policy for safeguarding and found staff were acting in line with this policy. The policy identified the trust adult safeguarding team as a single point of contact for all referrals to social care.

Cleanliness, infection control and hygiene

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

Ward areas were not always clean. We saw one area that was visibly dirty. We observed dust on the resuscitation trolley and specifically on the defibrillator pads packaging. However, there were suitable furnishings which were clean and well-maintained. Cleaning records were kept up to date. Each ward benefited from a housekeeper.

The service did not always perform well for cleanliness. Monthly Infection Prevention and Control (IPC) audits were carried out. We saw that wards and clinical areas did not always submit audit results. For example, one ward submitted reports for five out of six months and showed partial compliance for three out of six months with full compliance for two out of six months. On this ward we saw a bathroom area that was visibly dirty.

Staff did not always follow infection control principles. Staff told us hand hygiene audits were carried out as part of the clinical assurance tool on a monthly basis. There had been an increase in Covid infection rates on some medicine wards on occasions - because of this we were told that all staff were encouraged to promote hand hygiene and challenge poor practice.

We observed hand gel dispensers at the entrance to each ward.

Staff did not always clean equipment after patient contact, we found one bay area that was visibly dirty with dust and paper on the floor and commodes left unclean in the toilet areas. We did see equipment that was labelled to show when it was last cleaned.

We were not assured that all wards were maintaining good enough infection prevention and control practices. We reviewed infection rates for the wards and found there had been 13 Healthcare Associated Infections (HCAI's) across seven wards during the three month period of March to May 2023. This meant patients, staff and visitors could be placed at risk of spread of infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Access to all wards was via secure buzzer.

Patients could reach call bells and staff responded quickly when called. On one ward we saw that a call bell had fallen to the floor, this was picked up and placed within reach. However, we observed call bells on cords in private bays and in private toilet areas. These were a ligature risk. For example, on one ward we identified ligature risks throughout the ward. This meant there was potential for patient harm. We were not provided with a current ligature risk assessment for the ward.

Substances hazardous to health were not always stored in accordance with Control of Substances Hazardous to health (COSHH) Regulations (2002). For example, we found two bathrooms on ward 48 with cleaning products containing hazardous substances that were either in unlocked cupboards or visible to any person entering the unlocked room.

Staff carried out daily safety checks of specialist equipment.

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

Staff did dispose of clinical waste safely.

Assessing and responding to patient risk

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

Staff used the nationally recognised NEWS2 tool to identify deteriorating patients. The trust also recognised the importance of clinical judgement and recognition of additional clinical signs in identification of deteriorating patients, for example, unresolved pain. The trust had included additional clinical signs within the alerting process. These additions would not alter the NEWS2 score but would support clinical decision making.

NEWS2 escalation compliance was audited monthly across each ward and reported via the trusts Harm Free Care Dashboard and individually to each ward through ward meetings. The trust target rate for compliance with NEWS2 was 90%. Compliance rates as of 1st July were 85% for medicine services.

We reviewed 11 sets of notes across four wards at the RVI. We saw examples of two patients who had not had their NEWS scores repeated within appropriate timescales. There was no automatic alert on recording physiological observations to

trigger a change to NEWS scores. This meant that a response was dependant on the nurse completing a deteriorating patient alert which leaves a risk of delay to care and treatment of a deteriorating patient. On one ward we saw a NEWS2 score was not repeated as needed for a score of eight. On another ward we saw a NEWS2 was not repeated within the appropriate timescale. Staff repeated scores on prompting by the inspection team.

Staff completed risk assessments for each patient on admission to wards using recognised tools including falls risk, Malnutrition Universal Screening Tool (MUST), Braden risk assessment (for pressure risk potential), moving and handling, lines and devices, smoking and alcohol, and Covid tests.

All staff we spoke to told us that these risk assessments would be completed on admission and weekly thereafter except for Braden and lines and devices that were completed daily. All risk assessments would also be reviewed earlier if there was a change to a patient's circumstances indicating an earlier risk review, for example, a fall.

However, we found that this was not always the process within the same day emergency care department as the aim was for patients to be discharged home the same day.

All staff told us that matrons completed weekly audits regarding completion of assessments using the trust wide clinical assurance tool. We asked for copies of the recent clinical assurance tool audits and action plans for the wards we visited. We received monthly figures as a percentage for each ward. There were no actions shared.

Staff knew about and dealt with any specific risk issues. Staff were able to articulate risk concerns with individual patients well. Staff knew how to report and escalate risks.

Staff we spoke to demonstrated their understanding of the sepsis six protocol. Staff explained how to escalate concerns and contact the critical care outreach team.

However, the CQUIN audit information completed for 2022 -2023 showed that for trust inpatient admissions the service did not meet the operational standard of 90%. For the final quarter, a score of 63% was achieved. Within the medicine core service, the trusts automated recording process for recognition, escalation and treatment for sepsis was 40% compliance at the time of inspection.

The trust provided further information from a snapshot manual audit undertaken quarterly for those patients where the automated process was not used. This showed compliance of 54%. The trust carried out further monthly audit within ward areas reviewing five patients per month. This demonstrated that 100% of these five patients had appropriate escalation plans and review within one hour in place.

There was some inconsistency regarding the completion of venous thromboembolism (VTE) risk assessments. Completion of these assessments is the responsibility of medical staff and they are not routinely carried out by nurses. They were recorded in a separate location on e-records to the other risk assessments. We were told that medical staff would carry out these risk assessments and that nurses would prompt medical staff if they were missed.

The Venous Thromboembolism (VTE) Assessment and Management Policy stated that assessments would be carried out by admitting doctors (with exceptions of specialist nurses in specific clinical areas). The policy stated they would be re-assessed within 24 hours of admission and following clinical change. The trust wide VTE audit for completion of an assessment on admission showed 96% compliance for May 2023. This meant a total of 473 patients admitted trust wide did not receive a VTE risk assessment on admission. Data was not available specific to core service at the time of inspection.

Medical care (including older people's care)

We saw evidence of falls risk assessments in 11 of 13 patient notes reviewed. We did not access the two remaining assessments as at the time of the inspection the eRecord system was running slowly and we were unable to wait to track back to the assessments understood to have been completed. Two of these were not accessible as the e-record system was slow and would not allow us to track back to the assessments understood to have been completed. Staff told us about the bed rail risk assessment and demonstrated how to find the guidance for determining a need for bed rails.

We reviewed notes for six patients with bed rails in place and found that each patient scored for a risk of falls. However, we did not see evidence of the clinical rationale for use of bed rails and decision making beyond completion of the scoring system. Patient falls across the trust were reported to have increased during 2022 to 2023 by 25.6 %. However, falls resulting in harm remained static at 2% of overall falls. The trust told us that focussed auditing work had taken place regarding the enhanced level of care (ELOC) assessments for patients. We heard that this had led to the requirement for focussed education work to take place with all clinical staff.

Staff told us that pressure ulcers were reviewed through intentional rounding. On identification of a pressure ulcer a referral would be made through the e-record system to the tissue viability nurse team.

Patients were assessed by this team and a plan of care agreed. This plan of care would be documented within patient notes in an activity entry rather than a formal care plan document. The tissue viability team would close the referral once a plan for care was agreed and would accept re-referrals for review if there was a deterioration to a patient's pressure ulcer.

The review of pressure ulcers relied upon observations made by nursing staff and healthcare assistants through their regular checks. We were not able to identify detailed recording in the patient notes to evidence how staff unfamiliar with a patient's condition would recognise changes.

From 1 June 2022 to 31 May 2023, 66% of STEIS incidents reported by the trust relating to medical core services were in relation to pressure ulcers and slips/trips and falls. We saw evidence of falls risk assessments and assessments for pressure ulcer risks. Staff were able to describe and explain their knowledge of these risks, however, as there were no action plans formulated following completion of the monthly clinical assurance toolkit we were not assured regarding the process for monitoring and review of these risks.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). There was a psychiatric liaison team that worked into the hospital. Written referrals had to be made for this team to attend. Staff were aware of how to make referrals and knew when to make referrals.

Staff arranged psychosocial assessments and risk assessments by the psychiatric liaison team for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. For example, a handover took place at each shift change and written handover sheets would be shared.

Shift changes and handovers included all necessary key information to keep patients safe. Nurses worked from the handover sheet throughout the shift to inform care. The handover sheet included indication of risk, current plans of care, information on mobility, nutrition, social needs, and allergies. Nursing staff we spoke to told us that they would review e-records to get more detailed information as they needed it.

Staff also attended a multidisciplinary safety huddle each morning. This would be attended by physiotherapists and occupational therapists alongside medical and nursing staff. Therapy staff were not always able to attend every huddle due to covering multiple wards. Staff on the emergency assessment stroke unit told us how they would communicate regularly throughout the day following any specific patient multi-disciplinary meetings due to the high turnover.

Staffing

Nurse staffing

The service did not always have enough nursing and support staff with the right experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and proactively sought to fill staff vacancies.

On most wards we visited the actual nurse staffing met planned establishment. Where a shortfall was noted, we found that appropriate staffing levels were achieved by temporary closure of bays following a risk assessment, to maintain safe staffing levels and patient safety.

We found one ward where there were three nurse vacancies and two healthcare assistant vacancies. Staff told us that there were international recruits taking up some posts but often recruitment was done externally to the ward and staff allocated to wards from a pool. This meant that staff were not always placed in a speciality of their choice and some staff had moved on quickly. This meant there was instability of staffing on the ward. We heard that across the Medicine and Emergency Care Clinical Board between the two hospital sites there were 12 staff nurse vacancies of which 11 had people appointed to, awaiting to start. There were 30 (5%) healthcare assistant vacancies with active recruitment in place and a number of posts filled.

Leaders had an oversight of the staffing and reviewed this across the two hospital sites. Where there had been previously high vacancy and turnover rates in one ward area there had been adaptations to the recruitment process such as involving ward staff directly in their own recruitment rather than new staff being allocated through a pool. This was aimed at retention of staff.

On the wards staffing requirements were calculated by the senior sisters using the recognised Safer Nursing Care Tool (SNCT). There was a safer care meeting twice daily to review the staffing levels for day and night shift. Any staffing shortages would be raised through this meeting and additional staff identified following escalation.

Staff we spoke to told us that bank staff would be used if needed but this was rare that such additional cover would be needed. Staff explained that where possible wards would be staffed with a range of experience and grades. However, during staff focus groups we heard that often more experienced staff had chosen to leave recently, and wards were staffed with less experienced nurses.

The ward manager could adjust staffing levels daily according to the needs of patients. There was a red flag system in place to escalate staffing pressures along with a twice daily safe care review of staffing levels for each shift. There was also a ‘safer Friday’ review to ensure adequate staffing for the weekend shifts was in place.

On most wards we visited the number of nurses and healthcare assistants matched the planned numbers.

The service had reducing sickness rates and were in line with the sector average.

The service had low rates of bank and agency nurses used on the wards.

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

Medical staffing

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

The medical staff did not always match the planned number. Within medicine services the planned number of doctors across all grades was 318. There were 267 in post. For consultants, there was a fill rate of 112 out of 125 (89.6%). We were told that a team worked to ensure all shifts were filled with enough medical cover. There was a six week rolling rota and a dashboard that supported looking ahead to ensure there was always cover. Staff on the wards we visited told us there was enough medical cover.

The service had consistent vacancy rates for medical staff since 2021.

The service had consistent turnover rates for medical staff since 2021.

Sickness rates for medical staff were low.

The service had consistent rates of bank and locum staff.

Managers could not always access locums when they needed additional medical staff. The fill rate was 46.67% for locum posts.

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

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

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, and easily available to all staff providing care. Records were stored securely.

Patient notes were not comprehensive, and all staff could not access them easily. There was an electronic record system in place that had been implemented in 2019. We spent time reviewing patient notes with matrons, ward sisters, staff nurses and with the digital training team made up of staff with nursing backgrounds.

All groups of staff took lengthy periods of time to navigate the system and find information required to be able to understand a patient's needs. This meant there was a risk of patient care being delayed or a risk of missing important information. There was a disconnect in where ward staff were recording information and where the digital training team would expect to find information.

There was no evidence of a clear record keeping process and no evidence of regular record keeping audits specific to each ward. We saw results from the most recent trust wide record keeping audit dated October 2022. Over a five day period four sets of notes from each ward were reviewed. For medicine core services we saw variations in the results for the question 'Is daily nursing handover communicated using the appropriate standardised proforma?' Two of the seven

wards scored 100% whilst two scored 75%, three scored 50% and two scored 25% for compliance. There was an action plan in place to ensure the effective recording of details relating to patient conditions were handed over to ward colleagues using appropriate documentation. There was a timescale for reaudit in January 2024. There was no detail included regarding the monitoring of this between the audit completion date and the re-audit date.

The electronic patient record system provided a combination of discrete prompts for patient care and clinical decision support (tick boxes) and free text to document clinical reasoning and rationale. We did not always see the free text areas being used to the full potential to evidence clinical reasoning. Notes were not always contemporaneous as some staff recorded an addendum below a previous entry.

However, staff were used to this practice and would look for any additional information in addendums. There were no clear care plans recorded within the care plan section on the system. Templates had been introduced for use within activity recordings these included prompts for each area of concern to be considered and were completed by staff on each shift for their own patient group. We saw evidence of completion of these on each ward we visited. This information did not transfer into a handover document resulting in nurses completing an additional handover sheet. There was a risk that key information could be missed.

During the inspection staff could not always access patient information promptly using the electronic patient information system.

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

Records were stored securely.

Medicines

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

Staff did not always follow systems and processes when prescribing, administering, recording, and storing medicines. On our first inspection we found medicines were not always stored securely or safely. Fridge temperature records were not recorded consistently and when out of range no actions were taken. No room temperature monitoring was in place, therefore, we were not assured that medicines were fit for purpose.

We were also not assured that stock control systems were effective as we found five medicines that were out of date. The security and storage of medicines was raised with the trust during the first inspection.

On our second inspection we returned the same areas and saw a marked improvement in security and storage of medicines. This was because of concerns raised during our first inspection. However, room temperature monitoring was still not in place, therefore, we could not be assured that medicines were being stored in line with the manufacturer's instructions.

We reviewed four patient medication records and found that for the records we looked at medicines were prescribed appropriately. However, oxygen was not always prescribed in line with trust policy. Oxygen cylinders were not always stored securely. At our second inspection we found oxygen cylinders had been stored securely on the assessment unit where they previously had not been.

Controlled drugs were managed in line with the providers policy and pharmacy controlled drug checks were taking place.

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

We saw examples where pharmacy staff provided discharge planning and support to patients where appropriate, for example on the assessment unit daily.

Staff completed medicines records accurately and kept them up to date.

The trust prescribed medicines using an electronic prescribing system. On medical wards we found these were logged out after use with restricted access in place ensuring prescriptions could not be accessed by the incorrect staff.

Staff did not always store medicines safely. On one ward we found an unattended trolley with two prefilled saline syringes and medication trays. Ward staff were made aware of this and correctly stored the items. On another ward we found two sets of patient medications on a bench in a clean utility room. We raised this with a member of nursing staff who stated they were about to be used.

Staff did not always follow national practice to check patients had the correct medicines when they were admitted or moved between services. Pharmacy staff on the assessment unit informed us that discharge planning took priority over medicines reconciliation, this was also corroborated by other pharmacy staff at focus groups undertaken as part of the inspection.

Although the trust had an electronic prescribing system in place the trust was unable to provide real time medicines reconciliation figures therefore, we could not be assured that the trust had the required level of oversight to report on their key performance indicators (KPI) of medicines reconciliation being completed within 24 hours.

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

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

All staff knew how to report incidents but did not always recognise what to report as an incident and therefore did not always report incidents in line with trust policy. We heard from staff that patient harm should be reported but incidents where omissions had been made but there was no harm did not need to be reported.

We found no evidence managers shared learning with their staff about never events that happened elsewhere.

We were not assured staff reported serious incidents clearly and in line with trust policy.

We were not assured that actions from patient safety alerts were actioned and implemented. We found boxes of superabsorbent polymer gel granules in a clean utility room that was unlocked. There was a national patient safety alert issued in 2019 stating the need for secure storage due to risk of death or severe harm from ingesting superabsorbent polymer gels.

Medical care (including older people's care)

Staff we spoke to understood the duty of candour. We saw an example of a review of care where duty of candour had been actioned.

Staff gave us varying feedback regarding sharing of information from investigation of incidents within their clinical environment. Some staff told us this happened whilst other staff were not able to articulate any incident feedback that had been shared. A survey we carried out with staff as part of the inspection identified that of those staff completing the survey 45% stated they heard about incidents and learning from other parts of the organisation.

Staff met to discuss the feedback and look at improvements to patient care. Ward sisters told us that there was a meeting twice monthly to discuss incident report submissions. This information would then be fed back to staff through team meetings or through daily handovers. However, we did not see documented evidence such as minutes from these meetings as none were available.

There was evidence that changes had been made because of feedback. For example, we were told that following a serious incident regarding pressure damage there had been additional training provided regarding moving and handling and provision of equipment to the ward to minimise a reoccurrence of risk.

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

We heard mixed views from staff regarding debrief and support after serious incidents. Some staff told us they felt supported, however other staff during individual conversations and through focus groups told us that they felt there were no formal support mechanisms available for debrief.

Staff provided strong views that all ward-based staff and immediate line management were very supportive of each other, however, did not feel that this was replicated, or their needs fully understood from more senior management who did not work on the wards on a daily basis.

Is the service effective?

Requires Improvement 

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. On one ward we found that staff were not aware of the guidance or protocol for major haemorrhage and there was no major haemorrhage trolley in place. This was raised to ward staff at the time of inspection and staff were able to locate the major haemorrhage protocol on the intranet.

On all wards we visited we saw that nursing care plan documents were not used. Therefore, we were not assured that care was delivered in accordance with best practice. We saw evidence of tick box completion of the standard set of risk assessments that would achieve adherence with a range of National Institute for Clinical Excellence (NICE) guidance, however we did not see evidence of clinical rationale regarding all care provided.

In the absence of effective care planning there was a risk that patients received incomplete care and treatment and the success of any care provided could not be measured accurately.

We saw that there was an annual audit plan for reviewing the processes for the implementation of NICE guidelines. However, we did not see a copy of the completed audit for 2022/23. We reviewed the annual audit report for the directorate of medicine dated June 2021 to May 2022. We found that there were outstanding and incomplete actions on a number of national audits and NICE guidance identified. For example, there were three NICE guidelines relating to diabetes management with areas of non-compliance. It was understood that increased clinical pressures had impacted on the timely completion and development of actions. We did not see evidence that actions had since been completed, therefore, were not assured of compliance with all national guidance.

We saw display boards with sepsis awareness information guiding staff to complete sepsis screening and management in line with National guidance. Staff we spoke to were able to explain sepsis screening and management. We saw evidence of audit that identified action plans including increased education and awareness training to staff regarding the timely completion and recording of NEWS2 scores.

We reviewed the trusts own intranet system and saw that staff had access to policies, procedures, and guidance on the intranet. Nursing, medical and AHP staff were able to articulate rationale for their clinical practice with evidence-based practice examples. We saw examples of evidence-based practice displayed on wards such as dementia awareness and involving carers.

Staff did not always protect the rights of patients subject to the Mental Health Act or followed the Code of Practice. Across the trust we found inconsistencies in staff understanding of the Mental Health Act and of their role within this. Since our inspection in November 2022 there were folders on each ward containing information regarding the Mental Health Act, however, we found staff did not have detailed knowledge regarding the difference between their own role and the role of the local mental health trust that would be working alongside them with some patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff did not always record nutritional and hydration needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs.

During inspection we saw staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We heard examples of nutritionists attending wards and catering staff being invited onto a ward to discuss food options with patients. We heard of one initiative by housekeeping staff to offer additional snacks throughout the day. We saw menus that included a range of dietary choices, for example, gluten free, halal and vegetarian options. Food was checked against patient preferences before being given.

Staff did not always fully complete patients' fluid and nutrition charts where needed. We saw evidence of gaps in food and fluid charts. For example, we reviewed eight sets of notes across three wards and found none had a food chart in place. Of these eight there were two patients notes that had fluid charts in place. We could not, therefore, be assured that all patients consistently received enough food and drink to meet their needs and improve their health.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, we found that scores were not always calculated. Staff told us they were aware there had been some challenges with recording nutrition and hydration needs including completion and scoring of MUST scores. The weight and height were being recorded but the score was not being calculated correctly.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. If a specialist diet was recommended there was a colour coding system in place reflected within the kitchen area and at a patient's bedside. We saw nutritional advice displayed on the wards.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw pain charts were in place and pain was checked regularly and recorded in the patients e-records. Pain was reviewed through regular intentional rounding.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

There was a pain team available for extra support. Staff knew how to contact this team.

Patient outcomes

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

The service participated in relevant national clinical audits for example the sentinel stroke national audit programme (SSNAP), national respiratory audit programme (NRAP), national diabetes audit, managing frailty and the national early inflammatory arthritis audit.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Results for the annual SSNAP audit were consistently high nationally. The trust was rated as an A overall scoring within the top 12% of the country. However, the managing frailty benchmarking exercise identified that the service had no dedicated acute frailty service in place.

Whilst the service did not have a dedicated acute frailty service (AFS), it was able to deliver the core parts of an AFS as demonstrated in the managing frailty benchmarking action plan we received. This action plan assured us that the Trust was aware of opportunities for improvement and was actively working on these; this includes engagement with the Frailty CQUIN 2023/24. The Trust had established a frailty steering group to have oversight of this action plan and drive continuous improvement in frailty screening and other areas as outlined in the managing frailty report. However, there was no date by which to achieve these actions.

Managers and staff carried out locally agreed routine audits using the clinical assurance tool. Managers and staff told us these results would be shared with staff and areas of concern would be a focus for improvement giving examples of completion of MUST scores and pressure care. These audits were repeated monthly to check for improvement over time.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

We did not see any clear processes for sharing and making sure staff understood information from the audits.

The service was accredited by Royal College of Physicians for Quality in Primary Immunodeficiency Services (QPID) in November 2022. Accreditation was for 5 years subject to successful annual review. The service was accredited by Joint Advisory Group on gastrointestinal endoscopy (JAG) in June 2022 for one year.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance. Managers held supervision meetings with them to provide support and development.

Staff were not always experienced. Staff we spoke to told us that there were greater numbers of more junior lesser experienced staff working within the service as experienced staff had moved on. Staff told us that in response to this there was a drive to ensure that there were harm free care leaders identified within each ward for a range of subjects. Most wards we visited had identified staff to take on these roles where staff had a specific interest area.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to who were new to the service told us they had felt well supported by their peers and direct managers. New staff had a named mentor identified. Clinical educators told us that all newly qualified nurses completed a preceptorship and induction training. There was also an 18 month pathway to follow which was bespoke to clinical areas. There was a set of competencies for each area and specific training days set up to support staff to achieve competencies, for example, a tracheostomy day and neuro observations. Some competencies required signing off based on knowledge base or skills set for example, cannulation.

International nurses moving from overseas received an additional six week 'boot camp' training. There was a specific lead for the support of international nurse recruits. We heard examples of how the diverse needs of international recruits were recognised.

Managers aimed to support staff to develop through yearly, constructive appraisals of their work. The trust target of 95% was not achieved. For the medicine core service, the appraisal completion rate for May 2023 was 75%. This rate had remained stable throughout the previous year. Clinical educators supported appraisals, however, this post was vacant at the time of inspection with a new member of staff due to start.

Staff we spoke to told us they felt supported by their managers to develop through regular, constructive clinical supervision of their work. Staff told us that healthcare assistants and associate practitioner staff were supported and encouraged to progress.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. For example, Junior doctors told us they felt well supported by consultants and had regular meetings set up at the beginning and end of rotations with opportunities in between to seek support when needed. They also had the opportunity to attend weekly teaching sessions.

Managers held team meetings for all staff to attend. However, there was variation in the format and style of team meetings. Some team meetings were held formally for all staff to attend whilst some wards relied on sharing information through daily MDT meetings and safety huddles, for example any learning from serious incidents. We also heard one ward completed a monthly bulletin to share with staff.

Managers told us they identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, results for the staff survey demonstrated that 54% of people completing the survey for the core service identified they felt they had opportunity to develop in their career. 28% felt that the appraisal process supported them to set clear objectives for their work. 58% felt able to access the right learning and development opportunities when needed to.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, we observed daily MDT meetings including consultants, junior doctors, nursing staff, physiotherapists and occupational therapists. We saw evidence within these meetings of discussion regarding referrals to other professionals to support patient care such as the social work team.

Allied health profession (AHP) staff told us there were some staff shortages of AHPS across the core service and that it was not always possible to attend daily meetings for all wards where one staff member covered multiple wards. AHP staff worked as a team to prioritise patients who were due to go home sooner rather than the longer stay patients. This meant that longer stay patients did not always get the therapy interventions that they needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us there was a learning disability specialist team available within the trust to refer to for advice. The trust had 24-hour access to psychiatric liaison, specialist mental health support and a specialist learning disability team. The specialist learning disability team was available Monday to Friday. In most services there was a reliance on the psychiatric liaison service to provide an assessment of patients' risks and a management plan.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff knew how to make mental health referrals.

Patients had their care pathway reviewed by relevant consultants. For example, patients accommodated on non-medical wards due to medical bed shortages, were reviewed by the appropriate consultant for their care needs. The list of medical boarders was updated and reviewed daily. Each ward had contact details for the relevant consultant.

Staff we spoke to told us there was good teamwork across all disciplines. Staff liaised with the multi-disciplinary team directly. For example, referrals would be made to tissue viability nurses, learning disabilities, team, diabetes care, dieticians, and the falls team.

Seven-day services

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

Consultants led daily board rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Junior doctors were present on the wards daily and had access to more senior doctors as needed. All doctors we spoke to felt the arrangements for cover regarding patient care was sufficient to meet needs.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was a hospital at night team available during the night. Physiotherapy and occupational therapy staff operated a seven-day service.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. For example, we saw information posters regarding nutrition.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff asked each patient about smoking and alcohol on admission. We saw evidence of alcohol awareness and smoking awareness displayed on wards. There was an alcohol liaison nurse and smoking cessation service that could be easily accessed by staff for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always clearly evidence that patient's consent had been gained. They did not support patients who lacked capacity to make their own decisions.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. A recent audit demonstrated 62% compliance with conducting assessments of capacity across the trust.

We heard mixed views from staff we spoke to regarding the level of confidence and whose responsibility it was to complete capacity assessments. For example, on one ward we were told clearly that the understanding of capacity assessments was the responsibility of all staff. On another ward we heard that doctors would take responsibility for capacity assessments and nurses would then complete Deprivation of Liberty Safeguards (DoLS) where capacity was lacking, and best interest decisions had to be made.

When a patient's capacity to consent was queried, staff did not always undertake appropriate assessments of their mental capacity to determine the need for best interest decisions to be made. Staff did not always consider patients' wishes and the views of relevant people including family members.

During our inspection in November 2022, we found examples where staff had not established whether patients lacked mental capacity to make decisions about their care and treatment, however, indicated care was being provided 'in their best interests'. On this inspection we found this phrase was used less and more consideration given to assessing a patient's capacity before using the best interest terminology which was an improvement. However, we did find there were still inconsistencies in recording mental capacity assessments, best interests' decisions and DoLS. For example, we found inconsistencies regarding the recording of capacity assessments and best interests' decisions where there was a DNACPR in place for a patient lacking capacity.

Staff did not implement Deprivation of Liberty Safeguards in line with approved documentation. We saw evidence of a patient with a DoLS recorded as being in place, but staff could not locate evidence of the Mental Capacity Act (MCA) documentation or decision-making process. Staff were unclear regarding which profession would be responsible for the completion of this. Staff told us that sometimes they might just write in the notes rather than a specific identifiable area of documentation.

Medical care (including older people's care)

We found that patients subject to DoLS had this highlighted on the banner of the electronic records, so this was easy to see. Patients with a DNACPR in place also had this highlighted on the banner.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patient records.

Patients we spoke to told us they were informed of treatment options. However, we did not see detailed records to evidence these conversations always took place. We did not see detailed rationale documented where patients were found to lack capacity. For example, on one record we reviewed we saw 'best interests and discussed with family' recorded. The trust recognised that there was a need for a visible section in the e-records for staff to evidence their decision making. The format of this had not been finalised at the time of inspection.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance specific to the Mental Health Act and Mental Capacity Act although they knew who to contact for advice.

Mental Capacity Act level one e-learning had been completed by 88% of staff in May 2023. This was a significant improvement to 32% in April 2023. A package for level two training was being developed.

There was a Mental Capacity Act policy in place, however this was not updated to reflect the training requirements and responsibilities of staff in completion of mental capacity assessments. For example, it referred to optional Mental Capacity Act training for areas where this was felt necessary.

Managers monitored the use of Deprivation of Liberty Safeguards but did not always make sure staff knew how to complete them.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. A Mental Capacity Act steering group had been instigated following the previous inspection. The minutes from the group gave us assurance that practice was being reviewed and future action plans were discussed.

We found some improvements in practice since the focussed inspection was carried out in November 2022. We saw that each ward had a 'care for me, with me' folder in place that provided staff with guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff were aware of these folders and were familiar with the trusts plans for staff to become confident in completion of capacity assessments and Deprivation of Liberty safeguards. All staff we spoke to were aware they could contact the MCA lead for advice. Staff also knew how to contact the safeguarding adults' team for advice regarding MCA and DoLs.

Is the service caring?

Good 

Our rating of caring went down. We rated it as good.

Compassionate care

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

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. We observed nursing, healthcare assistant, therapies staff and housekeeping staff interacting with many patients. We saw staff took time to interact with patients and those close to them in a respectful and considerate way on all wards we visited. We saw patients had been supported to sit up in chairs or bed depending on their needs and wishes. Patients had been supported with self-care when needed.

Patients we spoke with said staff treated them well and with kindness. We observed all patients to have call bells available and evidence of regular comfort checks through intentional rounding. Patients told us that they were supported to be as independent as possible in maintaining their self-care. Patients told us they felt they were made to feel comfortable.

Staff followed policy to keep patient care and treatment confidential. Patients bed curtains were drawn when care was being provided.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, we observed one confused patient being guided sensitively and gently back to the correct bay area.

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff we spoke to told us that being able to provide good care to their patients was very important to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw an example of a caring nature and good communication between a nurse and patient.

We were told nurses would provide bereavement support to families and carers immediately after a death. Ward staff had access to a range of leaflets providing practical support advice and contact numbers for external agencies. The chaplaincy team were available 24 hours a day and seven days a week. End of life and palliative care nurse specialists were available seven days a week to provide short intervention bereavement support.

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We spoke to seven patients. Five patients we spoke to told us they had been fully informed about their care and treatment. Patients said that where possible their families had been kept informed. However, two patients felt that they had not always been heard and that they were not always clear on their care plan because they had seen different staff.

Medical care (including older people's care)

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. We saw one example of a sign language interpreter being used to communicate with a patient.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw examples of 'you said, we did' boards on wards we visited.

Staff supported patients to make advanced decisions about their care, however, did not always document this clearly.

Staff supported patients to make informed decisions about their care, however, did not always document this clearly.

Patients we spoke to gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

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

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

The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers did not always plan and organise services, so they met the changing needs of the local population. Staff told us that the patient population had become more complex following the covid -19 pandemic. Patient conditions have become more complex to assess and treat because of patients not being seen as early as they might have been before this period. Staff told us that patient expectations seemed higher. Staff told us that experienced nurses have left and are replaced by newer less experienced nurses. Some staff felt that these changes had not always been recognised by senior managers. We heard in some areas that staff felt they were expected to work outside of their scope of practice.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust reported 65 breaches across the trust for the month prior to inspection. These breaches were classified as where a patient requiring level two care or enhanced monitoring / assessment were not able to move to a single sex area within 4 hours of being ready to move.

Facilities and premises were appropriate for the services being delivered.

Staff could not always access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. The trust was working with the local psychiatric liaison team and the wards to improve working practices. We requested data for response times from making a referral. We were told this data was not always recorded sufficiently to be able to calculate a response time. However, based on the data available, we saw the average response time for wards was 1440 minutes (24 hours), the average response time of those with accurately recorded data across all wards on the site was 1690.76 minutes.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, there was a critical care outreach team that staff knew how to access. There was a diabetes in reach service available seven days a week.

The service relieved pressure on other departments when they could treat patients in a day. For example, same day emergency care (SDEC) was provided in the SDEC department. This provided a same day service to patients, improved patient experience and reduced hospital admissions.

The service worked with local charity groups to better understand barriers faced by minority groups and to identify ways to overcome these, for example, difficulties faced by deaf patients. Feedback from local communities was also gathered on a quarterly basis through an equality, diversity and human rights working group attended by several charities representing a range of people.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They did not always coordinate care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service applied the 'Dementia Friendly Charter'. Staff received training during induction for dementia awareness. Staff compliance with dementia awareness training was 98%. The service had a specialist dementia care team who were able to provide specialist assessments and treatment plans based on holistic assessments. The service used the 'forget me not scheme' to identify patients with dementia needs.

The trust had taken part in the National Audit of Dementia. Results published in August 2023 demonstrated that improvements had been made since the previous year's audit in areas including delirium screening, pain assessments and discharge planning for patients who met the criteria for the audit.

Some wards supported patients living with mental health problems, learning disabilities and dementia. For example, on ward 48 we were told about an initiative to ensure that all clocks were displayed clearly with the correct time and that all patients had their glasses within reach.

Wards were not always designed to meet the needs of patients living with dementia. We saw signage within the wards to identify bathroom and toilet areas. However, we saw evidence of equipment stored in corridors, we found rooms unlocked and COSHH substances accessible. This posed a risk to patient safety

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff told us they were aware of hospital passports. Each ward had a 'care with me folder' in place. We saw that these folders had been implemented since the focussed inspection in November 2022. These folders had been designed to give staff guidance on working with patients with co-existing mental health needs who were detained under the Mental Health Act.

The guidance stated that patients with a learning disability or autism should come into hospital with a learning disability passport. We reviewed records of a patient with complex physical health needs and a learning disability. There were no care plans in place to support the management of the patients' complex needs. We did not see evidence of how the staff had worked with other care providers to ensure the care provided was appropriate to meet the individuals' additional needs.

Medical care (including older people's care)

Prior to inspection we had received four concerns regarding lack of communication where individuals had complex needs, for example, communication between ward staff and care homes.

We did not see evidence of staff documenting how care was provided in line with hospital passports within the patients' electronic record. We reviewed the audit that was carried out monthly as part of the clinical assurance tool and found that whilst some wards scored 100% for patients with a confirmed learning disability having a passport in place and evidence of this being discussed two wards out of seven scored 50% and 55%. We did not see evidence of how audit scores were reviewed or followed up.

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw evidence of staff using interpreters during inspection.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus included a range of options to meet specific needs.

Pastoral care was available from a multi- faith chaplaincy service.

Access and flow

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

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. For example, the percentage of patients treated within 18 weeks slowly declined from 78% in May 2022 to 71.5% in March 2023. However, this was better than the England average of 65.8%. Referral to treatment times across the trust where patients were waiting more than 52 weeks had increased by 101 patients in the year from March 2022 to March 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. We were told there was a system in place to check daily which patients no longer met the criteria for right to reside, for example those with oxygen requirement and NEWS scores requiring hospital treatment. Those patients who did not meet the criteria to reside were reviewed by ward staff and would be referred to the discharge hub if their treatment could be provided at home. If patients did not meet the criteria to reside for more than two weeks the 'Newcastle System Escalation Process' would be followed. A multi-disciplinary team meeting would be convened and if there was still no resolution for a discharge plan after a further week then a complex case discharge escalation group would meet to agree a final decision.

There were no incidences reported of staff moving patients between wards at night.

Managers monitored that patient moves between wards were kept to a minimum. We saw some evidence that the trust monitored inappropriate transfers through the incident reporting system. We saw no evidence of inappropriate moves.

Managers and staff started planning each patient's discharge as early as possible. There was a discharge team and funding was in place for a discharge service lead. This post had been in place since March 2023 with the aim to embed the discharge process and to support staff in understanding criteria to reside.

Some past difficulties had been identified, for example not all staff had understood the criteria to reside. Staff told us that there were some delays in planning discharge because paper-based referrals were required for the discharge team and the spreadsheet system used for identifying patients ready for discharge was only accessible by one member of staff at a time.

We were told about the discharge improvement programme that included a new platform for electronic discharge processes to be set up. This also included a series of videos that were due to be launched in September 2023 to support staff, patients, and carers in understanding the discharge process and supporting safe discharges.

Staff planned most patients' discharge carefully, particularly for those with complex mental health and social care needs. On some wards we saw evidence of discharge boards with completion of tick lists to ensure all tasks had been carried out prior to a patient discharge. This was in response to recognition that there could have been improvements made to complex discharges.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. We heard that all non-medical wards had contact details for the appropriate medical consultant who would review their patients. The trust told us that at times of surge in numbers of medical outliers a dedicated border team would be assembled to ensure review of all patients.

Managers worked to minimise the number of medicine patients on non-medicine wards. We saw that the number of medical boarders across medicine had fallen significantly from 205 in January 2023 to 32 in June 2023.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. For example, they would speak directly to ward staff or contact the trust patient experience department. Senior ward staff would speak directly with patients and their families where concerns were raised verbally.

The service clearly displayed information about how to raise a concern in patient areas. There were posters displayed in ward environments explaining how to raise a concern.

Staff understood the policy on complaints and knew how to handle them. Senior ward staff would investigate complaints relating to their own ward. This supported ownership of any learning or actions required following complaint review.

Managers told us they investigated complaints and identified themes. We asked for a breakdown of the number of complaints for the service. We received figures without any further context to the complaints. We saw there had been 10 complaints over the previous year received regarding general medicine and seven for older peoples' medicine.

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

Staff told us feedback from complaints was shared and learning was used to improve the service. However, we did not hear any examples of complaints where learning had taken place during our inspection.

Medical care (including older people's care)

Staff could give examples of how they used patient feedback to improve daily practice. For example, on some wards we saw that patients had expressed concern regarding the amount of food available between mealtimes and this had led to a change to increase availability of snacks throughout the day.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced.

Ward managers were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Clinical specialities across the trust were organised within clinical boards. The Clinical Boards were established on 1st April 2023 and the transition from the previous Directorate structure commenced. Director of Operations were in post and the handover period began. The Clinical Board Chair commenced in May and the Head of Nursing for Medicine was not due to start in post until October 2023.

The service was part of the Medicine and Emergency Care Clinical Board. Each ward had an identified matron with responsibility for several wards within the speciality area. Each ward had senior sisters in post as leaders within the ward environment.

The senior leadership team had a range of experience and an understanding of each other's role which allowed them to complement each other's skills. They described the current challenges to the service including workforce shortages, changing challenges from patients such as increases to violence and aggression and a need to instil value back into the team. They recognised external factors creating internal challenges such as difficulties with delayed transfers. It was recognised that this was a national issue and consideration had been given within the service to expanding the medical footprint to ensure there were always enough beds for admission. They also recognised that this pressure may become more predominant again in the winter months and that forward planning was needed to be able to respond to pressures.

Senior sisters had the right skills and abilities to run the services.

Senior sisters understood the priorities and issues the service faced. They recognised changing demands on services including patients presenting with more complex health needs, increased violent and aggressive behaviour from some patients and staffing challenges.

Staff told us that their senior leaders external to the wards were not visible. Staff told us about the recent reorganisation into boards, however, were unclear about their direct leadership beyond their immediate line management. Staff told us members of the executive team were rarely seen.

Junior staff told us that senior ward staff and ward sisters were always accessible and supportive. Staff felt that they were supported by their immediate team leaders to develop. We saw evidence on each ward we visited of staff being supported to take on lead roles as harm free care leaders. We heard that staff were able to volunteer according to their specific interest area and skill set.

Vision and Strategy

The service did not share a clear vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were not clearly focused on sustainability of services or aligned to local plans within the wider health economy.

The trust had an overarching vision and strategy to be achieved over the 2019-2024 period. The trust was also in a process of embedding new clinical boards across core services. Staff we spoke to were not able to clearly describe the role of the clinical boards and how these would impact upon direct patient care.

Staff we spoke to were aware of some aspects of the trust vision and strategy such as the Flourish campaign to support staff to achieve their potential, however, staff saw this an outward facing public relations exercise and could not articulate the benefits to themselves.

The vision and strategy were developed prior to the reality of the covid -19 pandemic and therefore, was not current in reflecting the changing demands of health care post pandemic. Staff we spoke to recognised that patient needs had become more complex, patient expectations felt greater, there was an increase in violence and aggression from some patients and an increase in patients with co-existing mental health problems.

Alongside these challenges there had been an increase of experienced staff leaving or moving onto other roles which meant the wards were staffed with newer and less experienced staff. Ward staff and ward leaders that we spoke to were clear of these challenges and able to describe their own service vision to support staff in achieving a back-to-basics approach to ensure that all staff were skilled in appropriate risk assessment and care provision. We saw evidence of this through the implementation of harm free care leaders. We also heard that some senior leaders within the core service recognised the importance in finding ways to instil value back into the team.

Culture

Staff did not always feel respected, supported, and valued. The service did not always promote equality and diversity in daily work and provide opportunities for career development. The service did not have an open culture where staff could raise concerns without fear. However, clinical staff were focused on the needs of patients receiving care and continued to drive positivity. The service had an open culture where patients and their families could raise concerns.

Ward staff demonstrated a culture of good care towards their patients. We saw that ward staff were focussed on the needs of their patients. We heard that patients had opportunity to raise concerns with senior ward staff and resolve any concerns at that level.

We heard that staff were proud to work for the organisation and recognised the good care they provided. We heard from staff working in direct patient facing roles on a day-to-day basis that they worked well as a team to prioritise patient needs. Staff supported each other and felt they could raise concerns safely within their immediate line management. Staff felt that ward sisters were approachable and supportive. One comment within the staff survey carried out as part

of the inspection highlighted how committed staff were and how hard staff had worked over recent years 'to continue to deliver the highest standards'. We also saw staff comment on feeling 'very supported by the immediate line management team' however, senior management were 'never visible and communication was poor' with 'blogs and tweets promoting a false image of everything being fine'.

Staff told us they did not feel respected supported or valued within the wider organisation. The recent staff survey carried out identified that whilst 72% of staff who responded felt their immediate manager valued their work only 32% of staff felt they were satisfied or very satisfied that the organisation valued their work.

We heard mixed views from staff regarding equality and diversity. We heard from two staff speaking out within the trust that they felt they had experienced discrimination due to disability or gender. We reviewed the trust staff survey results for medicine and found that of those staff completing the survey 61.1% had answered yes to the question 'Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?' Seventy-four percent of staff completing the survey responded to say they agreed or strongly agreed that the organisation respects individual differences. Ninety-six percent of staff reported they had not experienced discrimination from a manager or team leader within the past 12 months. Staff told us they did not always feel they could speak up and raise concerns safely. Staff were aware of the Freedom to Speak Up and whistleblowing policy, however we heard through anonymous whistleblowing concerns raised during the inspection that staff were concerned there would be negative repercussions towards themselves even if they spoke out through these channels.

During the inspection we received 69 whistleblowing concerns from staff across all areas of the trust. Eighteen of the concerns were raised anonymously and had cited reasons being that even raising concerns externally in confidence would somehow lead to repercussion in a negative way. Bullying was referred to as a concern in 17 of these concerns whilst a culture of poor leadership and staff support was referred to in 26 of these concerns. The staff survey carried out as part of the inspection identified that 38% of respondents had witnessed harassment, bullying and abuse at work from colleagues or managers but only 51% of these had reported it.

Governance

Leaders did not operate effective governance processes, throughout the service. Staff were not always clear about their roles and accountabilities and regular opportunities to meet, discuss and learn from the performance of the service were not clear.

The trust had recently re-organised into clinical boards. Staff told us they were not clear about the management structure within their own boards. The staff survey carried out as part of the inspection identified that 40% of respondents felt that communication between senior management and staff was not effective.

We heard from staff regarding varying methods of information sharing between leaders and staff carrying out daily clinical duties. These methods varied between wards and included bulletins for staff, staff meetings or sharing of information through handovers. Matrons and sisters told us that there were regular meetings to review performance, incidents, risk assessment compliance and shared learning. We asked for minutes from the charge nurses and sisters' meetings for the previous three months, however, we were not provided with any.

The information we were given stated that minutes were not routinely kept for these meetings. We were provided with a list of standard agenda items for these meetings. We also asked for clinical governance meeting minutes for the past three months for the service.

Medical care (including older people's care)

We were provided with a selection of governance and risk meeting minutes from specialities in Medicine, dated from January 2023. Within this we were provided with evidence of an audit and clinical governance meeting specific to dermatology and a liver morbidity and mortality meeting. There was no evidence of consistency of meetings held in the information we were provided.

We also asked for the previous three months of care group performance meeting minutes. We were provided with minutes dated October 2021, April 2022 and January 2023. We were told that these meetings had been temporarily paused following the transition to the new clinical boards structure on 1st April 2023.

We were not assured of any consistent methods or approaches for feeding key information up and down through the service. We did not see a clear process for sharing key themes regarding risks, performance and learning opportunities. The staff survey completed as part of the inspection identified that less than half of respondents (45%) stated they heard about incidents and learning from other parts of the organisation. We were provided with information regarding key milestones within the transition. This information stated that clinical governance structures with clear lines of accountability were due to be devised by May 2023. Meeting structures within the board were to be devised by June 2023. We did not see evidence of these structures in place at the time of inspection.

Management of risk issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not follow a clear process to identify actions to reduce their impact. They had plans to cope with unexpected events.

We did not see evidence of comprehensive assurance systems in place. The trust had a reporting hub and harm free care clinical board dashboards in place. Leaders reviewed these on a weekly basis. We were told anomalies or areas for concern in relation to risk would be discussed directly on the wards. Staff told us that information might be shared at handovers, however, this was not recorded and there was no evidence provided to demonstrate how all staff received such information. There were no clearly identified forums for sharing information. We were not assured there was a clear process or vision moving forward for performance management, however recognised that the board was newly formed.

We were told about the services procedures for managing safety through audit and quality improvement. We were told that the incident reporting system was used to identify emerging themes that may warrant attention or intervention. We did not see evidence of discussion of emerging themes. We did see the clinical governance forward programme for 2022-2023. However, this was not an up-to-date plan. For example, the falls and fragility fractures audit programme was included. The timescale was recorded as ‘report submitted October 2020’. The description stated the trust was fully complaint with four recommendations and there were action plans in place for the other eight recommendations. We saw evidence that the trust had set out a trajectory for falls reduction and that there were actions in place such as increased education to staff, however we did not see clear action plans that identified dates for achievement, staff responsible for implementation of actions or re-audit dates.

Leaders told us about the top risks for the service. For example, staff shortages, increase of complexity of patients and increased violence and aggression. Staff we spoke to also identified these risks. However, we reviewed the service risk register and found this did not clearly align with the risks that we were told about. We saw six risks identified of which two related specifically to the emergency department. The other four risks we reviewed included winter pressures, staffing deficits, environmental issues on a community location impacting patient care and management of long covid patients.

It was not clear how risks were identified and escalated to the risk register with the latter two risks being added during 2022 and the earlier two being added in 2012 and 2013. We did not see the risks we had heard about clearly identified and did not see how accountability was assigned to each risk for development of or completion of action plans and risk mitigation. For example, staffing deficits were dated as identified in 2013, the description of the risk referred to increased absence due to covid-19 and evidenced recognition that staff retention and sickness could have been adversely affected by the pre-existing staffing deficits. We saw a 'controls in place' section which matched some staffing controls we had been told about, however there were no dates or named staff against these controls. We saw due and done dates against a number of action descriptions for this risk. For example, we saw an action to increase the number of healthcare assistants dated December 2015. We saw a done date for this of October 2018. For this specific risk there were six action descriptions ranging with dates from 2016 to 2018 and all were recorded as done in October 2018 apart from one dated 2015. However, the risk remained on the register, with additional concerns that would have arisen during 2020 onwards because of the pandemic. There was no clarity or further explanation of changing risks or named staff responsible for any ongoing review yet there was a review date of March 2023 recorded. The risks identified on the medicine risk register relating to medicine services were not reflected on the executive oversight register.

Staff we spoke to were not clear on how risks for their department might be reviewed. We did not see any evidence of ward meeting minutes, senior sisters or matrons meeting minutes that referred to risks within the department and how staff were kept updated on identified risks and plans for mitigations of risks. We were not assured that risks were adequately recorded and reviewed within the service.

The Safer Nursing Care Tool was used to review staffing levels on wards and identify any areas of concern which would be raised to the trust board bi-annually. Staff told us about actions that might take place in the event of short-term staffing difficulties such as closure of beds, overtime for additional shifts, use of bank and agency staff, deployment of staff form other areas. Leaders considered short term changes such as higher acuity of patients at any one point in time. We saw there was a bed closure request form that could be used to consider temporary bed closures. This form directed staff to identify reasons for closures, actions taken to prevent closures and escalation plans should demand exceed capacity. We did not see any completed forms. We saw evidence of increased staffing establishments agreed following review over the years 2019/2020 with implementation of the increased establishments during 2021/2022, for example on ward 49. We heard that winter pressures would be considered in advance although we saw no clear plan. At the time of inspection, the winter pressure plan had not been agreed.

Leaders told us that the trust patient safety incident response plan was currently in development. Once complete we understood this plan would align with the trusts incident management policy. We reviewed the serious incident policy and found this set out clear guidelines regarding reporting and escalation of incidents and risks. We looked at mortality and morbidity review meeting minutes and saw that each consultant would update the database monthly with level one deaths and level two deaths would be discussed in the monthly meetings. We were told that recommendations would be made, and feedback discussed with individuals where needed. We did not see evidence of how or where feedback was provided when it was identified there was learning.

Information Management

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

We reviewed the trusts systems and processes for recording information. We found inconsistencies in these recording systems, for example there was a paper referral for the discharge service required. We found inconsistencies and variations in staff understanding of how to use the electronic recording system. For example, ward staff worked with the system daily and knew where to find information when working directly with patients, however senior staff struggled to find information and the digital health team had differing expectations of where information would be stored.

Staff told us that some of the data within the electronic recording system was not accurate. In a small number of records there was an issue with MUST score reporting via the dashboard, which had only been launched 3 weeks prior to the inspection. This was quickly rectified and explained to us by the Digital Health Team during the inspection. The MUST score recorded in the EPR was accurate and available to all clinical staff, there was not a risk to patient safety. We also saw inaccuracies within the electronic whiteboard system in relation to isolating patients. We identified that during the pandemic all patients who had to isolate for health reasons had been recorded as requiring isolation. We understood that there was now difficulty in removing these markers from the system and therefore there was no accurate record on the display boards on each ward regarding which patients required isolation in real time.

We saw internet dropouts on some of the wards we visited and delays in reaching IT support when needed.

We found the electronic record system was not being used to its full potential. For example, care plan sections were not used, and daily activity entries relied upon for identifying the current plan of care.

The safety assessment dashboard currently includes moving and handling and falls risk assessments. At the time of the inspection the dashboard did not include additional key metrics, such as VTE assessments; we were told at a meeting with the Digital Health Team, plans were already underway to enhance the dashboard and expand the metrics included. Aspects of care related to nutrition and hydration are part of the clinical assessment and the usual handover processes.

We also saw that incidents which should have been reported through the National Reporting and Leaning data base were not reported in a timely manner. This had been raised to the trust prior to the inspection and was ongoing at the time of report.

During the inspection we heard information of concern regarding a backlog of ‘must sign’ letters following clinic appointments, patient treatments, operations and in patient stays across the trust. We were concerned that this had led to delays in patient’s receiving ongoing appropriate care if relevant healthcare practitioners had not received information detailing changes to treatment or conditions. The trust was asked to provide current information regarding the amount letters waiting to be sent out. The trust provided us with information that evidenced 1361 letters within the medicine and emergency care board required review for 2023 as they had not been signed off for processing further. In addition, there were a further 3548 letters that required reviewing for the years 2018 to 2022.

Engagement

Leaders did not always engage with staff to actively plan and manage services. Leaders and staff engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust participated in the National Patient Survey Programme and the NHS friends and family test. Results were monitored by the patient experience monitoring group. The trust also had volunteer involvement groups who would provide patient perspectives on quality improvement projects, research proposals and service changes, for example Cancer Perspectives.

The trust engaged with a range of charity groups to support reducing barriers to groups who may have found it more difficult to access services. These included disabilities, carers and ethnic minority groups. The trust also held an equality, diversity and human rights working group quarterly. This was attended by local charity organisations and provided an opportunity for the trust to hear feedback from within the local communities.

The patient experience team visited wards on an ad hoc basis to talk with patients and hear their views on possible improvements, for example regarding cleanliness.

Staff participated in the annual staff survey. We saw one example of a ward area that had identified dissatisfaction with working patterns and processes. We saw an action plan had been created to support changes that had been made.

We gathered information from staff through an anonymous and confidential survey during the inspection. Staff who responded to this survey had the opportunity to provide comments. Staff consistently reported feeling disconnected from leaders who did not understand, acknowledge, or address issues that staff 'on the ground' faced. We heard the same reports when carrying out focus groups with staff as part of the inspection. Clinical staff in particular reported feeling physically disconnected from senior management as they were not visible to them. They felt they had no opportunities to feed into the processes that directly affected them.

Senior leaders told us that clinical directors and directorate managers held forums for all consultants and senior nurses to attend. These were held with an open invitation via online meetings. We heard that a staff engagement strategy for the clinical board was due to be devised by May or June 2023.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They did not always have a good understanding of quality improvement methods and the skills to use them. Leaders did not always encourage innovation and participation in research.

We saw newsletters that were issued within the service entitled achieving clinical excellence for internal medicine at the RVI. These newsletters promoted current clinical topics for learning.

The trust had received feedback from staff that attending training sessions for additional learning was difficult due to ward and staffing pressures. In response to this we saw that visual education boards had been developed. This allowed staff to access education resources at a time convenient to them in their own ward environment. We saw boards that provided information that acted as prompts such as the 'care for me, with me' boards on some wards. We also saw boards that linked with events such as the learning disability awareness week.

We requested data regarding how services used lessons learned to improve services. Examples of five improvement projects trust wide were shared. We saw that they had been identified through lessons learned where there had been missed opportunities. For example, one project had arisen through recognition of two ways of recording urine output as part of fluid balance – one using the bedside electronic observation system and one using fluid balance chart in the separate electronic records.

Staff we spoke to were not able to give us detailed examples of quality improvement. However, we saw written evidence of local improvements that had taken place on wards such as development of dementia friendly activity packs and specific training sessions for students. We did not see evidence of how these initiatives were shared across wards.

Medical care (including older people's care)

Some staff told us that they had been supported with taking forward innovative ideas whilst others told us that they felt they had been dismissed and were not supported to promote quality improvement. We did see evidence of a trust wide ‘Q Factor’ award scheme which encouraged staff to create posters based on quality improvement and clinical effectiveness with cash prizes for the top three.

Urgent and emergency services

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff.

All staff received and kept up to date with their mandatory training. Within the emergency department nursing staff achieved 88% compliance and medical staff 73% compliance for statutory and mandatory training; compliance rates within the assessment suite were 90% for nursing staff and 93% for medical staff.

These did not meet trust compliance rate for mandatory training of 95%.

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

All staff working on triage had received triage training through a recognised training model and were competency assessed by the departmental triage training lead. In the paediatric emergency department, staff attended specific clinical skills days provided by the Great North Children's Hospital (GNCH), trauma training, paediatric immediate life support and advanced paediatric life support, as well as acute illness management, venepuncture and cannulation, tracheostomies, diabetes, and recognition of the ill child.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. In addition to a module in mental health, further training had been delivered by the associate director of nursing, lead for mental health, resulting in increased confidence in mental health risk assessments, completion of mental capacity assessments and documentation by nursing staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance was reviewed each month and individuals not compliant were reminded and given time to complete on-line learning either at mandatory training days facilitated by the clinical educator or given opportunities while on shift.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. At the time of inspection 85% of all staff within the department had received safeguarding adults level 2 training, and 92% of all staff had received safeguarding children level 2 training; 82% of medical and dental and nursing staff had received safeguarding adults level 3 training, and 85% had received safeguarding children level 3 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We observed safeguarding issues were discussed within handover meetings and safety huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of staff contacting relevant agencies ensuring safety concerns were raised appropriately.

Staff followed safe procedures for children visiting the ward. Processes were in place for medical staff to conduct child protection medical examinations and staff were able to explain how they would escalate concerns. Staff followed safe procedures for children visiting the department, access to the paediatric emergency department was security controlled through the paediatric department reception desk.

The trust's safeguarding adults and safeguarding children's policies were in date and version controlled. The policies stated '…the responsibility of all staff working with patients is to act on any suspicion or evidence of abuse or neglect, and to report their concerns to their line manager and adult safeguarding team'.

The department had identified a safeguarding link nurse to provide additional support and advice around safeguarding concerns.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. Although we did not see cleaning schedules displayed within the department, we saw cleaning taking place continuously within the department.

The service generally performed well for cleanliness. The latest patient led assessment of the care environment (PLACE) showed the hospital scored 98.7% for cleanliness, and 97.3% for condition, appearance, and maintenance.

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

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw treatment bays were visibly clean, disposable, and labelled curtains were used and all mattresses were clean, in good condition and passed audits for pressure support (January to June 2023). Sharps bins were dated, signed and we did not see any near capacity.

We saw staff following infection control principles appropriately, including the use of personal protective equipment (PPE) and bare below the elbow.

Hand gel and handwashing instructions were displayed next to sinks available in the department. Staff were observed washing their hands before and after patient contact.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We saw call bells had been installed appropriately within the department, this included within corridors where patients were receiving care and treatment and being observed continuously by nursing staff and in particular the rapid observation nurse.

Access to the department was clearly signposted externally with guidance on the criteria for attending to promote appropriate use of the service, and within the hospital. Face coverings and hand sanitising stations were available for those attending, at the time of the inspection mask wearing was not mandatory.

The design of the environment followed national guidance. There were discrete reception desks for the adult emergency department, minor injuries, and the paediatric emergency department. Waiting areas were available, however we did observe there was not always enough seating during busy periods particularly within the minor injuries unit.

We identified the particular issue of the lack of oversight within the adults waiting area. Reception faced the external entrance to the department with the majority of the waiting area to the side and behind the desk, limiting the line of sight from the desk. Reception and nursing staff told us there was no formal arrangement to observe all patients during their stay within the waiting area. This was confirmed by the senior leadership team who told us this was identified as an issue on the department risk register but there was no definitive solution.

Vending machines had been installed in waiting areas and drinking water was available. We saw staff providing patients with refreshments, particularly those waiting for care and treatment on corridors.

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

Ambulance crews registered patients with the triage nurse who prioritised patients in need of more urgent treatment, handed them over to nursing staff and allocated a position in the corridor within the majors area of the department. All ambulance crews told us handovers were handled quickly and efficiently with minimum waiting time.

Although staff carried out safety checks of specialist equipment, these were not always completed daily. The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment, for example hoists.

Within resuscitation we reviewed the log of daily checks of equipment, these were not complete. For example, we saw days were missing from the log and not all equipment was signed as having been checked when other equipment checks were signed, for example fridge temperatures, defibrillators, bloods trollies and controlled drugs.

This was reported to the trust and on our further visit to resuscitation four weeks later, the checklist had been completed on most days, but three consecutive days were completely blank. We were unable to establish a reason for this.

The service had suitable facilities to meet the needs of patients' families. There were dedicated relatives’ rooms located within quiet areas of the adults and paediatric emergency departments.

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

Staff disposed of clinical waste safely. Arrangements were in place for the segregation, storage, and disposal of waste.

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

Within the adults department, we saw a dedicated room which was allocated to patients at potential risk of harm as a result of a mental health crisis, and for those waiting to be seen by the psychiatric liaison team (PLT). This room was small and not suitable or comfortable for those waiting many hours to be seen.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Before registering, patients were directed to the triage nurse on reception who used a nationally recognised clinical risk management tool. This enabled the categorisation of patients, identified patient risk and supported patient flow through the department.

Staff completed risk assessments for each patient on arrival and admission, using a recognised tool, and reviewed this regularly, including after any incident. Further assessments of patients were carried out as soon as possible depending upon patient category within assessment rooms and on corridors by the rapid observation nurse.

Staff told us they relied upon members of the public and family to alert them should a patient deteriorate during their wait and require attention. During our inspection we saw a member of the public alert reception staff to a collapsed patient in the waiting area out of sight of reception. Although this patient was attended to immediately, there was no formal process for checking patients while they were in the waiting area.

We sent a ‘letter of concern’ to the trust highlighting the full waiting area was not visible from the reception and triage areas. This meant there was potential for patients to come to harm and any deterioration to go unrecognised especially when the department was busy, and patients were experiencing long waits.

The ‘letter of concern’ also highlighted there was no formal arrangement for staff to observe this area or complete regular checks on patients to identify any deterioration in their condition. In addition, there was no formal protocol or process in place to support staff in the actions they needed to take to observe patients placed in this area after initial triage. This was confirmed during interviews with senior managers for the service.

During our further visit to the department, a process was now in place for the waiting area to be checked every half hour by the rapid observation nurses and any issues recorded. We saw these records showed a number of patients asleep and also some patients sitting on the floor; one patient was recorded as having had a seizure at triage and escalated for treatment.

Risk assessments were completed for slips, trips, and falls, moving and handling, violence and aggression, lone working, stress management and incident management.

Staff knew about and dealt with any specific risk issues. The trust had a range of specific policies in place to reduce patient risk. These included psychiatric clinical guidelines, protocols for managing allergic reactions in children, imaging after urinary tract infection in children and urine collection for microbiology.

Major incident protocols were in place and departmental staff had attended 'Chemical, biological, radiological and nuclear (CBRN)' training led by a major incident responsible officer.

As part of the trust 'Care for Me with Me' programme, a mental health risk assessment tool had been developed and was used within the department. The tool prompted staff to assess and document a number of safety considerations, including the risk of suicide, self-harm, or harm to others. It also supported staff to determine the level of risk, take action such as enhanced observation, mental capacity assessment and referral to the psychiatric liaison team.

Staff were prompted to consider and complete a mental health risk assessment across the patient pathway, for example at triage and on assessment by nursing and medical staff. Staff also initiated a mental health risk assessment where they were concerned regarding the mental health of a patient.

There were relevant guidance and policies for managing falls and evidence in patient records that falls assessments had been completed appropriately for patients considered to be at risk of falling. Staff consistently checked patients' skin integrity through the use of a recognised tool for identifying patients at risk of developing pressure ulcers.

Audits showed that completion of the National Early Warning Score (NEWS) was 82% within the department and 87% within the assessment suite in the three months before inspection. Compliance for completion of the Paediatric Early Warning Score (PEWS) was 58% over the same timeframe but not all observations were always required and were not captured in compliance rates.

A sepsis link nurse was in place and additional support and advice was displayed throughout the department.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Department board rounds took place at regular intervals throughout the day in order to monitor patient risk and access and flow within the department. Shift handovers also included all necessary key information to keep patients safe.

The service had 24-hour access to mental health liaison and specialist mental health support through the psychiatric liaison team by agreement with the neighbouring mental health trust. During inspection we observed patients waiting to be seen by the psychiatric liaison team (PLT) up to 21 hours, this was not uncommon. Although, a specific waiting room had been identified for these patients, it was small and a difficult environment for patients to rest while waiting for the PLT. Staff within the department told us this was stressful for patients, and also stressful for the staff who felt ill-equipped to look after these patients while waiting for the PLT.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Completed mental health risk assessments were visible on the electronic system and staff were able to locate the risk assessment when requested.

Nurse staffing

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

Urgent and emergency services

The service had enough nursing and support staff to keep patients safe. We reviewed staff rotas which showed the department was staffed to or above establishment levels.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service used the emergency department safer nursing care tool (SNCT) to calculate nurse staffing requirements based on patients' needs (acuity and dependency) and professional judgment. We were told acuity and dependency scoring was undertaken regularly and as a result urgent and emergency care had increased staffing establishments by 30%.

Staff escalation was managed in line with the trust 'Nursing & Midwifery Staffing Guidelines – Ensuring Safe Staffing Levels in Wards & Departments'. At the time of inspection, the trust was operating at 'level 2 escalation' (amber, surge staffing – less than 30% workforce loss).

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

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

The service had low and/or reducing vacancy rates. A report to the board (May 2023) identified a 3% nurse vacancy rate within the service.

The service turnover rate was decreasing. Information provided showed the trust turnover rate for registered nurses was 7.7% against a trust target of 8%.

The service sickness rate was decreasing. Information provided showed the trust sickness rate for registered nurses was 4% against a trust target of 3%.

Managers limited their use of bank and agency staff and requested staff familiar with the service and ensured they had a full induction and understood the service.

Medical staffing

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

The service had enough medical staff to keep patients safe and the medical staff matched the planned number. Figures provided by the trust showed there was one medical staffing vacancy within urgent and emergency care.

The service had a low turnover and sickness rates for medical staff.

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Latest figures available (March 2023) showed the service employed 36% of medical staff at consultant level and 51% at registrar level, this is above England averages (25% and 45% respectively). Junior doctors made up 12% of the medical workforce (England average 16%) and middle career doctors 2% (England average 14%).

The service always had a consultant on call during evenings and weekends. The department had 24-hour consultant cover, in line with RCEM workforce recommendations. Consultant roles were allocated to each shift including doctor in charge, resuscitation consultant, clinical decisions unit consultant and paediatric emergency department consultant to ensure senior decision makers were available.

Consultants, supported by two middle grade doctors, were present on site overnight to manage major trauma and other high-risk emergencies.

Records

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

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

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

Patient records audits provided by the trust (January to June 2023) showed an overall compliance of 82.2%. Compliance for the completion of NEWS and pain scores were higher at 97.8%, recording nutrition needs and checks of pressure areas were both 86.1%. However, contact documentation was completed in only 71.7% of records on average in 2023.

During inspection we checked 18 patient records and found five did not accurately record the treatment that had been given to patients. This was reported to staff and was then completed retrospectively.

Medicines

On our initial inspection we found medicines were not always stored securely or safely.

We could not be assured that medicines were being stored in line with manufacturer's instructions as records of fridge temperatures were inconsistent with no action taken when fridges went out of range. This was not in line with trust policy.

Controlled drugs were stored securely, however on some occasions, controlled drug registers were not completed in line with trust policy.

At our second inspection we found medicines were stored securely and safely, with controlled drug registers being completed in line with policy.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed seven patient medication records and found that medicines were prescribed appropriately. However, we found oxygen was not always prescribed in line with trust policy.

Staff stored and managed all medicines and prescribing documents safely. The department lacked oversight of the management and security of FP10 prescription forms and did not follow trust policy. However, at our second inspection we found the process for the tracking of FP10 prescription forms had improved; further work was required to ensure the governance surrounding these processes was embedded.

Staff did not always complete medicines records accurately and keep them up to date. We observed staff did not always follow policy in relation to administration of medicines, for example on one occasion a patient was administered a medicine, but this was not signed for on their medicines record risking the potential of a duplicate dose being administered.

Although the department had an electronic prescribing and administration system in place, we found this was not always secure. For example, we observed computers which had not been logged out which meant prescribing and administration records were easily accessible.

Staff followed current national practice to check patients had the correct medicines. Although, there was no clinical pharmacy support for the department to carry out medicine's reconciliation, we saw evidence of some medicine histories taken at triage by other healthcare professionals.

Incidents

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

Staff we spoke with could describe how to raise concerns and knew how to report incidents and near misses in line with trust policy. Staff had reported 375 incidents between April and June 2023; for example, categories included accidents, aggression and violence, delays, medication, and pressure ulcer ('acquired' (one) and also 'on admission' (230)).

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

Staff received feedback from investigation of incidents, both internal and external to the service and discussed the feedback and look at improvements to patient care. We were provided with a number of examples of learning from incidents. These included changes to the processes for investigation of a 'suspected foreign body inhalation in children', changes in practice following a serious incident investigation into multiple attendances of a child, and recommendations to avoid repetition of a patient discharged with ECG leads still attached.

We also reviewed minutes of the directorate clinical governance committee, assessment suite briefings and monthly emergency department meeting, all of which identified learning from incidents.

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

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Requires Improvement ↓↓

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

Urgent and emergency services

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies and treatment guidelines, stored electronically. Policies and procedures were based on best practice from NICE and Royal College of Emergency Medicine guidelines (RCEM). These were regularly reviewed and updated.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The trust had an agreement in place with the neighbouring mental health trust to provide psychiatric and mental health support to patients in the department. This enabled staff to protect the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. All patients were assessed for their mental health needs at initial triage and throughout their assessment within the department of mental health issues were identified.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw patients were provided with nutrition and hydration throughout their stay in the department. Refreshment trolleys were available for patients being treated in department corridors and family members also confirmed they had been asked whether they needed refreshments.

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

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. A numerical pain score was used for adults and the 'Abbey pain scale' was used to measure severity of pain in people with late-stage dementia. Pain was identified through the use of the face, legs, activity, cry and consolability (FLACC) scale for children up to seven years old and a visual pain scale for older children.

Patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered, and recorded pain relief accurately.

The department had implemented the RCEM 'Pain in Children' quality improvement programme (QIP), as well projects to further develop procedural sedation, analgesia in sickle cell crisis and renal colic.

Urgent and emergency services

Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent, and met expectations, such as national standards. The department took part in RCEM audits and benchmarked its performance against best practice and other emergency departments. For example, fractured neck of femur QIP, infection prevention and control QIP, pain in children QIP and the mental health (self-harm) QIP.

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

There were 58,741 urgent and emergency care attendances (accident and emergency, minor injury units and walk-in centres) in the three months before inspection. The latest hospital episode statistics showed the service had a better unplanned re-attendance rate (1.9%) compared to the national rate.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. All staff who worked on triage had trained in the use of the 'Manchester Triage' training model and had been competency assessed by the departmental triage training lead.

Departmental competencies had been linked to Royal College of Nursing competencies levels one and two, including statutory and mandatory training.

The trust had appointed an associate director responsible for leading on the development and delivery of mental health training.

Paediatric emergency nursing staff maintained their skills and knowledge through attendance at training days such as in house trauma training, paediatric intermediate life support, advanced and emergency paediatric life support, venepuncture and cannulation, diabetes, burns, mediation, and recognition of the ill child.

The clinical educators supported the learning and development needs of staff. Clinical educators had been appointed and staff confirmed they had the opportunity to discuss their individual training needs.

Managers gave all new staff a full induction tailored to their role before they started work. The department had developed a new starter induction pack including expectations, introduction to senior managers, training, and competencies and the 'learning lab', policies and procedures, and aseptic non-touch techniques competency assessment tool.

Managers supported staff to develop through yearly, constructive appraisals of their work. Figures provided by the trust showed that 71% of nursing staff and 57% of medical staff had received an appraisal at the time of inspection; this did not meet the trust appraisal compliance rate of 95%.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw multi-disciplinary working with services, such as occupational therapy, psychiatric liaison, and diagnostics to identify the most appropriate care and treatment for patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. All patients admitted acutely through the assessment suite were under the care of the acute medicine team and reviewed by the acute/general medical consultant on duty.

The assessment of frail patients admitted acutely was managed by the integrated discharge team in both the emergency department and the assessment suite. The team comprised a physiotherapist, occupational therapist, and a nurse specialist, to support the discharge of frail patients who did not require inpatient medical treatment. Urgent mobility assessments were carried out, in addition to accessing equipment and reablement packages for patients being discharged.

The older people's therapy team identified and assessed all patients over 65 years of age with a clinical frailty scale of 6 and above who cannot be discharged. This ensured they had mobility assessments early in the patient's admission and provided appropriate walking aids. This also identified patients who needed a more detailed multi-disciplinary team assessment.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. During inspection we saw patients experienced delays for treatment, especially for those waiting for mental health services and input from the psychiatric liaison team.

Staff told us this was difficult for patients and also for staff caring for these patients while awaiting specialist input.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support within the department. Posters were displayed on departmental walls providing information and services available for the treatment of a range of health conditions.

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

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us the appointment of an assistant director of nursing to develop and deliver mental health training had increased confidence in identifying when a patient needed a capacity assessment and also in carrying out these assessments. The nursing team had also received dedicated training to support the new changes to mental health documentation and risk assessments.

The trust provided data which showed 92% of nursing staff and 84% of medical staff had completed mental health awareness training at the time of inspection. Compliance was reviewed monthly and individuals not compliant were reminded and given the time to complete training online either through the departmental mandatory training days run by the clinical educators or were facilitated to do training on shift.

Although, staff gained consent from patients for their care and treatment during triage in line with legislation and guidance, this was not always clearly recorded in the patients' records. However, the service did not have effective systems to ensure staff assessed and managed the risks to service users in relation to their mental health. Patients who presented with mental health risks were referred to the PLT by the triage nurse. A flagging system was used on admission; red for falls, blue for learning disability, green for mental health and a booklet with support for MH needs.

A review of patient records showed a risk assessment of the patient's mental health needs was not always completed or an appropriate plan to manage their mental health risks recorded. Staff did not always complete a 'concern about patient/mental capacity act' holding form. Although the PLT also completed an assessment, these were not transferred over to trust systems.

Managers did not monitor how well the service followed the Mental Capacity Act and make changes to practice when necessary. The review of patient records showed that staff identified the need for restraint and completed the trust's 'Request for Security Staff to Restrain a Patient' form and indicated that the patient lacked the mental capacity to consent to or refuse care. However, staff did not always complete an assessment of the service user's mental capacity or record a decision made in the service user's best interest before identifying the service user to security staff as requiring restraint.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The service did not have effective systems to ensure staff assess the mental capacity of service users and record decisions made in service users' best interest when applying to deprive the service user of their liberty. This meant staff had not established whether the decision to deprive the service user of their liberty was in the service user's best interest because they did not have capacity to consent to their admission and treatment.

Managers did not monitor the use of Deprivation of Liberty Safeguards and make sure staff knew how to complete them. The trust's most recent audit of mental health risk assessments was completed in 2019 and identified poor practice.

Is the service caring?

Good 

Urgent and emergency services

Our rating of caring went down. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. On arrival in the department all patients were greeted appropriately, staff introduced themselves and explained who they were and their role. Staff directed patients to the triage nurse, to the paediatric emergency department or to minors. They spoke quietly to patients to try and ensure they maintained a level of patient confidentiality.

All patients said staff treated them well and with kindness. However, patients did raise frustration at the length of time they had to wait in the department, and also the lack of update on what was happening. Staff were vigilant in updating signs giving the expected length of wait in the department, but patients told us they were unsure what their individual wait would be.

Feedback from patients was universally positive, for example '…seen and treated in an extremely professional manner', '…we were genuinely in awe, as they could not have done more to help', '…they took time to chat to patients and relatives, treated each one as an individual and with empathy' and '…every single staff member was kind, patient and knowledgeable'.

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

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. All contact between staff and patients were conducted professionally, sensitively and in a way which respected confidentiality and the emotional wellbeing of both patients and their relatives and carers.

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

Understanding and involvement of patients and those close to them

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

Staff talked to patients in a way they could understand, using communication aids where necessary. The department had access to interpretation and communication services to facilitate contact with patients.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback posters and actions taken by the trust to act upon concerns were displayed in the department and waiting areas.

The feedback from the Emergency department survey test was positive.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the needs of the local population. Current pressures in the wider health care system continued to place pressure on the access to the department and patient flow through the hospital. There were long waits for patients attending the department.

Patients told us they had attended the department as it was difficult to get an appointment with their GP. Although, one patient attended with serious dental issues, the triage nurse contacted the nearby dental hospital and gave advice on attending there or registering with a dental practice.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. However, patients with mental health issues experienced extended waits due to the availability of the psychiatric liaison team. We escalated to senior management within the department who immediately raised this issue with the neighbouring mental health trust.

We saw patients experiencing mental health crisis attend the department to seek support as there was limited support within community settings, this put additional pressures on the department.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw positive interactions between staff and patients with complex needs to ensure they remained settled within the department. Link nurses were trained and available for patients with safeguarding, mental health, learning disabilities and dementia needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff and patients had access to a language, interpretation and signing service.

Urgent and emergency services

Access and flow

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

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment. Patients accessed the department in a timely way. The triage nurse assessed all patients on their entry to the department, either those arriving by ambulance (22%) or self-referral (72%). Patients were directed to minor injuries and the on-site primary care service or the paediatric department as appropriate.

The service had introduced a rapid observation nurse, 'PONCHO' (pressure areas, observations, nutrition, continence, hydration, other (for example, falls risk)) nurses and designated 'floor' nurses to address extended waiting times for patients and access and flow through the department.

The service performed well against regional and national comparisons for ambulance handovers and transfers into the department. On the three days of inspection 95.1% of ambulance handovers were completed within 30 minutes against an England average of 81.4%; 4.3% were completed within 60 minutes against an England average of 12.6%, and 0.3% completed over 60 minutes against an England average of 6.0%. Ambulance staff told us the department was the best in the region for handovers and there was no requirement for a hospital ambulance liaison officer as a consequence.

The rapid observation nurse supported clinicians with the streaming of patients to the appropriate care pathway. Nurses and support staff observed patients placed on trolleys in corridors within the department and regularly offered refreshments. PONCHO nurses checked these patients over 65 years of age and corridor patients under sixty-five were checked by designated floor nurses. Concerns identified were escalated directly to clinical staff and the rapid observation nurse.

The same day emergency care unit (SDEC) was co-located with the assessment suite, within the hospital's acute medical unit. All patients presenting through triage to the assessment suite were assessed for suitability for management in SDEC on an ambulatory pathway. Patients were also signposted directly to SDEC and then admitted to the assessment suite if in need of inpatient management on arrival.

Between 50 and 70 patients attended SDEC each day with a range of new emergency presentations and a smaller number of planned follow up reviews. SDEC operated a 'see and treat' model, streaming patients from the front door of the department and getting patients to the right place, first time. SDEC was open 7 days a week, 365 days of the year with patients referred by the emergency department, primary care, other hospital departments, walk-in and urgent treatment centres, and directly from paramedics. Patients were not admitted to SDEC with a NEWS score above 5, cardiac chest pain with ECG changes or high-risk features, requiring cardiac monitoring or frail, complex co-morbid patients requiring MDT review and admission.

Managers and staff worked to make sure patients did not stay longer than they needed. In the three months before inspection there had been 38,584 attendances in the department, averaging 424 patients each day. We saw patients had long waits for treatment at busy times within the department caused by increasing numbers of patients attending the department, lack of beds within the hospital and wider pressures within the local care system delaying discharge. From April to June 2023, 19% of patients waited in the department for over six hours. Patients waiting to see the psychiatric liaison team regularly had excessively long waits.

In the same period 52.4% of admitted patients waited less than four hours in the department; this did not meet the national standard. The percentage of patients admitted waiting 4-12 hours from decision to admit to admission was 10.4%.

On the days of inspection, 80% of patients spent less than four hours in the department. Although this was better than the England average (71%) for the same days, this did not meet the national standard of 95%.

The average waiting time in the department over the last twelve months was 253 minutes. From April 2023 to June 2023, 60 patients waited in excess of 12 hours from decision to admit to admission. This did not meet national guidelines.

Information provided by the trust showed 75% of adult patients arriving by ambulance were seen within 15 minutes (time to initial assessment) and the average time to initial assessment was 12 minutes; 64% of paediatric patients arriving by ambulance were seen within 15 minutes (time to initial assessment) and the average time to initial assessment was 15 minutes.

This also showed 53% of adult patients arriving by non-ambulance means were seen within 15 minutes (time to initial assessment) and the average time to initial assessment was 24 minutes; 67% of paediatric patients arriving by ambulance were seen within 15 minutes (time to initial assessment) and the average time to initial assessment was 14 minutes.

Data provided showed 35% of adults were seen by a clinician within 60 minutes and the average time to see a clinician was 138 minutes. For paediatric patients 37% were seen by a clinician within 60 minutes and the average time to see a clinician was 100 minutes. These averages are above the national target of 60 minutes.

Although the department had a full capacity protocol in place, the sister in charge told us this had not been used.

The number of patients leaving the service before being seen for treatments was low. In the last twelve months 3.5% of patients left the department without being seen.

Managers and staff started planning each patient's discharge as early as possible. There were delays to the discharge of patients from the department due to a lack of community-based resources and limited bed availability. It was not always possible to discharge or transfer patients in a timely manner, particularly for those with complex mental health and social care needs. Staff ensured patients remained safe when accessing the department.

The service moved patients only when there was a clear medical reason or in their best interest.

Learning from complaints and concerns

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

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

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

Urgent and emergency services

Managers investigated complaints and identified themes. Information provided showed 26 complaints had been received by the service between January and June 2023. Of these, the majority (15) concerned clinical treatment, other complaints received related to values and behaviours (3), admissions and discharges (2) and access to treatment and drugs (2).

Eleven of the complaints had been resolved at the time of inspection with nine not upheld and two partially upheld.

Complaints were acknowledged within three working days, and following triage, complainants were contacted by the assigned complaint-handler within the patient experience department to explain the complaint process, obtain consent, outline the scope of the investigation and the anticipated timescales for response.

The trust timescale for a written complaint response was 60 working days, from commencement of the formal investigation.

Parliamentary and Health Service Ombudsman (PHSO) information and contact details were provided to all complainants.

Staff we spoke with could give examples of how they used patient feedback to improve daily practice. We saw examples clearly displayed within the department and also the staff room.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced.

The senior management team had the relevant skills, knowledge, experience, and integrity to run the service. The department was part of the Medicine and Emergency Care Clinical Board and led by a clinical board chair, director of operations and a head of nursing. The current make-up of the team had a variety of complementary experience and worked constructively.

The team was working on improving patient flow through the department, in-reach to the emergency department and capacity and flow. The team recognised the limitations of a small number of treatment spaces compared to the number of patients admitted and had identified initiatives to increase capacity.

An example was the further development of the integrated discharge team (IDT) within the assessment suite, supporting the discharge of frail patients who did not require inpatient treatment. The team comprised a physiotherapist, occupational therapist, nurse specialist and they carry out urgent mobility assessments in addition to accessing equipment and reablement packages for patients being discharged.

We were told that there was a positive reporting culture of incidents within the department, and the team was able to confirm the top risks, including filling medical rotas, nurse staffing, changing patient acuity, departmental layout, overcrowding and capacity, and meeting the mental health needs of patients.

During the inspection local managers understood the challenges from internal and external system pressures to quality and sustainability. We saw examples of departmental initiatives which had been put in place to optimise access and flow challenges and to maintain patient safety, such as the triage nurse, rapid observation nurse and the PONCHO initiative.

Vision and Strategy

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

We discussed the vision and strategy for the department with the senior leadership team; there was a combined vision and strategy for the Medicine and Emergency Care Clinical Board.

Current issues were identified as the physical capacity within the department, and flow through and out of the department. Priorities were identified as increasing capacity within the emergency department and effectively streaming patients to the appropriate services.

The team recognised the department was small for the number of patients seen on a daily and annual basis, and with the lack of provision of urgent treatment centres within the local area, the department was the main urgent care service at night. The team identified ways to alleviate some of this pressure by keeping open the minor injuries service and SDEC until later in the evening, and also maintain general practitioner streaming in the department.

The clinical decisions unit had also been opened to provide more physical space and enable better privacy and dignity for patients and reduce the number of patients that are cared for on corridors.

The team confirmed a priority was to ensure the workforce was able to meet the capacity and demand on the service increasing each year and that a variety of places for assessments are available, for example a social assessment unit. A major strand of the strategy was to invest in developing the department's workforce, such as advanced clinical practitioners and junior doctors, through staff retention initiatives, improving the work environment and making the department as stress free to work as possible.

As a regional trauma centre, the team was conscious the service was essential for a wider population and had never closed. The department had a clear strategy to admit patients arriving by ambulance as soon as possible to enable them to return to duty quickly, rather than waiting at the hospital.

Culture

Staff were focused on the needs of patients receiving care. Although most staff said the service had an open culture, staff commented on a range of positive and not so positive experiences.

Most staff within the department told us there was an open culture and they felt confident to raise concerns with their managers:

- they were comfortable raising bullying, harassment, or discrimination concerns;

- communication was effective between senior management and staff;
- the organisation values staff and provides them with effective support to do their jobs to the best of their ability; and
- senior managers act on staff feedback.

However, we carried out a staff survey at the time of inspection that showed some members of staff within the department did not agree. Comments received reflected the mixed positive and not so positive experiences of staff within the department, for example:

- I am proud to work within this organisation. we strive to deliver the highest standard of patient care on a daily basis with the resources we have available to us;
- The clinical and operational management teams at directorate level remain extremely committed to patient care and the teamwork is outstanding. Staff have worked themselves into the ground in recent years to continue to deliver the highest standards that they can. There is nowhere that I would rather have my relatives looked after as a patient, but a change in leadership at Executive level is desperately needed and well overdue;
- We have outstanding teams who deliver outstanding care given the context of working in the NHS right now, but as senior managers, there are many things we can and need to do to improve working lives at NUTH;
- I feel very well supported and am kept well informed by my clinical director and my directorate (now board) managers. However, the upper levels of hospital senior management feel very remote;
- I feel very supported by my immediate management team and line manager, I do feel however there is disconnect with the Senior Trust Management Board and Executive Team, who are never visible, and communication is poor!
- There are a high number of staff that are unable to deliver the level of service they feel they can deliver due to staffing shortage and failures in recruitment... Exhaustion and low mood are setting in as workload is unsustainable in many places which result in levels of absence due to stress which then only exacerbates the situation;
- There has been a significant disconnect between Execs and clinical staff although Clinical Directors and Directorate Managers have worked incredibly hard to support staff despite challenging circumstances; and
- It has become increasingly difficult to challenge mantra that everything in the trust is fine and 'flourishing' when it clearly isn't. Despite the staff survey deteriorating year on year, engagement remains poor, and the senior leadership team are now one of the organisations biggest problems rather than the solution;

The trust participated in the North-East and North Cumbria review of urgent care in June 2023, and liaised with voluntary and care sector organisations representing Asian and Asian British patients, patients needing mental health support, migrant women, and older people.

Previously, a departmental engagement week had been held where the directorate manager, departmental matron and the associate director of nursing engaged in conversations with staff. The aim was to identify the characteristics of a 'good' and 'bad' day and how these can be influenced.

These sessions identified immediate and longer-term improvements, such as further development, training, and education opportunities, improving documentation and information processes, improved skill mix, support for new staff (for example, supernumerary periods) and improved privacy and dignity for patients.

Teams of nurses visited other departments and major trauma centres around the country to confirm possible improvements. Work had been completed on reviewing rotas, organising education, and training activities, exploring the development of new roles such as mental health nurses and the triage nurse role.

Further, a practice development nurse has been appointed, as well as a rapid observation nurse (RON) who now undertakes observations on patients when waiting times are long to identify deterioration in patients.

A departmental patient information working group has been established which reviewed all information available to patients within the department.

Governance

Leaders did not operate effective governance processes. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

Although governance processes were in place, these were not always effective. For example, we were not assured medicines were being stored in line with manufacturer's instructions, controlled drugs were not stored securely, and drug registers were not completed in line with trust policy. The department lacked oversight of the management and security of prescription forms and did not follow trust policy.

During inspection we found not all patient records accurately recorded the treatment that had been given to patients. Although, they were completed retrospectively after the issue was raised by inspectors, this was a risk to the patient receiving further unnecessary treatment.

Daily checks of equipment, particularly within resuscitation, were not completed accurately; days were missing from the log and not all equipment was signed as having been checked. During a further visit to the department, the log had still not been completed accurately on all days; senior managers within the department were unable to give a reason.

The service did not have effective systems to ensure staff assessed and managed the risks to service users in relation to their mental health. A review of patient records showed a risk assessment of the patient's mental health needs was not always completed or an appropriate plan to manage their mental health risks recorded; staff did not always complete a 'concern about patient/mental capacity act' holding form.

These issues had not been identified and actioned through existing trust processes and audits and were addressed only after they had been raised at the time of inspection.

We reviewed the minutes of the latest (July 2023) monthly emergency department meeting attended by clinicians and directorate management. Under a standing agenda item of 'governance', reports and discussion were held around compliments, incidents, complaints, and serious incident panel feedback.

However, it was noted in the minutes that following CQC inspection '…concerns were raised regarding visibility of waiting room. Going forward the assessment room behind reception is to be utilized so the nurse can actively observe waiting patients as she calls patients through for assessment. In addition, a 30-minute waiting room check sheet will also be completed 24/7'.

Management of risk, issues, and performance

Leaders and teams did not use systems to manage performance effectively. They identified relevant risks and issues but did not implement actions to reduce their impact.

The senior leadership team told us they had three risks identified on their risk register related to the emergency department; one that's a performance risk around performance indicators, one concerning mental health and one around overcrowding and capacity in the department (including waiting areas).

The trust provided the directorate risk register which included risks impacting the department as follows:

1. Reduced services and ability to treat patients due to extended 'winter pressures' period';
2. Excessive wait for mental health review in the emergency department; and
3. Risk of harm to patients due to overcrowding in the emergency department.

Risk one had been opened in September 2012 and identified '… a risk to quality of patient care, ED breaches, bottlenecks in Assessment Suite...' rather than current increases and surge in activity.

The management of risks was inconsistent. For example, risk two (opened February 2019) had a current risk rating of 20 and had been escalated to the executive oversight register (corporate risk register). However, risk three (opened December 2022) had a current risk rating of 25 and was not included in the executive oversight register.

The controls in place to mitigate excessive waits for mental health review in the emergency department included a referral to the psychiatric liaison team within one hour and referral to the crisis team within four hours if needed, and '…to open conversation around mental health patients presenting to ED and what improvements can be made' with the mental health provider.

Although these actions were completed in March 2021 and last reviewed in June 2023, we saw patients waiting excessive times for mental health and psychiatric input to their treatment.

Further, the leadership team had identified '…overcrowding and high patient numbers could result in long delays, impact patient flow, patient care and patient safety'.

On the first day of inspection, we saw the waiting area in the main department was not fully visible from the reception desk, with limited oversight, we saw a member of the public alert reception staff to a collapsed patient in the waiting area out of sight of reception. We were told by staff and senior managers there was no formal process for checking patients while they were in the adults' waiting area, this was reported to the trust through a 'letter of concern'. Following this, a formal process was put in place, however, this was a long standing and known risk to patients but had not been placed on the department's risk register and actioned until identified through inspection.

Following this we returned to the department, a process was now in place for the waiting area to be checked every half hour by the rapid observation nurses and any issues recorded. We saw these records showed a number of patients asleep and also some patients sitting on the floor; one patient was recorded as having had a seizure at triage and escalated for treatment.

Concerns were identified during inspection regarding delays in sending correspondence relating to care and treatment including referrals, planned operations, clinic letters, and discharge summaries. The extent of these delays was not clear; however, they were not identified within the directorate risk register.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We found information systems were integrated and secure, to prevent unauthorised access of information.

Systems were used to record and share patient sensitive data and there were clear processes to ensure compliance with access protocols.

Managers understood performance targets including quality and data from clinical and internal audits. The trust participated in national clinical audit projects and clinical outcome quality indicators.

Engagement

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

The trust continued to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback, such as the Urgent and Emergency Care Survey (2022). The results from this survey showed 75% of patients rated their experience as greater than 7 out of ten, 95% said they had been treated with dignity and respect and 97% had confidence and trust in the doctors and nurses.

Overall, the department ranked 13 out of 62, type 1 departments nationally. However, in response to some feedback the department recognised and developed actions to improve security at weekends and night through dedicated police presence and highlighted to all nursing and junior doctor medical staff the importance of explaining the purpose of medication prescribed.

The trust had established a public and patient engagement sub group and a public and patient engagement task and finish sub group.

The most recent NHS Staff Survey showed the trust scored similar to the average for 'we are always learning' (5.4, average 5.4), the same as the trust for 'we are a team' (6.5, average 6.6) and 'staff engagement' (6.9, average 6.8).

Results for the survey benchmarked to the 'People Promise' showed the directorate scored well for 'I am trusted to do my job' (94.3% agree), 'I always know what my work responsibilities are' (91.1% agree) and 'I feel that my role makes a difference to patients' (85.9% agree).

However, the directorate did not score well for 'How often, if at all, do you feel worn out at the end of your working day/ shift (Never/Rarely) (8.8%), 'How often, if at all, do you find your work emotionally exhausting (Never/Rarely)' (10.8%) and 'I have unrealistic time pressures (Never/Rarely)' (15.3%).

The trust had developed an interactive staff survey portal for leaders; as well as containing staff survey results this also contained the 'six key themes that matter to us all'.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The trust had initiated a quality improvement project to improve the management of back pain in the emergency department by increasing adherence to RCEM standards for the assessment and management of pain in adults by a minimum of 20% within six months.

Urgent and emergency services

The department ensured patients with moderate and severe pain received adequate analgesia within 15 minutes of arrival, this was then re-evaluated within 15 minutes of receiving the first dose of analgesia and routine recording of pain was documented in a similar manner as the regular documentation of vital signs. Outcomes showed there was improvement in the four RCEM standards.

The department had introduced a rapid observation nurse, opened a clinical decision unit, developed a clinical area with maxillofacial surgery and introduced a registrar into the medical investigations unit to reduce waiting time in the department.

The department had developed the role of advanced clinical practitioners in majors and further developed the scope of practice of nurse practitioners in the medical investigations unit as well as appointing a practice development role and a professional nurse advocate.

The trust developed a project to improve the identification and follow up of patients with asthma who attended or are admitted to hospital outside of the respiratory department; in particular the project identified patients attending the emergency department with an exacerbation of asthma who were discharged to offer specialist asthma input.

The department worked with a number of partners including the Northumbria Violence Reduction unit to implement a social prescribing and link worker project. This was aimed at individuals presenting in the department but do not necessarily meet the thresholds for clinical assessment or clinical intervention. The aim is for the link worker to see a person quickly following initial triage to offer advice and a compassionate ‘listening ear’ in the immediate situation with follow up if required. This approach was aimed at freeing up clinical capacity in other services, such as psychiatric liaison, enabling quicker clinical assessment and avoiding potential long waits.

Services for children and young people

Requires Improvement ↓↓

Is the service safe?

Requires Improvement →←

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

Mandatory training

The service provided mandatory training in key skills to all staff. Staff had not completed all mandatory training in line with the trust's compliance target.

Nursing staff did not always receive and keep up to date with their mandatory training. Mandatory training completed was 75.35% for nursing staff which did not meet the 95% trust target compliance.

Medical staff did not always receive and keep up to date with their mandatory training. Mandatory training completed was 87.45% for medical roles which did not meet the 95% trust target compliance.

The mandatory training met the needs of children, young people, and staff. Mandatory topics included fire safety, health and safety, equality and diversity, infection prevention and control, information governance, moving and handling, safeguarding and basic life support.

Matrons worked with line managers and HR managers to identify training areas of low compliance of nursing staff completing training. The director of operations and clinical directors for their clinical boards identified areas where medical staff compliance levels require improvement. Some mandated training was also covered in specialty mandatory study days at intervals across the year. Mandatory training was also discussed in one to ones with staff, and as part of the appraisal process and speciality mandated study days happened intermittently throughout the year.

Staff we spoke with told us they were not always given protected time to complete training.

Staff did not always complete training on recognising and responding to children and young people with learning disabilities and autism which became mandatory from 1 July 2022 under the Health and Social Care Act 2022. Staff told us they had not received training specifically in learning disability or autism awareness, but that there was a e-learning disability and mental health awareness course.

The trust told had introduced Learning Disabilities Diamond Standards mandatory for all clinical and patient facing staff in March 2023 and had introduced autism awareness education sessions in April 2023, however Autism awareness was still not part of the mandatory training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff had not completed all safeguarding training in line with the trust's compliance target.

Services for children and young people

Staff received training specific for their role on how to recognise and report abuse. Nursing staff we spoke with told us they had received training and completed levels 2 and 3. Medical staff received training specific for their role on how to recognise and report abuse. Clinical staff that we spoke with told us that they all had completed Level 3 safeguarding children..

Paediatric staff were 88.7% compliant with level 2 safeguarding training and 81.4% compliant with level 3 safeguarding training which was below the trusts target of 95%.

Matrons, managers, or head of service leads, met with both line managers and HR managers to highlight areas where compliance was lower with a focus on improvement. The safeguarding and clinical educator team identified solutions to barriers to compliance such as providing dedicated training sessions, or additional pay for staff to access on-line training in their own time.

Staff were aware of female genital mutilation (FGM) and Child sexual exploitation and told us these subjects were covered in their safeguarding training.

Staff knew how identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. Learning from specific cases of safeguarding was discussed and disseminated throughout the departments.

There was a designated safeguarding team. Staff told us they could escalate concerns to them and seek advice from them if they had any concerns. The safeguarding team consisted of a named nurse, doctor and nurse advisors who were available Monday to Friday. Out of hours support were provided by the social care team. Each ward that we visited had a named link nurse for safeguarding who provided training and support to each of the teams. Staff we spoke with knew the name of safeguarding children leads on their wards.

We observed medical and nursing staff routinely discussed safeguarding concerns or children who were subject to a child protection plan at daily team safety briefing meetings and multi-disciplinary meetings (MDT) on each of the wards we visited.

Staff knew how to escalate safeguarding concerns and told us the procedure they would follow to make a safeguarding referral. Staff gave examples of when they had suspected abuse and actions taken in response, which had resulted in positive and safe outcomes for the children involved.

Staff showed us a pocket-sized guide to safeguarding information card which had the details of each staff and team to be contacted in the event of a safeguarding incident or concern including out of hours and community.

Patient electronic records showed that appropriate safeguarding concerns were identified, recorded and referrals documented and made clear when a child was on a child protection plan.

Staff had a clear guidance to follow in the event of child abduction.

Access to all the wards and units we visited was restricted and only accessible by authorised swipe card. Staff checked and challenged people entering the wards.

Staff told us that if children were under child protection plans, they were made aware of any family members that were permitted on the ward. This was reviewed regularly, and the staff liaise with the local authority. We saw evidence that this was discussed and documented at MDT meetings.

Services for children and young people

Cleanliness, infection control and hygiene

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

Wards visited were visibly clean, tidy, and free from dust. There were suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

The service performed well for cleanliness with 97% compliance rate for hand hygiene and bare below the elbow between April and June 2023. At the entrance to the wards hand sanitisers were available and hand washing facilities with hand hygiene posters provided guidance to hand washing where readily available.

We observed staff following infection control principles including the use of PPE and take regular hand washing opportunities.

Staff told us side rooms and ward areas were cohorted to keep children with immune-compromised and infectious conditions separate. We saw patients who required isolation nursed in side rooms with the doors closed, additional PPE outside and appropriate signage in place.

Environment and equipment

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

We received whistleblowing in regard to equipment failures. Information reviewed during the inspection showed that staff did not always carry out safety checks of specialist equipment. We observed that across the wards/units that electrical equipment portable appliance testing (PAT) dates were overdue. We requested the service's register for the servicing of equipment. This showed 414 items of equipment that required servicing between 1 and 2 years ago. We did not observe any examples of equipment failing whilst on inspection.

We observed staff checking the equipment on the resuscitation trolley and records were completed. Tamper proof tags were used correctly in line with local policy.

We saw that wards and units were brightly decorated and some of the areas were personalised to the child.

Each ward that we visited had notice boards visible to patients and families. They included information about staff teams, staff uniforms, 'thank you' cards, staffing levels planned versus actual, and how are we doing specific to each area. This was presented in easy to understand and read format.

Children, young people, and their families could reach call bells and staff responded quickly when called.

The service did not always have suitable facilities to meet the needs of children and young people's families.

We received whistleblowing in regard to the functionality of the specialist feeding unit. The service only had 1 specialist feeding unit to prepare prescription feeds set by dieticians for all children that required them in GNCH. The kitchen was very small and hot to enter with no windows or ventilation. Staff told us they had no fan and found it difficult to monitor and regulate the heat and felt this was not an easy area to keep sterile. Leaders had recognised this and included it in their risk register with ongoing discussions about its future relocation.

On the Neonatal ward, staff told us their main challenge was space in the environment as the ward was built before the most recent building legislation, they often had 4 cots in a space that would now be used to nurse 2 babies.

However, there were accessible toilets for people and nappy changing facilities for parents with children within the department.

The service had enough suitable equipment to help them to safely care for children and young people. We checked a range of consumables items including syringes and dressings. All were within their expiry date. All sharp boxes that we looked at were signed, dated, and stored appropriately.

Staff disposed of clinical waste safely. We saw different coloured waste bins and sharp boxes for different types of waste such as general waste, clinical waste swabs and dressings. However, we did see clinical waste was often stored in areas that were left unlocked.

Assessing and responding to patient risk

Staff completed risk assessments for each child and young person however they did not always identify and quickly act upon children and young people at risk of deterioration.

Staff used a recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service currently used a paediatric early warning score (PEWS) to assess, detect and respond to any child deterioration.

The trust had a sepsis policy in place that was in date and in line with best practice guidelines. Staff were trained in sepsis awareness. The trust provided training materials in a variety of ways to increase staff awareness of sepsis including bespoke training and recognition days, video links and paediatric sepsis podcasts from The Royal College of Paediatrics and Child Health. There was a specific inpatient paediatric sepsis/deterioration screening and action tool to be used when staff were treating children with a suspected infection or abnormal observations without a clear cause, this included risk factors, red flags, timeliness of clinical review and treatment in line with paediatric sepsis 6.

The trust did not have clear escalation and transfer processes for serious unwell and deteriorating children coming into Great North Children's Hospital (GNCH). An incident had occurred in which a patient was delayed accepting into GNCH due to discussions around level of care required and available bed space. Once transferred to The Royal Victoria Infirmary (RVI) emergency department further delays occurred due to decision making in which time the patient deteriorated.

The trust did not have adequate psychology provision to meet the needs of children with severe or life changing injuries. Leaders had included this on the children's risk register and stated that the trust had not supported additional investment, despite the risk of children's psychological needs not being met could worsen mental health and was non-compliant with the National Institute of Care Excellence (NICE) guidance (CG53 and NG78). There was no onsite paediatric psychiatry liaison service with support being offered from a neighbouring trust. Controls in place on included a working group between the trusts to develop a business case for a psychiatry liaison service.

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were completed for every child and young person on admission and were reviewed regularly.

Services for children and young people

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep children and young people safe.

We received whistleblowing in regard to appropriate assessment and referral of children with epilepsy. We reviewed this on Ward 1b (neurological) and found that appropriate referrals had been made and spoke with a family that had appropriate and least restrictive interventions throughout their child's treatment. However, concerns were identified post inspection in relation to delays in sending correspondence relating to the care and treatment including referrals, planned operations, clinic letters, and discharge summaries which are being addressed within the Well-Led section of the report.

Staff completed safety briefings for each ward, these included key safety information such as infection control, intentional rounding, assessments, safeguarding, DNACPR status, medication, staffing, incidents and complaints and patient flow.

Staff completed World Health Organisation (WHO) surgical safety checklist a checklist to prompt professionals to check aspects of surgical safety, in paper format prior to a patient's surgical procedure.

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to ensure the skill mix allowed staff to provide the right care and treatment to children, young people and their families. Managers regularly reviewed and adjusted staffing levels. Bank and agency staff received a full induction.

The service had enough nursing and support staff to keep children and young people safe, however as there were a lot of newly recruited, staff told us the skill mix made it difficult to care for high acuity patients.

The service did not always have enough experienced staff to provide appropriate care on specialist wards. Managers reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, however, on PICU newly qualified staff were allocated lower acuity patients. Senior staff told us they were often responsible for care of their allocated patient, whilst supporting newer staff and felt they would not have enough experience in the skill mix if they had an influx of high acuity patients.

Staff reported that they were not able to take breaks and there was a feeling that the organisation "ran on the goodwill of staff," with patients being kept safe due to efforts of staff increasing their workload. Others reported a lack of experienced or suitably skilled/qualified staff. This resulted in increased feelings of exhaustion, burn-out and being "overworked and undervalued". They felt working under such pressure increased risk to patients and worried that serious harm would occur.

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

Leaders supported ward manager decisions to adjust and/or reduce the number of available beds according to the needs of children and young people and availability of staff.

The number of nurses and healthcare assistants (HCA's) matched the planned numbers.

The number of nurses and healthcare assistants (HCA's) matched the planned numbers. Where the numbers of qualified staff was lower than planned numbers, there were additional supporting staff such as HCA's, health play specialists and other mitigating actions would be implemented.

The service had 12.6% turnover rate in July 2023 which had reduced from 14.9% in August 2023.

The service had 5.6% staff absence rates between July 2022 and June 2023.

Staff used red flags on the electronic reporting system as an alert to show staffing pressures. Staff told us senior managers tried to provide additional staff when experiencing these pressures. Ward staff told us that they did not always report unsafe staffing figures, due to ward pressures and time limitation. We reviewed the trusts incidents and saw that datix submissions related to staffing incidents, averaged 2 per month in paediatrics.

The use of bank and agency staff was limited and when required staff familiar with the service were requested.

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

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We requested the planned and actual medical staffing figures for wards visited, these were provided for departments as a whole as opposed to by ward.

The service had 15.5% turnover rate in July 2023 which had increased from 14.2% in August 2022.

The service had 0.65% FTE medical staff absence rates between July 2022 and June 2023.

The risk register identified junior doctor gaps in paediatric surgery with mitigations including locum rates negotiated to fill shifts and elective lists being stood down if necessary. However, data provided did not include the current number of junior doctors in post.

The service only had 2 paediatric radiologists in post with 3 vacancies. The service had made repeated attempts to recruit but had not been successful and risked delays in radiology assessments and reports. A number of mitigations had been put in place and recruitment continued. The trust told us following the inspection that the service was now fully established.

Consultants from PICU were at times required to cover the Northeast Children's Transport and Retrieval (NECTAR) out of hours. As consultants covered both services this could increase wait times in either service and increase the risk of exhaustion and possible sickness, locum and additional hours were also used to staff the rota to minimise the requirement to cover both services.

The service had high rates of bank and locum staff use.

Managers could access locums when they needed additional medical staff.

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

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

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

Records

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

Staff recorded patient information. We reviewed 9 sets of records which all accurately captured patient information.

Staff could not always access all the information required about patients easily. The children and adult patient record systems contained different assessments such as only adults having moving and handling assessments. Staff told us that moving and handling assessments were available through the adult records system, but not all paediatric staff had access to this. Moving and handling risk assessments were available to all clinical staff through the electronic patient record system. A training need had been identified as some paediatric teams were not aware of this.

Staff did not complete plans of care for all patients as the records system didn't generate these. Staff completed risk assessments for patients which would then determine whether a care plan needed to be developed but would not automatically generate this.

For two records we saw, skin integrity risk assessments had been completed it was difficult to identify from patient records where the skin damage had occurred of if there were multiple areas of skin damage as personalised plans of care had not been generated. However, staff were aware of children with skin damage, completed regular risk assessment and had made appropriate referrals where necessary.

Staff were working around the gap in records by making their own notes in patient records, adding information to the handover, and reverting to paper records where possible. This meant there was a risk that information could be lost.

When children and young people transferred to a new team, staff provided a full handover and there were no delays in staff accessing their records.

Records were stored securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their carers about their medicines.

Staff completed medicines records accurately and managed prescribing documents safely however these were not always kept up to date. We reviewed 2 electronic medicine records where discontinued medications were still listed in the patient's medications, however the system did not allow staff to complete an administration record for these medications.

Services for children and young people

Medicines were stored securely in appropriate facilities. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked in line with the providers policy. Controlled drugs were kept in separate locked cupboards and appropriate checks recorded. We saw records for electronic fridge temperatures, and all were within acceptable limits. All medicines we checked were within their expiry date. Oxygen cylinders were stored and secured appropriately and within expiry date.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

The service followed a reducing restrictive interventions policy for adults and children and young people which was in date and developed in line with NICE guidance. This ensured children's behaviour was not controlled by excessive and inappropriate use of medicines, advice was sought from the psychiatric liaison service and safeguarding team and that consideration was given to capacity and safeguarding issues.

Staff learned from incidents to improve practice. Staff on NICU ward had created a 'Neonatal 10 Steps to Safer Medication' visual aid following a theme of medicine incidents.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. However, although managers investigated incidents, they did not always share lessons learned with the whole team and the wider service. When things went wrong, patients did not always receive an apology.

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

Managers shared learning with their staff and across the trust. Ward sisters told us they were asked to present complex cases and learning at meetings, rotationally to share learning across wards.

The was a specific incident investigation team known as C-Guard who investigated serious incidents and never events.

There was evidence that incidents were investigated, learning recognised and shared across the trust to make improvements. In incidents of pressure damage, learning and recommendations were identified. We saw no repeated theme of how pressure ulcers were acquired.

Staff did not always receive feedback from investigation of incidents. Staff told us that they did not always receive outcomes and learning to incidents in a timely way and gave an example when they had met with a family to discuss an incident and were unaware that the outcome had been shared with the family.

Data provided showed that DOC was not always provided in full for all incidents graded moderate or severe in line with their statutory duty. Staff we spoke to understood DoC and demonstrated an open and transparent approach.

Is the service effective?

Good ↓

Our rating of effective went down. We rated it as good.

Services for children and young people

Evidence-based care and treatment

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

Staff had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were evidence based on national guidance including National Institute for Health and Care Excellence (NICE) guidance, Royal College of Nursing (RCN) and other professional guidelines such as National Burn Care Standards, Paediatric Intensive Care Society and the British Association of Perinatal Medicine.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We saw in records that the was appropriately completed.

Staff referred children and young people to Child and Adolescent Mental Health (CAMHS) when deemed appropriate. We saw evidence in records of the appropriate timely referrals.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. We observed handover meeting and staff discussed all aspects of the wellbeing of children and young people and their families.

Nutrition and hydration

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

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed.

Staff documented specific dietary requirements clearly such as allergies and cultural diets. The service developed bespoke menus to meet their needs and kosher and halal food was prepared as appropriate.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Wards used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. It is a simple five-step tool to identify if a child’s condition has any nutritional implications, what the child’s nutritional intake is plus their weight and height.

Based on the results from the first three steps, the overall risk of malnutrition is calculated, and a care plan developed as appropriate.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it. A team of dietitians and speech and language therapy (SALT) worked with patients and their families across the wards.

The community eating team visited children to carry out debriefs with children and young people with eating disorders following their discharge.

On NICU, the service provided families with hot and cold snacks and had facilities in place such as microwaves and fridges for families to bring food from home. Staff had worked with the local fruit and vegetable stall on hospital grounds to receive a delivery of fresh produce twice weekly to increase the availability of healthy snacks with to women expressing breast milk, deliveries were increased throughout school holidays to extend the offer to siblings.

On Ward 11, burns and plastics, a grant had been secured to provide families of children and young people staying on the ward to receive a breakfast. Over the three-week pilot, a total of 2,396 meals were provided at no cost to parents. Feedback from families described the scheme as “lifesaving” and “making such a difference.”

Pain relief

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

Staff assessed children and young people's pain using the Face, Legs, Activity, Cry, Consolability (FLACC) scale, a recognised tool, and gave pain relief in line with individual needs and best practice.

Children and young people received pain relief soon after requesting it.

Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

We requested the most recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) audits relating to Children and young people. The last audit was published in June 2023.. The trust told us that they were currently reviewing the report to identify any areas on no-compliance and risk.

The National Neonatal Audit Programme (NNAP) data, which monitors aspects of the care that has been provided to babies on neonatal units in England and Wales showed that in 12 NNAP measures in the latest audit provided from 2021, the RVI scored under the national average in 7 out of 12 measures. The service scored similar to or better than the national average in deferred cord clamping, antenatal magnesium sulphate, medical follow up at 2 years, parental presence at consultant ward rounds, parental consultation within 24 hours of admission.

The National Paediatric Diabetes Audit (NPDA) 2021/22 showed that the GNCH performed similarly or better than the national average when delivering six annual health checks in children with Type 1 diabetes. This was with the exception of foot examination health check completion which was at 62.6% compared to the national average of 78.7%, and the additional check of eye screening at 12.9% completion in comparison to the national average of 62.6%

Services for children and young people

We requested Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) data, a a national audit programme to collect information about all late fetal losses, stillbirths, neonatal deaths and maternal deaths across the UK. The trust did not provide this audit information. The trust provided risk review meetings and department meeting minutes that referred to discussion in regards to MBRRACE data, but this did not include how the trust compared nationally to others.

Managers and staff used the results to improve children and young people's outcomes.

The neonatal service was UNICEF Baby-Friendly Stage 1 Accredited, and staff were proud of this achievement.

Managers and staff carried out a programme of repeated audits to check improvement over time. These included the Clinical Assurance Toolkit (CAT), a suite of audits to oversee core standards on wards, and The Newcastle Reporting Hub, which used the electronic record system to monitor staff compliance with assessment tools and gave staff an oversight of how their ward were performing comparatively to other wards.

Managers did not consistently use information from audits to improve care and treatment. Processes were not embedded to share audit findings to staff despite this being provided regularly to ward managers, sisters, and matrons. Staff we spoke to had varying knowledge of audit findings.

Improvement was monitored and checked. Audit findings from the CAT tool showed sustained or improved scores of compliance between April and June. In April, Ward 1b was non-compliant with the CAT tool, scoring only 29% compliance. In May this had improved to 100% compliance and achieved 99% compliance in June.

The service was an outlier for Epilepsy Specialist Nurse input in the National Clinical Audit Seizures and Epilepsies for Children and Young People 2023.

Competent staff

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

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

There were not always enough staff with experience, to meet the needs of children, young people and their families. There were a lot of newly qualified staff recruited that were developing their skills and knowledge.

Managers gave all new staff a full induction tailored to their role before they started work. The Trust offered comprehensive preceptorship programmes providing support and guidance to newly registered practitioners.

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

Staff had the opportunity to discuss training needs and development opportunities with their line manager and were supported with their skills and knowledge. The Trainee Nurse Associate role had been introduced, a programme to upskill Band 2 and 3 Healthcare Assistant (HCA) staff through a 2-year programme of learning and placements to be able to progress to a Band 4 Nursing Associate position. Staff told us this had made it financially viable for them to invest in their education and development.

Managers made sure staff received any specialist training for their role. The clinical education team were made up of nurses from different specialities and were responsible for supporting students and newly qualified staff and ensuring staff stayed up to date with their competencies and best practice. All ward staff we spoke with spoke highly of the clinical education team and managers felt able to contact the team if they identified a training need for their staff group.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers recognised the training needs of junior staff in specialist areas but limited time they had to complete their training within working hours, they prioritised training requirements and temporarily offered optional overtime to complete this outside of working hours.

Managers identified poor staff performance promptly and supported staff to improve with different teaching methods, reflections, and action plans. Staff underwent a full probation to demonstrate their competencies.

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

Multidisciplinary working

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

We observed daily multidisciplinary meetings across the wards/units. Staff discussed each of the children or young person to plan, monitor and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for children, young people, and their families. We observed a multidisciplinary team approach which included consultants, nurses, nursery nurses, play therapists, physiotherapists, occupational therapists, and teachers delivered the care and treatment provision to each child and young person.

Staff that we spoke with give us examples of co-ordinated planning and delivery of care, and communication between teams was excellent, focusing on the needs of the child and their family. For example, when the MDT made the decision, in collaboration with the family, to withdraw care from a very poorly child, the team supported the family through the process and explained the stages for palliative care. One of the outcomes included the donation of the child's organs to help other sick children.

Staff appropriately referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

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

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

Staff could call for support from doctors and other disciplines diagnostic tests and pathology 24 hours a day, seven days a week. Consultants were available out of hours and supported the junior doctor rota in the paediatric intensive care unit, covering night shift when necessary.

Nursery nurses and play specialists were available seven days a week.

Services for children and young people

Physiotherapy and occupational therapy services were offered to children on specialist wards seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Each ward/unit had an array of information to promote healthy eating, infection control and sexual health.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw that when a child or young person was admitted a full assessment was completed on admission and if needed referrals to dietitians or speech or language therapy were requested.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. The trust had a mental capacity policy with a section specifically referenced to children and young people. We reviewed 10 records all had the appropriate mental health risk assessments to assess if a child or young person had capacity to make decisions about their care.

We saw evidence that when children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture, and traditions. This was appropriately recorded.

Relatives and loved ones of children and young people to us they consented to treatment based on all the information available and felt fully informed. Staff recorded consent in children and young people's records. They did not always document the information discussed to inform and gain consent prior to surgical procedures. NICU surgical examples. However, we spoke to the family of patients that felt they were fully informed about their children's procedure.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff we spoke with understood the Gillick competencies and Fraser guidelines and gave examples of how they would be applied in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care. Gillick competency helps staff assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Staff that we spoke with knew and understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Clinical staff did not always complete training on the Mental Capacity Act, medical staff were 69.2% compliant with training and nursing staff were 94.9%, which did not achieve the trust's target of 95%.

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

Services for children and young people

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for children, young people, and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way.

Children, young people and their families said staff treated them well and with kindness.

Staff followed policy to keep care and treatment confidential.

Results from the NHS Children and Young People's Patient Experience Survey showed the trust scored better than other trusts when asked if the staff looking after them were friendly.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. The service had a chaplaincy team that provided pastoral, spiritual, and religious belief support which were available 24 hours for patients, relatives, and staff.

Emotional support

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

Staff gave children, young people and their families help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The trust provided a specialist service known as the CHIPS team who supported staff, children, and families physical, emotional, social and spiritual elements of their wellbeing of and ensured care, support and choices continued at the end of life.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing.

Following the inspection, the trust provided examples from a recent commissioner assurance visit to the neonatal unit. Parents received updates on their baby through vCreate, a web-based application that allowed staff to record and send secure updates to parents for reassurance. Staff created memory boxes for babies for parents and their families.

The service collaborated with charities to deliver the SPACE pilot (Social Prescribing And Community resources for Children and Young People), which offered wellbeing support for families who would benefit from non-medical support.

Services for children and young people

Understanding and involvement of patients and those close to them

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

Staff made sure children, young people and their families understood their care and treatment.

The service had created and displayed posters to help parents understand their children's care and observations such as PEWS scores. Posters gave information in accessible formats to help parents understand information such as why, when, and how observations of their child would be taken.

Relatives and loved ones told us they were fully informed in their child's care; they were kept informed and up to date on what was happening.

Staff talked with children, young people, and their families in a way they could understand, using communication aids where necessary.

We saw information boards promoting Makaton (a unique language programme that uses symbols, signs, and speech to enable people to communicate). We spoke to a parent who told us some staff were trained and used Makaton to communicate with their child.

Children, young people, and their families could give feedback on the service and their treatment and staff supported them to do this. The service displayed friends and family posters and we saw feedback boxes on all areas we visited.

Staff actively sought feedback from children, young people and their families when planning to make improvements to the service.

The NICU unit took part in and were benchmarked 1st place in the United Kingdom and 6th place globally in an incentive programme to increase skin to skin contact in parents and their babies.

Following the inspection, the trust provided examples from a recent commissioner assurance visit to the neonatal unit. The report highlighted parents gave positive feedback about the care provider by staff to their babies and felt fully informed and involved in their babies' care. In Ward 2b, the trust had approved improvements of the sensory room. Staff had created a visual idea tree on the door with post-it notes for patients and their loved ones to leave ideas as to how the sensory room could be improved to benefit their needs.

Staff supported children, young people and their families to make advanced decisions about their care. The CHIPS team provided expert palliative support for babies, children and young people with life-threatening conditions and their families.

Relatives and loved ones told us that staff supported them to make informed decisions about their child's care.

Results from the NHS Children and Young People's Patient Experience Survey 2020 showed the trust scored much better than other trusts when children 8-15 and parents were asked if they were involved in decisions made about their care and treatment.

Services for children and young people

Is the service responsive?

Outstanding ☆ ➔➔

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

Service delivery to meet the needs of local people.

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

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

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

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support for children and young people with mental health problems and learning disabilities. We saw examples of referrals made and advice sought when required.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

Managers monitored and took action to minimise missed appointments. Managers ensured that children, young people and their families who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat children and young people in a day.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Staff worked with families and children to learn their physical and holistic needs to provide individualised care. A parent told us their child was under several specialities but when admitted on this occasion was admitted to neurosurgery, they told us their child was admitted there as "this is where they know them best."

Wards were designed to meet the needs of children, young people, and their families. On Ward 7, staff were researching the best haemodialysis (a treatment to filter wastes and water from your blood) chairs for children that were comfortable, safe and had the ability to lie flat in an emergency. Children were able to personalise their seating space

with their names and crafts they liked. On Ward 11 large screen televisions were installed in bathrooms to help distract children who required potentially painful dressing changes for burns and scalds. On Ward 1b, cubicles had pull down beds for parents to stay with their child if they had to stay on the ward for extended periods. Wards had cleanable sensory rooms and interactive play areas that were suitable for different ages and ability of children and young people.

Staff used transition plans to support young people moving on to adult services. There was a transitional policy for children that were moving into adult services and staff we spoke with were knowledgeable about this.

Staff supported children and young people living with complex health care needs by using 'This is me documents and passports.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. The service had information leaflets available in languages spoken by the children, young people, their families, and local community. Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed. The service was fitted with a hearing loop and had pictorial signage throughout.

Children, young people, and their families were given a choice of food and drink to meet their cultural and religious preferences.

The service worked with charities to make the hospital accessible to families and loved ones of children and young people. Crawford House supported families of ill children being treated at the RVI by giving them a communal 'home from home' close to the hospital. The NICU offered parents training in resuscitation and the opportunity for families to stay in a flat close to the ward whilst preparing to return home. For families that weren't local to Newcastle, NICU used their specialist transfer service to move babies back to their local Special Care Baby Unit when safe to do so. Families were also given free parking or travelling expenses.

The service had 2 transport services to support families and loved ones in being as close to their child as possible. The Northern Neonatal Transfer Service (NNeTS), a transfer service staffed with specialist paramedics transferred babies to another hospital when well enough to be closer to home and the Northeast Children's Transport and Retrieval (NECTAR) service, a standalone commissioned service that provided intensive care for children from the point of referral to the handover of care at the receiving unit. NECTAR also transported children home for palliative care.

The service had amenities such as a cash machine, post box, shops and cafes to make it easier for people spending long periods of time in the hospital.

Access and flow

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

The service had clear admission pathways for children and young person's admissions into GNCH including PICU and NICU.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

Services for children and young people

Trust wide data in relation to 18-week referral to treatment times, showed the trust was in the second highest decile for level of risk for patients waiting over 18 weeks for treatment. In March 2023 71.5% of patients at the trust were treated within 18 weeks, compared to the England average of 65.8%.

Trust wide data showed 52-week referral to treatment time was in the second lowest decile for level of risk for patients waiting over 52 weeks for treatment. In March 2023, 6% of patients at the trust were treated over 52 weeks compared to 8.5% nationally.

We requested data from the trust to show average length of stay for both elective and non-elective surgery, but the data could not be interpreted in the format it was submitted. However, we saw trust wide the trust does have a higher proportion of longer stay patients over 21 days than comparators (10.5% compared with 8% national average). However, the average length of delay for patients who stay in hospital for 7 days or longer is better than regional and national averages, at 5.8 days delay after being clinically ready for discharge. Compared with 7 days for regional peer average and 8.4 days national average. Since October 2022, the proportion of bed occupancy patients that were clinically ready to discharge has been better than the regional and national averages.

The number of paediatric patients waiting within 52 weeks for treatment was 106 patients, this meant 98.9% of children waiting were within the 52-week target compared to the national average of 94.8%. The service also performed positively with 99.2% of paediatric patients receiving treatment within 52 weeks compared to the national average of 92.2%. The percentage of paediatric patients waiting within 18 weeks for treatment was 82.9% compared with the national average of 59.2% with children treated within 18 weeks was 81.6% compared to the national 62.6%.

The service moved children and young people only when there was a clear medical reason or in their best interest. Staff did not move children and young people between wards at night.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Matrons and surgeon staff were doing a daily walk around to estimate patient discharge dates and identify themes that may be preventing children from leaving hospital if medically optimised, such as equipment or housing. Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported children, young people, and their families when they were referred or transferred between services.

The trust had funded an additional ECMO system to be kept at the GNCH to offer support to both adult and paediatric patients rather than transporting one system between the Freeman and GNCH to improve response times.

Learning from complaints and concerns

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

Children, young people and their families knew how to complain or raise concerns.

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

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

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

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

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

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

The Children's Services at the Trust was managed by a leadership team which sits within the wider Children's services. Neonatal services sat within the Women's services division.

The leadership structure chart was clear and comprehensive.

The matrons visited each site every week and attended team meetings. Staff told us they knew who they were and how to contact them. Leaders supported staff to develop their skills and more senior roles.

Vision and Strategy

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

The service had a vision to be a leading national healthcare provider with a strategy to achieve this which included putting patients first, focusing on quality and safety, integrated care, research, and development underpinning their services, reputation, and sound financial management to secure ongoing development.

The trust had developed 5 values known as the 5 P's, patients, people, partnerships, pioneers and performance.

Staff were aware of the vision and strategy.

Services for children and young people

There was a Youth strategy that focussed on improving outcomes for children and young people by giving them opportunities to develop skills, empower, challenge, and build resilience and confidence through engagement groups and outreach work.

Culture

Staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care.

We received a number of anonymous whistle blowing concerns leading up to and during the inspection. In order to gain a wider view of staff morale we developed and collated a staff survey as part of this inspection, to enable all current staff to feedback regarding their experience of working within the trust. We received a total of 2,360 respondents trust wide with 44% of staff working at the RVI and 33% working at the Freeman hospital. We saw 66% of respondents were clinical staff and 71% of staff had worked in their roles for at least 3 years. Findings showed that 40% of respondents disagreed that communication between senior management and staff was effective. Over a third of respondents (38%) disagreed that senior managers act on feedback. More than a quarter of respondents (28%) disagreed that they felt safe to report concern without fear of what will happen. One in five (21%) disagreed that they felt comfortable raising bullying and harassment or discrimination concerns and one in five (20%) disagree that they felt confident raising patient safety concerns or other concerns within the organisation.

Analysis of the free-text comments we received, revealed a workforce who felt disconnected from leaders who did not understand, acknowledge, or address issues that staff 'on the ground' faced. Comments spoke to a culture of favouritism and bullying, where problematic behaviour went unchallenged, and concerns went unheard. Staff did not always speak-up because they felt "nothing changes", or from fear of repercussions. Staff spoke of the huge pressure they faced and the negative impacts it had on them, and on patients who they felt were at increased risk of harm as a result.

Leadership was an important theme for respondents who often described a culture of top-down communication, of feeling unheard, and of disconnection at the Trust. Respondents felt information was cascaded down from management, rather than in dialogue with them. They did not feel there were many opportunities for feedback.

However, some staff told us they felt respected and valued. They were encouraged to be open and honest and believed their views were listened to.

Ward managers, sisters and matrons spoke highly of their teams and praised them for the work and care they provided on an ongoing basis.

Staff told us the best part of their role was the team they worked within. Matron staff told us they were proud of the staff teams and the amazing job they do. Staff told us that a recent turnover of staff had improved moral.

The service display Freedom to Speak Up information and details of champions to contact if staff wanted to raise concerns about patient or staff safety confidentially.

Staff were offered support following emotionally difficult cases from services such as the children's palliative care team debriefs and (CHIPS) psychologist.

The trust provided resources for staff to manage their own wellbeing. Staff were able to self-refer into counselling services and were offered self-help resource leaflets for serious health related conditions such as stress, anxiety, self-harm, domestic abuse, alcohol, controlling anger, abuse and eating disorders. Managers were also able to refer to these services.

Governance

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

The GNCH had its own governance structure for the Children's services it delivered.

Governance meetings were held to ensure information was escalated and cascaded to relevant staff as necessary for both children's wards and neonatal unit. These included a monthly steering group, monthly GNCH sisters meeting, bi-annual GNCH quality and safety forum, quarterly deteriorating patient group and patient safety group. Items for these meetings were informed by themes identified by deterioration and sepsis nurses' monthly compliance reports, electronic observations review and ward walkarounds.

The trust shared with us the last 3 governance meetings for January, February and March 2023. These occurred monthly and showed good attendance, however rolling agenda items were not always included such as risk, and performance data was not discussed.

In July's GNCH Quality and Safety forum minutes, the risk register was included as a standard agenda item, and covered how items had been on the register for some time and required an update. In August minutes there was no discussion of the risk register.

Staff for each ward took turns to present complex cases, their management, and the patient outcome at the GNCH sisters meeting to disseminate good practice and learning.

Service leads identified their top three risks. These were reflected on the risk register; measures put in place to mitigate the risks and were regularly reviewed. Neonates had appointed a risk lead, they used a dashboard to monitor themes and patterns in risks such as (review dashboard).

Trust policy was not always reflective of staff practice. Staff told us about how medications were shared between wards where required, with two staff attending from the receiving ward, and taking away medications already prepared by the providing wards staff. Pharmacy colleagues brought to attention that this process was outside of the medication policy, in which one member of the receiving ward should attend, and a member from the providing ward should assist them back with the medications to be prepared on the receiving ward. Ward sisters told us they were uncomfortable with this process as they could not be assured as to what and how medications from their ward were prepared and that the policy required review.

Staff told us they discussed quality and safety issues, audit outcomes and feedback from complaints.

Performance information was collated through the Newcastle reporting hub dashboard and shared with ward managers monthly. This included various performance indicators such as risk assessments completed and level of falls. However, there was no formal process in place managers to cascade and improve performance information with some managers printing information and placing in staffing areas, some discussing in safety briefings and others sending emails. This meant that the availability of performance information did not always result in measurable improvement.

National audits underwent a baseline assessment by the Associate Director of Nursing for Children's services and an action plan formulated. These were reviewed at the Clinical Outcomes and Effectiveness Groups.

The trust's patient safety team completed quarterly audits of compliance against the duty of candour regulatory requirements. We reviewed the data provided to us and found that the trust delivered duty of candour in full to 2 out 7 patients who were involved in a moderate or severe patient safety incident.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

Ward level leaders had oversight of their team's risks, issues, and performance through on going ward level audits and were aware of the service's risk register. We spoke with senior managers and consultants who were aware of the individual ward risks which was based around staffing, records.

The paediatric risk register identified 50 risks. Each risk had been given a risk score depending on the level of risk. Risks ranged from staffing pressures, to dated environment, wait times and non-adherence with national guidance and best practice.

The risk register was not always reviewed in line with policy. We were unable to identify from the risk register when risks had been added. Review dates were not always recorded, although all risks had been assessed within the last 2 months, we saw 15 risks where the last action recorded was between 2016-2022 and appeared to have actions taken annually. We were unable to identify from the risk register when the other 35 risks had been reviewed.

The risk register was not always clear as to the status of current risk. For example, the lack of psychology provision had been added to the register before 2016 with an initial risk rating of 15. The latest action taken to mitigate this risk was an allied health professional review in June 2023, but did not state whether risk continued or actions to mitigate risk despite the risk score being lowered to 6. Following our inspection, the trust provided an updated risk register stating some columns in the register had been omitted by human error at the time of our request and all risks had an 'open' status.

Risks were not always escalated appropriately. We saw 12 risks with a current risk rating of 15 or above but had not been escalated to the executive oversight register in line with policy which meant their was a risk senior leadership did not have oversight of risk within paediatrics and therefore to take further actions to mitigate risks.

The risk register did not always identify risks we found on inspection, such as the lack of a clear transfer pathways and timely clinical decision-making processes when children were transferred between services. Risks on the register such as low compliance with PEWS scores, were still occurring and resulting in patient incidents which showed that risk was not managed and reduced effectively.

Senior leaders met daily to discuss any staffing escalation to mitigate staffing risks and manage unexpected events. They redeployed staff across the service to meet the planned staffing levels.

Staffing pressures were escalated, and action taken to mitigate risks. Staff were redeployed across the service to meet planned levels and bed closures were considered and made when necessary to keep services safe. The service was undertaking a large recruitment campaign and staff we talked to told us about decreasing staff vacancies and adult nurses were used where appropriate in intensive and critical care environments. Staff were being recruited creatively, such as advertising for critical care as opposed to specialist care baby unit to reach a larger audience.

Risks to patients, such as hospital acquired infections (HAI), were monitored and escalating risk discussed at the Nurse Staffing and Outcomes Group with areas of concern receiving additional intervention and support which we saw.

The CAT was one of the methods used to collect information through clinical practice, patient care records and risk assessments and staff knowledge to inform ward sisters, charge nurses and matrons how their areas were performing monthly and provide clinical assurance to the Trust Board.

Information Management

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

Staff could not always easily access the electronic patient record system and care records. We received whistleblowing in regard to the effectiveness of IT systems and how this was slowing down improvement within the service. Information reviewed during the inspection showed that system issues were a risk.

The community team did not have access to inpatient electronic records, staff told us they felt this “restricted the development of a really good service.”

Staff were not always able to use systems to their full potential. For example, paediatric teams did not have access to some risk assessments such as moving and handling. The system did not trigger care plans from its risk assessments and therefore staff had to make notes about plans of care in the annotations section.

Staff raised concerns with us that IT systems were slow and ineffective.

Mandatory training covered information governance for staff to complete. Staff were 87.4% compliant with information governance training which did not meet the trusts 95% compliance target.

The Newcastle reporting hub was available to all staff and allowed them to monitor their compliance and performance against other wards. This was not always disseminated consistently to staff teams.

Staff had access to policies and guidance on the trust intranet.

We reviewed incident information submitted for the last 12 months; the trust had only submitted 4 incidents to CQC under the Paediatric speciality. The trust provided incident information as part of data request and staff had reported 931 incidents in the last year.

Services for children and young people

Information provided as part of the data requests post inspection visit was not provided in a format that was easy to interpret.

Data management systems were integrated and secure.

Engagement

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

Wards displayed staff engagement boards that included general information about ward performance in various areas.

We saw celebrating success boards across all areas and thank you cards showing appreciation to staff.

Family and friends test boxes and posters were displayed across children and young people services, this gives patients and their families the chance to give open and honest feedback about their care.

The Trust held a youth forum for patients, or their siblings aged 14-24 with a focus on Trust improvements and research.

The Trust had a young person's advisory group with 62 members aged between 11-19 engaging with research and quality improvement projects such as the review and development of the paediatric food menu offered by the trust.

Learning, continuous improvement and innovation

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

The trust were one of three trusts involved in a pilot to develop a new national standardised tool for paediatric observations (SPOT System-wide Paediatric Observation Tracker). The GNCH had introduced parental concern element to their PEWS scoring system and had auditing and exploring the outcomes of collecting parental concern to feed into the pilot.

Ward 11 was 1 of 3 centres in the UK trialling the use of 2 products to treat burns. These were Epiprotect is a synthetic epithelium, a type of tissue that forms the covering on all internal and external body surfaces, made from a unique material can be efficiently used to treat burns and Spincare, a handheld device which creates a customised skin-like matrix that remains on a wound until the skin improves.

The GNCH had 14 active research studies in place with appropriate practitioners leading. These studies varied from psychosocial outcomes and clinical practice to staff wellbeing with the intention of using positive findings and outcomes to inform practice. The Neonatal service had appointed a research nurse to focus and lead on 13 active research cases. These included, but were not limited to, COOLCUDDLE2, a study investigating the implications of infants receiving cuddles from parents whilst undergoing therapeutic hypothermia (cooling therapy), PEACOCK which used behavioural and physiological neonatal responses to train machine learning algorithms to assess their ability to recognise the comfort state of neonates and SWIFT, support with or without formula trial for infants at risk of hypoglycaemia.

Services for children and young people

Staff were supported to develop in their education and contribute to practice within the service. A staff member completing their masters had done research in healthcare practitioners' perceptions of how incivility affects patient safety which was being used to develop and improve practice within the service.

Surgery

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

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

Training was offered as either face to face or through an electronic learning portal. Staff told us they were offered time to complete the course when they could.

Nursing and medical staff received and generally kept up to date with their mandatory training. We reviewed training compliance figures across all the wards we visited and saw that the compliance rates were slightly below the trusts 95% target, although we also saw that staff awaiting training had been provided with a date to complete it. We requested the mandatory training data for the surgical health group overall and saw overall mandatory training compliance was slightly below the trust target at 90% for June 2023.

The mandatory training was comprehensive; and meet the needs of patients and staff. Staff told us they were able to access all aspects of mandatory training and were fully supported by senior ward staff to undertake both face to face and electronic learning.

However, we reviewed Aseptic Non-Touch Technique (ANTT) training rates and saw that they were consistently low across the surgical wards we visited. Overall trust compliance rates were 64% which was significantly below the trust target. Senior managers described the low compliance rates as disappointing as there had recently been an increased focus in regard to improving the overall rates.

Clinical staff completed some training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The trust told us they had introduced Learning Disabilities Diamond Standards mandatory training for all clinical and patient facing staff in March 2023 and had introduced autism awareness education sessions in April 2023, however Autism awareness was still not part of the mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance figures were collated through a recently introduced compliance dashboard in which senior ward staff were able to view live training compliance rates. Senior ward staff spoke positively about the new electronic recording hub and we saw the system being utilised on each ward we visited.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Surgery

We reviewed the mandatory training compliance figures and saw that 93% of staff within the health group had completed level 2 adults safeguarding training and 91% had completed level 2 children's safeguarding training. These figures fell slightly below the trusts target of 95%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff knew who to contact and where safeguarding policies were for support. Staff were able to articulate examples of recent safeguarding alerts made and understood those patients who were most vulnerable and required safeguarding input. They used online forms to refer any safeguarding notifications or queries to the local authority multi-agency safeguarding teams. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern and discuss with the social work team who were based within the trust. Staff described multi-disciplinary team working to ensure patients were protected. Staff could also add any safeguarding issues to the electronic recording system.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed the most recent safeguarding alerts submitted by the trust and saw that patients were referred to the local authority safeguarding team as appropriate. Staff told us they received feedback following submission of these alerts where possible.

Cleanliness, infection control and hygiene

The ward environment was visibly clean; however, the service did not always control infection risk well. Staff used equipment to protect patients, themselves and others from infection. However, control measures were not always in place on ward 22.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We also saw completed cleaning schedules in ward areas.

We reviewed the trusts infection prevention and control audits and saw that compliance was high across the wards we visited.

However, staff did not always follow infection control principles including the use of personal protective equipment (PPE). We visited ward 22 at The Royal Victoria Infirmary (RVI) and saw that isolation processes to prevent the spread of infectious disease or virus were not being followed. We observed staff enter an isolated cubicle to provided food to a patient and proceed to take food to other patients without wearing any protective personal equipment or carry out any hand washing. We brought this to the immediate attention of senior ward staff, however this practice continued without intervention of senior staff.

Audit results were finalised at the end of the month and were shared monthly and as part of assurance measures, were discussed monthly in one-to-one meetings between Matrons and Associate Directors of Nursing.

We reviewed the most recent infection prevention control audits completed by ward matrons for ward 22 and saw 98% compliance. In a different audit completed for the same area we also saw 100% compliance with staff wearing appropriate personal protective equipment. However, it was not clear from the audit data if all environmental IPC risks were monitored through auditing. It was also not possible to determine hand hygiene compliance rates as they were integral to the overall results.

IPC information displayed across the wards we visited were often historic and had not been updated for several months. We requested recent PLACE audit data; however, this did not show all wards across the surgical speciality.

Surgery

Staff did not dispose of clinical waste safely. We also saw across both hospital sites that clinical waste storage areas were not always secure. This posed a risk that both patients and visitors to the hospital may enter unauthorised areas, resulting in an increased risk of contracting an infection. We again brought this to the immediate attention of senior ward staff to ensure areas were maintained safely.

Sanitiser was available at the entrance of all wards we visited, and we saw these were regularly replenished.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE). We observed most staff using gloves and aprons appropriately.

We reviewed portable equipment with 'I am clean stickers' which were generally in date.

We saw in March 2023 data shows the trust is also in the bottom 25% of trusts nationally for the rate of infections per 100k bed days, for MSSA, E. coli, Klebsiella, P. Aeruginosa and C. difficile infections. When compared with other Trusts of a similar size and complexity the Trust performed more favourably' For MRSA infection rate the trust is in the top 25% performing trusts nationally.

Senior ward staff told us that monthly infection, prevention and control (IPC) audits, incorporating hand hygiene audits were carried out as part of the Clinical Assurance Tool (CAT) via an electronic recording system, by each ward on a monthly basis and shared with staff through meetings and emails.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment was not always suitable and equipment used was not always serviced and checked.

The service did not always have suitable facilities to meet the needs of patients' families. No wards we visited had environmental provision for patients with dementia or delirium. In addition, we did not see any equipment provided such as brightly coloured drinking cups and plates in use on the wards we visited. We saw this was a concern highlighted as part of the recent PLACE audit results. The Patient-Led Assessments of the Care Environment are an annual assessment of the non-clinical aspects of the patient environment. We reviewed portable electrical equipment across all wards we visited and saw several items of equipment which had not been tested in accordance with the trusts own testing policy or had expired.

For example, on ward 22 we saw an out-of-date service certificate for a bladder scanner. On ward 16 we saw out of date servicing for scales, bladder scan and several items of sterile clinical supplies such as saline. On ward 44 we saw some sterile supplies which had expired and on ward 45 an out-of-date servicing certificate for a VAC machine.

We also saw several clinical areas unlocked, for example treatment rooms which stored clinical supplies such as needles and IV fluids. We saw this on wards 15 at the RVI. This is a risk due to the type of vulnerable patients nursed on this ward.

COSHH chemicals were not always stored safely or in line with the trusts own policy. For example, we saw cleaning store cupboards unlocked on wards 15, and 22. These stores had acticlor tablets visible and ready to dilute. This again posed a risk to vulnerable patients who may gain access into these areas and digest accidentally.

We also reviewed resuscitation trolley equipment checks on all wards we visited and saw inconsistent equipment checks on RVI ward 15, ward 22 with gaps shown across several days.

We visited several wards with out of date or blank information boards and panels. On other wards we saw that information that was displayed did not always match what staff told us. Staff told us this was due to staff shortages and the movement of staff throughout the day.

We found no medical gas signs on the storeroom doors of all wards we visited. These rooms stored some entonox and oxygen inappropriately on the floor behind the door. Storeroom doors were all unlocked which meant medical gases were accessible to anyone on the ward.

Sluice room doors were also unlocked in some areas. For example, wards 15 and 22. This was a risk due to the type of vulnerable patients nursed on wards within the service.

We also saw across several wards that fire doors were blocked due to limited storage facilities. This was a particular concern on ward 22.

Therefore, we were not assured that equipment across the wards we visited were stored, serviced and managed in accordance with trust policy to ensure patients were kept safe.

However, the service had sufficient suitable equipment to help them to safely care for patients. All staff told us they had sufficient equipment to safely care for patients.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimised risks. However, escalation scores were consistently completed.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score (NEWS2). We reviewed 13 patients' records and found that all had a completed NEWS2 score recorded within the electronic database system. All staff told us that an escalated NEWS2 score would automatically trigger a medical review. However, this involved a manual process by nursing staff to ensure the NEWS2 was escalated.

The Trust's digital patient observations system (eObs) was designed to trigger an alert to the nursing staff with the requirement to manually escalate this to the medical responder. A safety review and consideration of Human Factors principles concluded that this was safer than automatic data entry and electronic alerting.

We requested data in relation to the most recent NEWS audits and saw only a statement provided by the trust to state current NEWS2 compliance rates as of the 1st of July 2023 were 85% for surgical services.

The Trust was currently working on the deteriorating patient and sepsis digital compliance dashboard tool, which were due to go live the end of July 2023.

Staff completed a series of safety assessments at the point of admission. We reviewed the trusts own policy in relation to completion of these assessments and saw that the requirement was to complete at the point of admission, followed by a review seven days later.

We saw several wards had developed their own process for ensuring these assessments were completed or reviewed as the electronic recording system did not prompt staff to complete them as a priority. Senior ward staff allocated specific days to complete specific assessments, however all staff told us completion was affected by the general pressures of the ward. Staff told us they completed these assessments for each patient and included pressure ulcer risk assessments and venous thromboembolism assessments where appropriate.

The electronic patient record system is used within the trust's theatre environment for anaesthesia, theatre and recovery. Recovery staff record all patient vital signs in the Electronic Patient Record. These are currently inputted manually into the system with an automated solution planned for the future. None of the wards we visited had a recognised pain scoring tool and although the electronic recording system had capacity to record pain, staff were not using it.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff told us that risk was always discussed at handover. However, although some wards used s-bar to standardise key patient handovers, this was not common practice across all wards we visited. Some wards told us they had no handover processes in place at all.

We saw bedrails were in situ on most of the wards we visited across both sites. We requested risk assessments for these but were told by all staff there were no risk assessments completed. We saw the trust had developed a guidance sheet for staff to assist with the consideration of use of bedrails, however this was generic guidance and not individual to the needs of each patient. Occupational therapists we spoke with told us they knew the use of them was unsafe without an appropriate risk assessment and had escalated this as a concern.

Therefore, we were not assured that risk and safety management processes were robust and did not always protect patients from possible harm.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and proactively sought to fill staff vacancies.

On some wards we visited the actual nurse staffing was consistently below planned establishment. This was particularly the case for one ward at the RVI Senior ward staff however told us that a recent recruitment drive had been successful in the recruitment of registered general nursing staff. Most of the wards we visited were therefore fully recruited on paper and newly registered nurses were either waiting for essential recruitment checks to be processed or were approaching their actual start date, at the time of inspection. Staff saw this as hugely positive and a boost to the staff's morale.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior lead nurses held daily beds management meetings across all divisions. This included oversight of staffing numbers, access and flow with cross-divisional matrons reviewing pressures across each site. We observed a beds management meeting which was held twice a day and was attended by senior ward staff from each division. They discussed expected admissions and discharges, wards with particular challenges such as high acuity patients and increased admission numbers. We observed proactive discussion between the staff who prioritised the demand across the various health groups and considered appropriate staffing levels.

Managers limited their use of agency staff and requested staff familiar with the service. For example, internal bank staff. Senior ward staff told us unfilled shifts were offered to bank staff and if these remained unfilled after two days they would go out to agency. We observed this during the bed management meeting. We requested induction checklists for bank staff who had recently worked on the wards we visited; however, ward staff told us that bank staff brought their own induction checklist for senior staff sign off.

Fill rates trust wide for registered nurses on days are on 89% and on night shift have an average fill rate of 89%.

We saw the use of red flags which were utilised as an alert to show particular staffing pressures on the electronic reporting system. We saw these flags in use during our inspection. Staff told us senior managers tried to provide additional staff when experiencing these particular pressures. However, it was not always possible. Ward staff told us that they did not always report unsafe staffing figures, due to ward pressures and time limitation. However, we reviewed the trusts most recent nursing and midwifery staffing report and saw that incident submissions related to staffing incidents, averaged 20 per month trust wide. The majority relating to unfilled shifts, staff sickness and high acuity and dependency of patients. We also reviewed a whistleblowing concern relating to unsafe staffing levels on ward 22 at the RVI.

As of March 2023 (latest data), overall, the trust had a sickness rate of 6% in line with sector average. Sickness levels overall for the surgical speciality had improved over the last year. Sickness rates for all separate staff groups have also improved over the last year.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

In the last twelve months reviewed the proportion of consultants and junior doctors reported to be working at the trust were higher than the England averages.

In the last twelve months reviewed the proportion of consultants and junior doctors reported to be working at the trust were higher than the England averages. We saw the percentage of consultants at this trust were 49% when compared to 43% as the England average and we saw the percentage of Registrar doctors at this trust were 42% when compared to 38% as the England average. In the same reporting period, we saw the percentage of junior doctors at this trust were 7% when compared to 9% as the England average and we saw the percentage of middle career doctors at this trust were 2% when compared to 10% as the England average.

Both junior and middle career doctors at both hospital sites, told us that they felt the workload was unmanageable at times and expressed concerns as to how ‘stretched’ they felt. Staff described particular pressures whilst working nightshift and told us there were too many wards to cover. The trust recognised difficulties regarding the rostering of junior doctors and the ongoing pressures. We requested the current Junior Doctor fill rate per core service, but the data could not be interpreted in this format.

We requested assurance from the trust regarding the challenges junior and middle grade doctors were experiencing. The trust submitted information outlining actions taken including rota changes and the introduction of teaching fellows. The trust also outlined plans to make further improvements from August 2023.

We requested medical sickness rates for the surgical division, but the data could not be interpreted in this format.

Surgery

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always kept up to date. Records were available to all staff providing care but not always stored securely.

The service was moving towards a paper lite model and predominantly used electronic recording systems when recording vital signs, nursing and medical observations records. Some paper-based records were still in use such as do not attempt to resuscitate (DNACPR), deprivation of liberty applications, consent and dementia and learning disability passport records. The Trust's DNACPR system has been digital since October 2019, and its functionality was enhanced in November 2022. One aspect of this process remains paper-based, as this is currently required by a third party provider and requires the Trust a DNACPR paper form for patients on discharge from hospital.

We saw theatre staff used predominately paper-based documents for all aspects of recording as they had not yet moved across to the electronic systems. Staff competency of using the electronic recording system varied across the wards we visited and staff openly told us they had received limited training on the system before it was introduced. Staff told us they received only four hours of training included as part of the trust's own induction for new staff.

The ability to navigate the electronic system varied according to the time they had used it and staff were open in relation to their own competencies using the system.

We reviewed the electronic records of eleven patients and saw they were all incomplete. Nurses were able to add free text updates for each shift covering some aspects of the care and treatment that had been given and this box then prompted nursing staff to complete care plans for the key words identified such as catheter care, mobility and wound care. We saw in 100% of the records we reviewed, that no care plans were being used following prompting by the system. This posed a risk that patients would not receive care and treatment in line with national guidance and best practice, which may result in potential harm or failure to provide necessary safe care and treatment. This also meant that nursing intervention could not be accurately measured to ensure the care provided was appropriate and beneficial for the patients. We spoke with several matrons and asked how they ensured they monitored effective intervention of nursing care. Matrons told us they did not have accurate oversight due to the failings of the electronic recording system.

Nursing staff told us that they were too many records to complete on the electronic systems and navigation was confusing and time consuming. Staff told us they simply did not have the time or staff resources to navigate through patient's records. Following our first site visit, the trust told us they had implemented handover templates to ensure key information was recorded for each patient at the end of each shift. However, we reviewed four nursing records and saw handover templates were used as a basic prompt for staff to record some aspects of nursing care, but it was not comprehensive and did not in any way replace a nursing treatment and intervention plan. This is not in line with the royal college of nursing guidance in relation to patient records and care planning.

Nursing staff attempted to mitigate the lack of accessible key information, by developing a safety handover and a printed nursing handover document. This information was presented to all staff at the beginning of each shift to ensure staff understood the key risks for each patient. However, these documents were developed using nurses' own skills and knowledge and we saw the documents were inconsistently applied across all wards we visited.

Patient notes were not always comprehensive or up to date. The trust did not ensure that the electronic system capabilities were used to promote patients' safety. For example, aspects of care to ensure safety around areas such as falls risks, dementia and learning disabilities needs were not flagged on the electronic white board. The system had the capability to do this, but the trust had not opted to use the functionality.

Care plans which were initiated by the system were not completed. For example, we saw examples of this on wards 45 and 46 at the RVI, following review of specific patients with complex needs. We saw no care plans for any of the diagnosed conditions. The lack of care planning was evident across all wards we visited. In the absence of effective care planning there posed a risk that patients would receive incomplete care and treatment and the success of any care provided could not be measured accurately.

We also saw on all wards we visited, isolation icons applied against some patients on the electronic white boards, however the patients shown to require isolation were not isolated as the information displayed was incorrect. All staff we spoke with told us that this was a system error which had not been corrected since the pandemic.

We saw confidential patient records were left unattended on most of the wards we visited. We saw laptops left unlocked and bags of patient confidential waste in doorways on most of the wards we visited.

The safety assessment dashboard currently includes moving and handling and falls risk assessments. At the time of the inspection the dashboard did not include additional key metrics, such as VTE assessments; we were told at a meeting with the Digital Health Team, plans were already underway to enhance the dashboard and expand the metrics included. Aspects of care related to nutrition and hydration are part of the clinical assessment and the usual handover processes. Several staff described the system as 'not fit for purpose' and we saw members of the digital support team struggle to navigate certain aspects of the system.

We reviewed three patient records, all of whom had a diagnosis of dementia. Despite their being a note on the nursing handover to show the patient had a diagnosis of dementia there was no further support outlined within the system, such as communication tools, visual and nutritional aids.

Therefore, we were not assured that individual care records including clinical data, written, stored and managed, kept people safe.

Medicines

Staff did not always use systems and processes to safely, administer, record and store medicines.

The trust prescribed medicines using an electronic prescribing system. On surgical wards we found these were logged out after use with restricted access in place ensuring prescriptions could not be accessed by the incorrect staff.

We reviewed medicine storage arrangements on the wards we visited and observed poor stock control in relation to safe storage and general management of all medicines. We found ten medicines on Ward 22 that were out of date and saw controlled drugs were not managed in line with the providers own policy. Also, on ward 22 we found unaccounted for patient own drugs and amendments made to the controlled drugs registers, which were without witness signatures. We brought these concerns to the immediate attention of the provider and issued a letter of concern. We also requested an incident report for this significant controlled drug register discrepancy, but this was not provided. Following our inspection, the trust responded with actions taken to improve medication storage arrangements and their investigation findings, however this did not give assurance there was appropriate oversight from the trust to identify the concerns themselves.

Ward 22 staff told us they received no pharmacy clinical input. Nursing staff told us that they could contact pharmacy for queries, however on some occasions there was a delayed response.

We saw oxygen was incorrectly stored across most of the wards we visited.

We reviewed fridge temperature monitoring across the wards we visited and saw general fridge temperature records were not recorded consistently. Where fridge temperatures were found to be out of temperature range, no actions were taken. In addition, no room temperature monitoring was in place and therefore we were not assured that medicines were fit for purpose, due to the potential negative effects of extreme temperatures, on some of the medicines.

Staff followed current national practice to check patients had the correct medicines. Although the trust had an electronic prescribing system in place the trust were unable to provide real time medicines reconciliation figures therefore, we could not be assured that the trust had the required level of oversight to report on their key performance indicators of medicines reconciliation, being completed within 24 hours.

We requested medication audit results, carried out across the trust but we received only anti-biotics interventions audits for some wards and therefore we were unable to interpret any general findings.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support. However, managers did not always ensure swift action was taken following incidents or consistently share the learning following incidents.

Staff knew what incidents to report but did not always act upon them. The service reported four surgery related never events between June 2022 and May 2022. Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers. The never events varied in theme and were unconnected. The incident types included retained swab, retained surgical sponge, retained guide wires and femoral artery puncture.

Managers did not always investigate incidents thoroughly. We saw insufficient pace when sharing the learning, resulting in potential subsequent harm to patients**.** We saw at the time of inspection that the post incident investigation action plans were incomplete for all four never events that we reviewed. We also saw that two never events involving retained guide wires occurred within four weeks of each other. We requested data from the trust to evidence learning following these never events from the trust, but this was not provided. We also spoke with theatre staff regarding lessons learnt following these never events but none of the staff we spoke with, were aware of the incidents. We returned to the trust to carry out a further visit and staff were then able to describe actions taken by the trust.

Following inspection, we also received updated post incident investigation action plans and saw that most of the actions were complete. However, in the most recent never event investigation report dating back to May 2022, senior supervisory staff appointment was still not in place, to ensure safe running of paediatric theatres. We requested an update from the provider, but this was not submitted.

On review of incident information, we found a serious incident had been declared in October 2022 in relation to Ophthalmology. It was found that there was a lost to follow up (patients did not receive timely follow up care for their health condition) theme of 2,000 patients who had not received follow up appointments in the recommended timescale. Of these, six patients had suffered irreversible harm. On further review of incidents, we found a continuing theme of lost to follow up patients in Ophthalmology, throughout 2022 and 2023 where there were incidents detailing significant delays in patients receiving follow up care. This meant we were not assured the service had sufficiently identified learning, shared learning outcomes or put in place robust actions to prevent reoccurrence of the incident.

Surgery

We reviewed the trusts policy in relation to incident reporting which included a pathway outlining the process, however timescales for completion of the full investigation were not defined.

We reviewed the three most recent serious incidents, which had occurred within the surgical speciality. In one serious incident report relating to ward 22 (2023/6161), the post investigation action plan stated that all staff should complete pressure ulcer and categorisation training. We requested this training, but the trust told us they were unable to provide an overall completion compliance figure as the training was not mandatory.

In another serious incident report (2023/1942) we saw delays between recognising the need for plastic surgery and sending a referral. We reviewed the post incident investigation action plan and saw that this action had been missed off by the investigator and therefore there were no action in place to ensure further delays were avoided for other patients.

In the third serious incident relating to a fall on ward 44 (2023/3251) we saw again that MUST scores were to be monitored by senior ward staff through the electronic dashboard whom would also complete regular safety assessment audits. We requested these audits from the provider, but they were not submitted.

We also reviewed a serious incident which was reported to inspectors by staff during the inspection. This related to an incorrect patient being taken to the anaesthetic room prior to surgery. We saw the incident was still under investigation at the time of inspection. Initial findings showed that some of the pre-transfer documentation used when supporting patients to theatre was not completed. Please then add ‘However, we were provided with the learning points and interim action plan that had been put in place by the trust in response to the incident.

Most junior ward staff we asked could not give us recent examples of any shared learning from incidents. They could not list the top three incident-related risks on their ward or department beyond broad categories such as falls. However, senior theatre and ward staff at both sites had received information regarding the most recent incidents and told us these were discussed at staff meetings and safety huddles.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they reported patient incidents as quickly as they could, but this was affected by wars pressures. Most staff told us they received feedback following incidents and these were discussed with senior ward staff.

Some staff were confident to report staffing concerns, but others said staffing concerns using the electronic incident reporting system were rarely resolved, and they had stopped using the system. Some medical staff also told us it was pointless reporting incidents and concerns because nobody listened anymore.

We saw notice boards in staff areas displaying bulletins, but these did not include evidence of learning from never events. Many of the notice boards we reviewed displayed historic information and in some cases, this dated back six months or more.

Therefore, we are not assured that patients are protected from the potential of harm due to the lack of pace when both investigating incidents and sharing the learning

Is the service effective?

Requires Improvement 

Surgery

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff told us that policies were regularly reviewed and updated in accordance with national guidance and best practice.

We reviewed the trusts own intranet system and saw staff had access to policies, procedures and general guidance pertaining to clinical and operational matters. Staff knew where to access policies and guidance on the intranet and we experienced nursing and medical staff were able to articulate clinical practice with evidence-based research and best practice.

However, staff did not always follow up-to-date policies to plan or deliver high quality care according to best practice and national guidance.

Staff described the electronic care planning system as ‘time consuming and unhelpful’ and in many examples acted as a barrier for delivering clear effective care implementation.

We spoke with ward matrons and asked in the absence of care plans, how they would ensure appropriate care was being delivered for all patients in accordance with evidence-based practice or national guidance, but we were told they could not ensure this. Matrons told us that they had many experienced and skilled nursing staff across all wards. However, they acknowledged that the influx of newly qualified nursing staff created challenges when trying to provide ongoing mentorship, support and general training.

Staff did not always protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed three patients' records, all of whom were recorded as being confused and may lack capacity. We saw capacity assessments were not always completed and we did not see any evidence of best interest decision making processes. On ward 22 at the RVI we saw a deprivation of liberty application was submitted for one patient without a prior capacity assessment completed. This patient was experiencing delirium at the time of assessment. In another patients records we saw they were subject to section 2 of the mental health act, but no papers were in place to confirm this was in place. We also saw for the same patients that no capacity concerns had been completed within the electronic recording system. We also reviewed a patient whom staff told us had power of attorney arrangements in place. The papers pertained to financial affairs only and did not provide the appropriate powers in relation to their care and treatment. On ward 15 and 45 at the RVI, we again deprivation of liberty applications in place for patients who were deemed to lack capacity, without a formal mental capacity assessment in place. This is not in line with the Mental Capacity Act 2005 and therefore, we were not assured that policies were always developed and reviewed in accordance with best practice and national guidance.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients requiring additional hydration and nutritional intervention were monitored through fluid balance charts

and nutritional intake records. As with other patient records, recovery staff used paper records and consistently recorded fluid intake and output. These stopped once the patient reached the ward and electronic records were completed instead. Fluid balance intake was recorded on both paper and electronic systems depending on which wards has access to the electronic systems. We reviewed nine fluid balance records and saw a variation in the timeliness of completion. However, all patients who required fluid balance were in receipt of fluid balance monitoring.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw MUST scores were used for all patients and explained those at risk such as patients with frailty had dietician input.

Specialist support from staff such as dietitians and speech and language therapists were available for those patients who required them. We saw evidence of dietician involvement in the records that we reviewed.

We saw no volunteers were being used at the time of inspection to support patients with eating and drinking. These volunteers had ceased during the pandemic and had not been reinstated.

We requested the trusts recent audit data in relation to pain and preoperative fasting. The Trust provided a presentation demonstrating re-audit data in regard to pre-operative fasting in adult trauma patients. This included current guidelines, audit data and actions. A fractured neck of femur audit had recently been carried out, with embedded pain specific information under collation at the time of inspection.

However, feedback we received from patients during the inspection regarding food was negative. All patients we spoke with told us that the food could be better, and options were often bland and uninteresting. Recent patients surveys also highlighted the quality of food as a concern but we did not see any plans in place to improve this.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, staff did not always support those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff prescribed, administered and recorded pain relief accurately. We reviewed medication administrations charts across both hospital sites we visited and saw analgesia was prescribed and administered appropriately.

However, staff did not assess patients' pain using a recognised tool, although pain relief was given in line with individual needs and best practice on the wards that we reviewed.

We saw patients receiving care following surgery were assessed in recovery, using a pain score. Numerical scores were recorded on the paper documents that we reviewed. However, these scores were not continued once the patients transferred to the wards. We asked ward staff on each ward we visited what pain scoring tool was being used and all staff told us there was none in use. Ward staff told us that they would ask patients to describe their pain but there was no tool to support patients who were unable to communicate or for those with specific needs such as dementia or learning difficulties. Some staff told us that the electronic recording system could be used to record pain but none of the staff we spoke with knew how to do this.

Ward staff told us they could refer patients to a specialist pain team and we saw evidence of involvement within the records we reviewed.

Patients we spoke with told us they received analgesia when required, however they understood when there were delays due to busy periods on the wards.

Patient outcomes

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

The service participates in National Clinical audits. The Orthopaedic service had full participation in national clinical audits. The National Hip Fracture database data is updated monthly on a rolling basis with a report summary each year. Following publication of audit reports the provider completes a baseline assessment to identify areas of good practice and areas for improvement. For the RVI the hospital performed worse than other hospitals for two indicators in the audit, better than other hospitals for one indicator and similar for two indicators.

The indicators that were much worse were the crude percentage of patients documented as developing a pressure ulcer and the crude overall hospital length of stay.

We also reviewed the National Emergency Laparotomy Audit and saw it was last published in February 2022 using data from December 2019 to November 2020. In the National Emergency Laparotomy Audit Royal Victoria Infirmary had a case ascertainment rate of 98.9% which exceeded the national standard of 85%. It met the standard for three of the indicators in the audit and was within the expected range for one indicator. It did not meet the standard for one indicator.

In the 2021 national bowel cancer audit, the trust had a ‘good’ data completeness of 97.3%. The trust within the expected range for the four indicators in the audit.

In the National Prostate Cancer Audit the trust reported 75% of men had complete information to determine disease status. This did not meet the national standard of 100%. The trust performed with the expected range for all three indicators in the audit.

In the National Ophthalmology Database audit, the trust had a case ascertainment rate of 100%. The trust reported a risk-adjusted posterior capsule rupture rate of 0.6% which was much better than other trusts.

In the National Joint Registry audit, the site had a case ascertainment 100%, which exceed the national standard of 95%. The site reported that 6.8% of patients consented to have personal details included (hips, knees, ankles and elbows). This was much worse than other hospital sites and did not meet the national standard of 95%. The site was within the expected range for the remaining four indicators in the audit.

At the Royal Victoria Hospital, we saw in the National Joint Registry Audit the site had a case ascertainment 100%, which exceed the national standard of 95%. The site reported that 56.9% of patients consented to have personal details included (hips, knees, ankles and elbows). This was much worse than other hospital sites and did not meet the national standard of 95%. The site was within the expected range for the two indicators and was not eligible for the remaining two indicators in the audit.

The trust met the standard or was within the expected range for four out of five of the indicators in the 2021 National Vascular Registry Audit. The trust reported a crude median time from symptom to surgery [Carotid Endarterectomy] of 15 days. This was higher than the national standard of 14 days and higher the national aggregate of 12 days.

Surgery

We saw the trust had implemented action plans for each of the audits where recommendations were required. Review of these action plans was ongoing and had been assigned a risk rating score in order of priority.

Outcomes for patients were mixed, and inconsistent when compared to the England average.

The Model Hospital data flagged 36 indicators relating to surgical specialties as concerning with most indicators related to length of stay and readmission rates. Anaesthetics and perioperative medicine had the most indicators or concern, followed by spinal services and urology.

For all specialties overall at trust and hospital level and also for elective and non-elective patients, the trust had longer average stays than the national average between January 2022 and December 2022. The speciality with the most notable differences compared to the England average were ear nose and throat, vascular and urology.

Managers and staff carried out some audits to check improvement over time. We requested the trusts recent audit data in relation to pain and preoperative fasting and saw no specific audits had been completed, although the fractured neck of femur audit had recently been carried out, with embedded pain specific information under collation at the time of inspection.

We saw the trust had no CQUIN's in place relating to the surgical speciality, at the time of inspection.

PROMS data was limited at the time of inspection. The PROMs are a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. These areas are nationally selected procedures. We reviewed the reduced data available for the period 2021/22 and saw results were mixed. It is acknowledged nationally that questionnaires may have been impacted when compared to earlier years.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance. Staff induction was not always recorded and link nurse training had not always been renewed.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke with several staff working in newly appointed senior nursing roles. Many of whom had been in their current role for less than 12 months but were supported by matrons and colleagues working at a similar grade. Senior ward staff told us that the numbers of newly qualified staff was challenging due to the level of support however saw the recruitment as positive overall. All staff underwent trust induction training. We saw some digital training was provided, however all staff we spoke with told us it was insufficient preparation for the use of the system. The trust induction also included advanced care planning which included the use of emergency health care plans and DNACPR training.

Managers gave all new staff a full induction tailored to their role before they started work. We saw preceptorship and mentoring was tailored to the staff specific role to ensure training was appropriate. Bank staff arrived to the wards with their bank induction document, to ensure consistency of completion.

We asked to review bank staff induction checklists, to ensure staff working on these wards were provided with a basic overview of the operational aspects of the ward such as patient escalation processes. However, senior ward staff told us they did not always have sight of these as no copies were kept on the wards we visited.

Managers did not always make sure staff received specialist training for their role. The provider previously provided named staff with additional training in specialist areas (link nurses). This enabled those staff to share key learning and act as a 'go to' person to provided advice and information in these specific areas. Senior ward staff told us that told us that link nurses had been in place across wall wards and departments prior to the pandemic but due to recruitment difficulties most of the wards we visited had not reinstated these staff roles. Only one of the wards we visited had named link nurses covering training such as tissue viability, dementia, and falls.

We saw however that qualified nursing staff were provided with x4 study days per year.

The clinical educators supported the learning and development needs of staff. Senior ward staff told us that newly qualified nurses were provided with ongoing support through their preceptorship period. All staff we spoke with told us that the support received was invaluable. We also saw clinical educators had supported all staff in areas, such as pressure ulcer management, safety assessments and falls management.

Managers worked flexibly to ensure staff received information from governance meetings, safety briefings, MDT meetings and trust updates. Managers told us meeting notes were emailed to all staff or shared at ward handovers. Social media platforms were also used creatively to reach out and ensure information sharing.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Trust wide staff appraisal data was submitted by the provider for the health group. We saw that the overall appraisal compliance figures for surgery in May 2023, was 82%, which was lower than the trust target of 90%. We saw the lowest compliance rate was with estates and ancillary staff. Most wards we reviewed during our inspection demonstrated a high compliance figure for clinical staff appraisals.

Some managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. New roles had recently been developed and introduced such as risk leaders and additional nurse educators.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Ward staff told us that managers ensured time was made available where possible to complete training and share courses which were available throughout the trust.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers described the support they offered to staff and actions taken when improvements were required.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We reviewed ward rounds which were conducted several times and saw patient information was exchanged using the electronic recording system. However, this information was not detailed and did not always include discussion in regard to risk. We spoke with medical staff and their understanding of the electronic nursing records including safety nursing assessments. Several medical staff told us they did not review the nursing assessments and reviewed a separate section of the electronic recording system.

Surgery

We saw consultants and allied health professionals arriving to the wards at various points of the day, which impacted on the senior sister or nurse in charge having to repeat essential handover information. In addition, wards which held a dual speciality role at the time of inspection, such as ward 44 RVI, was visited by medical staff from both medicine and surgery specialities. Senior ward staff told us this created operational difficulties due to the different ways of working and inconsistencies within the ward rounds and information exchange.

Senior ward staff told us they had developed 'work arounds', as the electronic recording system did not provide a prepopulated information print out to enable consistent information sharing across all members of the multi-disciplinary team. We saw ward staff provide printed handovers, based on the knowledge and skills of the nursing staff overlooking the care of patients. This posed a risk that some key information may be missed off due to human error and failure to recall certain key points.

We attend a board round and saw that they were well attend, with all members of the clinical team in attendance.

We also attended a multi-disciplinary meeting for a complex patient requiring intervention and treatment from a multitude of teams within the hospital. Again, we saw this was well attended and there was comprehensive discussion from all who attended. However, senior staff in attendance delegated the role of the co-ordination of the MDT actions to the ward sister, despite a request from the sister for some support due to the challenges of the ward. We observed a reluctance by senior staff to undertake some responsibility to support more junior colleagues.

Some wards were supported by discharge co-ordinators and all ward staff we spoke with told us that they were invaluable. However, many of the wards did not have these additional staff which impacted on timely discharge planning. The Trust and their key system partners told us they had made a significant commitment to developing and improving how they support safe, timely and effective discharge from hospital. This includes a weekly discharge group which supported the implementation of the national discharge policy and the associated pathway and service re-design required to support this. This had also included a daily operational discharge escalation huddle, during times of significant operational pressure to support ward teams with a focus on more complex discharge planning. A system flow coordinator post was established to support all of the partners to focus on whole system capacity and coordination. The Trust had established a significant Discharge Improvement Programme, with a dedicated discharge improvement lead and over the last 12 months had engaged multiple ward MDTs to support their own discharge planning improvements. The discharge pages on the Trust intranet had been updated to provide staff with accessible information about processes and pathways. This was paired with a Trust-wide communications programme to highlight changes implemented in recent years. Multiple teaching sessions had been completed within professional groups across the Trust including two discharge planning masterclasses and a medically focussed discharge grand round. More recently a ward training pack had been developed for leaders to use at a local level and the required paperwork to support the discharge to assess pathway has been significantly reduced over the last 6 months.

We also spoke with ward clerks who liaised with families, social workers, and care home managers, and booked district nurse and GP practice nurse appointments to ensure patient discharges went as smoothly as possible.

Pharmacy support was not consistent with some wards advising they were well supported whilst others received no support at all. For example, ward 22 at the RVI.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. All managers we spoke with told us that trying to bring staff together due to staffing shortages was challenging but tried to ensure meeting minutes were read by all staff where possible.

Surgery

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. However, escalation processes were potentially delayed for some patients.

Ward staff told us consultants led daily ward rounds on all wards and we observed this during our inspection. Staff told us patients were reviewed daily by consultants depending on their particular health group or speciality. However, medical staff expressed concern that the review of deteriorating medical patients residing on surgical wards at the Freeman hospital was not timely. We requested to review the medical on call rota, but staff told us they were not provided with this information and all calls were made through switchboard. Medical staff explained that their call would then relay to the consultant at the RVI who would then discuss with the registrar at the Freeman before then talking to the medic. There was no support from critical care in reach. This created potential delays for specifically unwell patients with complex medical needs. Medical staff also told us that there had been examples when these delays had resulted in patient harm. We requested data in relation to these delays and saw four incidents had been logged.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, phlebotomy services ended at both sites in the early afternoon. Junior medical staff told us this created additional pressures for them, particularly at weekends.

The service offered seven day 24-hour discharge and the pharmacy was open seven days a week at the RVI.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw the trust had presented a number of information days for patients diagnosed with specific conditions and health challenges such as epilepsy, safe eating and drinking, Parkinson's disease, gynaecology services and early pregnancy advice services. Patients diagnosed with Parkinson's were referred to the nurse specialist team by their consultant. A leaflet was sent out to the patient with team information, contact details and useful links. During the initial introductory phone call there was a discussion and education covering recommended diet, exercise regimes, services available and an option to be referred to Physiotherapy/Occupational Therapy/Speech and Language Therapy if needed.

Epilepsy specialist nurses provide a monthly seizure education session with the aim of this session to explain about first/single seizures, epilepsy or any reason why the patient might have attended the first seizure clinic. The educational session covered safety, avoiding triggers including limiting alcohol consumption, avoiding recreational drugs, ensuring good sleep health, the importance of discussing any mental health problems with their GP and ensuring they are well hydrated and eating a balanced diet.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Wards we visited had lots of information available for patients on leaflet racks. We also saw a patient education day had recently been established once a quarter where patients and a friend or partner could come along and meet the team for an afternoon. Similar information was also available such as typical symptoms to look out for, side effects and tips to try and keep patients being admitted to hospital.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or complete consent protocols appropriately, in accordance with provider policy.

We found some improvements in practice since the focussed inspection was carried out in November 2022.We saw that each ward had a 'care for me, with me' folder in place that provided staff with guidance on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff we spoke with, were aware of these folders and were familiar with the trusts plans for staff to become confident in completion of capacity assessments and deprivation of liberty safeguards. All staff we spoke to were aware they could contact the MCA lead for advice. Staff also knew how to contact the safeguarding adult's team for advice regarding MCA and DoLs.

However, staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. A recent audit demonstrated 62% of capacity assessments had documents completed. However, it was identified that a more in-depth review of clinical notes was required.

Mental capacity act level one e-learning had been completed by 84% of staff in July 2023. This was a significant improvement to 32% in April 2023. A package for level two training was being developed. We heard mixed views from staff we spoke to regarding the level of confidence and whose responsibility it was to complete capacity assessments. For example, on one ward nurses were new to competing these assessments whilst on other nurses told us they had more experience of completion.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Staff did not always clearly record consent in the patient records.

When a patient's capacity to consent was queried, staff did not always undertake appropriate assessments of their mental capacity to determine the need for best interest decisions to be made. Staff did not always take into account patients' wishes and the views of relevant people including family members.

During our inspection in November 2022, we found examples where staff had not established whether patients lacked mental capacity to make decisions about their care and treatment, however, indicated care was being provided 'in their best interests'. During this inspection we saw some examples of best interest making. However, staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. On wards 22 and 15 at the RVI we saw a DoLS application was submitted for patents experiencing confusion or delirium, without first completing a mental capacity assessment.

Staff did not understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act although they knew who to contact for advice.

We did not always see detailed records to evidence staff made sure patients consented to treatment based on all the information available. We did not see detailed rationale documented where patients were found to lack capacity. For example, on ward 22 at the RVI we saw two patients experiencing delirium who were consented for treatment using consent form 4. These specific consent forms are used when patients are unable to consent due to a lack of capacity. We saw no capacity assessments were completed prior to consent.

Surgery

There was a Mental Capacity Act policy in place, however this was not updated to reflect the training requirements and responsibilities of staff in completion of mental capacity assessments. For example, it referred to optional mental capacity act training for areas where this was felt necessary.

Is the service caring?

Good  

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity

Staff followed policy to try to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and medical staff holding sensitive conversations respectfully.

Side rooms were available on all of the wards we visited and were utilised where possible, for those patients particularly in need, such as end of life or those requiring isolation.

Patients said staff treated them well and with kindness. Patients at the RVI told us "all the staff are great and they have a sense of humour, which makes a huge difference to my day", "they're very kind and explain everything to us all". When we asked patients about privacy and dignity, they told us 'staff always draw the curtains and give me plenty of time'.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw communication with the hospital chaplains and general privacy provided to enable patients to undertake prayer and spiritual reflection.

The service had not participated in a recent national patient survey, however locally feedback was sought from a number of internal surveys.

The last annual inpatient survey held in 2021 showed that the trust scored about the same when compared with similar trusts. Compared to the previous survey the trust showed a statistically significant increase for information provided to patients leaving hospital.

We reviewed the trusts latest friends and family survey summary dated May 2022 to My 2023 but it was incomplete and did not include all of the surgical wards.

We reviewed recent internal patient feedback sources and saw that generally feedback regarding surgical services was positive. This included feedback to the enhanced recovery programme team, pre and post operative assessment clinics, Saturday clinics and the new day treatment centre.

Feedback provided to the enhanced recovery team included 'Incredible staff, professional but very approachable caring and always good humoured. I was treated with respect and felt part of the process (rather than just being treated) my husband was treated well to a lot of attention goes to the patient but family need support too and this was given'.

Surgery

Emotional support

Staff provided emotional support to patients to minimise their distress. However, there were no personalised care plans for any patients, including those with specific emotional needs.

We reviewed three patients who required additional support due to a diagnosis of dementia. In all three patient records that we reviewed we did not see any care plans to support the emotional needs of these patients. An icon on the electronic whiteboard was also absent to inform staff of the additional needs of these patients. Whilst the digital whiteboards do not have the capability to show falls risks, dementia or learning disabilities, these are shown in the electronic patient record, the whiteboards have been designed to show patient safety information which may change rapidly. Examples of this include, highlighting when observations are due, NEWS2 score, high or low blood glucose, acute kidney injury, infection risk and DNACPR. The EPR also has electronic flagging and clinical alert functionality than can be added to by any member of the clinical team. This alert then appears on the Banner Bar (patient demographic and information strip at the top of every record). If a flag or alert has been added for that patient, this is visible to staff and by clicking on that alert to ascertain the nature of the flag or alert. For example, difficult intubation.

Staff told us that additional care was always provided, for example, additional observations known as high observations, but none of the records we reviewed demonstrated personalised care planning for specific needs or emotional support. We saw no care planning in regard to emotional support for any of the patients we reviewed at both hospital sites.

We reviewed spiritual documentation and although there were no specific areas in which to define spiritual needs and wishes we saw a section could be completed when recording religious beliefs. However, we saw none of these sections completed regarding spirituality in the electronic recording system.

Staff recognised that time providing emotional care including enhanced interaction was limited. All staff we spoke with found the lack of staff to be a significant barrier to delivering quality emotional support. However, all staff were motivated to provide this care whenever they could and we saw staff working together to ensure patients received the optimum level of care with the staffing resources that they had.

Patients or their relatives could be referred for access to counselling and psychological support if required.

Understanding and involvement of patients and those close to them

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

Staff made sure patients understood their care and treatment. We observed the communication and interaction between patients and clinicians at both hospitals we visited. We observed clear dialogue and conversations which enabled patients to ask questions regarding their surgery and treatment. We also observed ward rounds in which patients were proactively involved in their care journeys and were provided with comprehensive updates and next step planning.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff interaction with families and patients' carers and saw information was provided in a way that was easily understood.

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

Surgery

Patients gave positive feedback about the service. However, we saw within the last patient survey report, that patients felt that staff did not always provide communication around expectations following surgery. Patients said that further communication was needed so that they know what to expect before and after surgery.

Feedback provided to the enhanced recovery team included 'The continuity of seeing the enhanced recovery nurse preop and during my hospital stay was really helpful the excellent ward staff obviously work shift and rotas so seeing the same person each day and feeling that she knew and understood me was really helpful she was motivating and encouraging and able to offer reassurance'.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service aimed to plan and provide care in a way that met the needs of local people and the communities served. However, the demand for bed availability presented ongoing challenges.

Managers planned and organised services, so they met the needs of the local population. The service relieved pressure on other departments when they could treat patients in a day. We reviewed the beds management process and saw patients who were safe to be transferred were moved regularly to accommodate elective surgical patients. We also saw several of the wards we visited were of a dual function offering beds for both surgical and medical patients. The demands on the beds however meant some patients operations were cancelled on the same day, however the numbers were small. We requested data showing the number of surgical procedures which had been cancelled on the same day within the last 12 months and saw 1525 operations were cancelled. Of these 64 related to a lack of beds.

We requested data from the trust to show average length of stay for both elective and non-elective surgery, but the data could not be interpreted in the format it was submitted.

We saw the trust worked proactively with neighbouring hospitals to reduce backlogs across several specialities. The trust told us since May 2023 referrals for neurosciences have been redirected to South Tees from that locality. Existing capacity had been maximised via mapping theatre resources against the patients with the greatest clinical urgency. Additional neurosurgery/ spinal elective capacity has been created by re-opening a ward that was previously used for private patients. Additional MRI and EEG capacity has been insourced to reduce delay in pathways and a review of consultant job plans has taken place to maximise theatre use. Within plastics waiting list initiatives and private sector capacity has been utilised to reduce waiting lists and the speciality is in discussion with Cumbria trust to establish a skin cancer pathway, which will create additional capacity at the RVI. Joint spinal clinics were set up with Northumbria healthcare to triage patients into their most appropriate local services. Trauma and orthopaedics planned to continue using the independent sector for spinal, hip, knee, foot and ankle surgery. In addition to utilising waiting list initiatives and insourcing to increase capacity

Within ophthalmology the trust were exploring the possibility of repurposing standalone theatres following a reduction in Cataract waits and redeveloping the use of the imaging hub for diagnostics is set to be increased to shorten the patients' pathways. There is also a plan to revisit collaborative working via mutual aid with Sunderland to repatriate patients back to their local hospital eye service.

Surgery

Beyond the Trust main sites there are collaborations in place with ten other NHS Trusts across 235 pathways. There are also arrangements in place with independent sector providers, with agreed activity levels which are being met. Many of the patients waiting are too complex to go to independent Sector and therefore remain on NuTH waiting lists.

All specialties have access to the Digital Mutual Aid System (DMAS) to upload who are suitable to be transferred to other providers in a timely manner.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last six months and none told us they had.

The service had some systems to help care for patients in need of additional support or specialist intervention. We saw specialist teams such as pain, mental health, social work and dietary service staff involved in the care and treatment of the patients we reviewed. However, there were some delays in responding at times. In particular, the mental health team. The electronic system however did not support staff to refer to these services as it did not have the functionality to raise an automatic referral. Manual contact was required to access supporting services, which added to the existing workload of staff. There was also no manual flag to alert specialist teams when a patient had been admitted that was known to them prior. This again required a manual process by ward staff.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff we spoke with told us they used information passports for patients with learning disabilities. The use of this passport however was inconsistent and we saw some passports were in place, but we were not assured that these were routinely reviewed or commenced. For example, we reviewed a patient at the RVI, diagnosed with learning disabilities and the passport had not been commenced. The patient had been admitted several weeks ago. And the patient had also been visited by the learning disability team but there was no record of review of the passport, or a discussion as to who should assist to complete this. We saw no care plans in place for this patient to reflect their current needs.

Wards were not always designed to meet the needs of patients living with dementia. We did not see any evidence of adaptation for patients with a dementia such as appropriately coloured bays or specifically designed signage. Several senior ward staff told us they would include discussion around the needs of specific patients with dementia as part of the safety huddle, but we did not see records relating to specialist intervention or support. Senior ward staff told us that plans to ensure areas were designed to meet the needs of patients with dementia were part of the refurbishment plans for those wards affected.

The service had information leaflets available in languages spoken by the patients and local community. All staff we spoke with told us they were able to request a variety of leaflets in various languages, however we did not see these freely available on the wards that we visited. Two patients we spoke with could understand English but had been offered access to information in their first language if they needed it.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could access language support when required and we saw access numbers available to all staff on the wards that we visited.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw menu choices were available offering kosher, vegan and gluten free options. Staff told us they could also make bespoke requests for individuals should there be a specific need.

Access and flow

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

The 18-week referral to treatment times for March 2023 showed that 71.5% of patients at the trust were treated within 18 weeks, compared to the England average of 65.8%.

There were 3,626 patients still waiting over 52 weeks in March 2023, 101 more patients than were waiting over 52 weeks in March 2022.

Specialities with the most waits were ophthalmology, trauma and orthopaedics, dermatology and trauma and orthopaedic services.

We saw waiting times for the surgical division were mixed across the various specialties. Cancer waiting times indicators were in line with regional and national averages for 2-week urgent referral and 62-day target. But the trust was in the lowest 25% of trusts nationally for patients treated within 31 days of a decision to treat in March 2023. The greatest improvement was seen in breast cancer 62 week wait data.

We also reviewed two week wait target data and saw in March 2023, 85% of patients were seen within 2 weeks, which was in the middle 50% of trusts nationally. This compared with 87% regionally and 84% nationally.

In relation to 31-day target data, the trust was in the lowest 25% of trusts nationally for patients treated within 31 days of a decision to treat. In March 2023, 86% of patients were treated within 31 days of a decision to treat, compared with 92% regionally and nationally.

In the 62-day target data we saw in March 2023, 59% of patients were seen within 62 days of an urgent GP referral, which was in the middle 50% nationally. This compared with 65% regionally and 63% nationally.

We reviewed the data specifically for the surgical speciality and compared performance against similar sized regional and national trusts, looking at key specialist areas.

We saw Neurology, neurosurgical and plastics were in the bottom five of all trusts for 18 week waits for treatment.

We also saw ophthalmology and plastics were in the bottom five of all trusts for 52 weeks waits for treatment.

Trauma and orthopaedics were in the top five of all trusts for 18 week waits for treatment and general surgery services were in the top five for all trusts for 52 week waits.

The trust reported long waiter times for hepato pancreato biliary surgery, however there were no projected 78 week waits by the end of March 2023. We saw extra clinics had been implemented to address the ongoing waits.

Trust wide the trust was in the second highest decile for level of risk for patients waiting over 104 weeks for treatment.

Surgery

In March 2023 there were 21 patients waiting over 104 weeks at this trust, 90% were waiting for the trauma and orthopaedic service.

There were also 159 patients waiting over 78 weeks+, despite the NHS target to eliminate these by April 2023. The majority of patients were waiting for trauma and orthopaedic and dermatology services.

We requested data from the trust to show average length of stay for both elective and non-elective surgery, but the data could not be interpreted in the format it was submitted. However, we saw trust wide the trust does have a higher proportion of longer stay patients over 21 days than comparators (10.5% compared with 8% national average. However, the average length of delay for patients who stay in hospital for 7 days or longer is better than regional and national averages, at 5.8 days delay after being clinically ready for discharge. Compared with 7 days for regional peer average and 8.4 days national average.

Since October 2022, the proportion of bed occupancy patients that were clinically ready to discharge has been better than the regional and national averages.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service displayed information about how to raise a concern in some patient areas. We saw some PALS information displayed on wards we visited but this was not consistent. Wards we visited did not have friends and family test feedback boxes and display boards were out of date and did not show current feedback. However, patients, relatives and carers knew how to complain or raise concerns. A patient we asked said they would feel confident asking ward staff how to raise a complaint or concern.

The trust supplied a log of complaints for the surgical health care group that showed 14 complaints had been received from patients and relatives, in the last twelve months. The highest number of complaints related to treatment and the second highest communication. Matrons told us they investigated complaints and identified themes on behalf of other wards to retain an independent view, investigation and any identified themes. We requested from the provider, the top three complaints for the surgical speciality and any outstanding actions taken, but this was not provided. We also requested the latest divisional turnaround time for resolving and closing complaints, but this was not provided.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. However, the complaints spreadsheet provided to us did not show what actions had been taken or any changes made as a result of complaints. We saw examples of concerns raised by patients in staff communication files on some of the wards we visited.

Staff could give examples of how they used patient feedback to improve daily practice. This included access for ward staff to interpreter equipment to help patients whose first language was not English and for patients who used sign language.

Surgery

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Senior leaders were not always visible and staff did not always know who their leaders were.

Clinical specialities across the trust were defined as divisional health boards. These boards were introduced on the 1st of April 2023 and were led by a Clinical Board Chair and Director of Operations, however clinical board priorities were in place which included staffing and workforce, Flow including theatres, governance structure, quality and safety, innovation and transformation, efficiency.

In addition, these clinical priorities we saw key pillars were defined to support each of the clinical boards. These included quality and safety, performance, finance and work force. The pillars represented the journey of transformation and formed part of the Newcastle model of organisational development for the trust.

Senior leaders we spoke with understood the new direction and were able to define the priorities of the clinical boards. Ward managers were less knowledgeable about the priorities but understood the reason for the changes overall and saw the changes as positive.

Ward staff were not able to explain the new leadership arrangements or who senior leaders were for their clinical board. However, these positions were new to the organisation and it was acknowledged information was still being shared across the trust at the time of inspection. A number of new appointments had been made at the time of inspection, including a new head of nursing, clinical board directors and chairs.

Staff told us historically they had not seen they did not see senior members of the previous health divisions and attendance on the wards was rare. Most of the ward staff we spoke with were unable to name their clinical directors.

All staff we spoke with spoke highly of their local leaders but felt there was a disconnect at more senior levels. Only one member of staff told us senior leaders had engaged with them and had acknowledged the operational challenges experienced by staff. Staff gave many examples of escalated concerns and issues which had not resulted in change despite staff voicing their concerns over a prolonged period of time. For example, junior and middle grade doctors experiencing excessive workload pressures and digital system frustrations experienced by local clinical managers.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy. However, the vision and strategy was not underpinned by detailed, realistic objectives and plans for high quality and sustainable delivery. Staff do not understand how their role contributes to achieving this strategy.

We reviewed the trust Strategy 2019-24 which detailed the vision for achieving local excellence and global reach through compassionate and innovative healthcare, education and research. The vision, values and ambitions and strategic framework were agreed by the Board of Directors in the summer of 2019 following a period of discussion and

engagement with a wide range of staff and stakeholders. The vision expressed the collective aspirational and purpose and summarised the desire to achieve the highest standards in service delivery, improve health for local people and capitalise on world class expertise and research capacity. We saw the strategy also outlined the values of the organisation which were, 'We care and are kind, we have high standards, we are inclusive, we are innovative, we are proud'. The Board of Directors and Council of Governors held the responsibility to ensure the strategy was delivered.

The trust aspired to be an outstanding organisation now and support regional and national colleagues. The trust told us they were committed to being a full civic partner contributing to the health and wellbeing of the city and to be an anchor organisation in the Northeast and Cumbria. Key areas for recovery included orthopaedics, urology and oral surgery. Increasing theatre and cancer treatment capacity was also outlined. A number of objectives including the retention of staff and the recruitment of new staff were also listed.

We saw operational plans were also developed for each of the subgroups within the new clinical boards. The trust had set a time frame of five years from September 2019 for an updated strategy with a planned update on an annual basis.

We requested the annual update reports following the development of the strategy and saw delivery goals were set for the 2023/2024 period. We saw a timeline to ensure trust strategy objectives were refreshed however, they were not aligned ICP integrated strategies, and we did not see any wider trust engagement or stakeholder engagement at the time of inspection. These were highlighted as actions within the trust strategy; however, these were not completed or in progress at the time of inspection.

We saw the overview and summary outline for the surgical transformation programme including the improved theatre optimisation plans. We reviewed the timeline for implementation, but this did not include detail for completion, or the steps required to ensure the project deadlines were achieved or were achievable.

Culture

Staff did not always feel respected, supported and valued. The service did not always promote equality and diversity in daily work and provide opportunities to speak openly in relation to concerns or risk. However clinical staff were focused on the needs of patients receiving care and continued to drive positivity, despite the ongoing operational challenges.

Staff morale and wellbeing varied across the wards we visited, and staff told us their morale at times was quite poor due to the staffing challenges. Staff openly spoke of periods of exhaustion and frustration with operational demands, however the drive to work collaboratively as a local positive team was palpable. All clinical staff told us they were proud to work in the region and represent the trust, but also spoke of increasing frustration at the introduction of new systems and models with the ongoing necessity to seek basic staffing numbers. Staff spoke about the general increasing frailty of patients requiring care and treatment balanced against the high levels of staff who had left the service.

Staff generally felt well supported by their local managers and matrons and several staff told us that they felt managers were doing 'all that they can to support them', 'great' and 'supportive' and 'always there when you need them'.

However, some staff felt that leadership styles were inconsistent, which affected the culture within certain areas. Some staff told us they felt their senior staff were not approachable and did not listen when they tried to escalate persistent issues or concerns. Several staff told us they no longer submitted incident reports regarding low staffing levels or near miss harm incidents, as there was simply insufficient feedback or change from senior managers to motivate them to submit the reports.

Some staff told us they had escalated concerns in relation to specific staff conduct issues or fears of possible patient safety risks and felt as if they were being ignored by senior managers.

In order to gain a wider view of staff morale we developed and collated a staff survey as part of this inspection, to enable all current staff to feedback regarding their experience of working within the trust. We received a total of 2,360 respondents trust wide with 164 respondents from the surgical speciality. 44% of staff working at the RVI and 33% working at the Freeman hospital. We saw 66% of respondents were clinical staff and 71% of staff had worked in their roles for at least 3 years. Findings showed that 40% of respondents disagreed that communication between senior management and staff was effective. Over half of respondents (74) disagreed that senior managers act on feedback and 61 respondents disagreed that they felt safe to report concern without fear of what will happen. However, we saw 97 respondents felt comfortable raising bullying and harassment or discrimination concerns and 110 respondents agreed that they felt confident raising patient safety concerns or other concerns within the organisation. However, 37 respondents had experienced harassment, bullying or abuse from colleague at work with 7 of them stating it had happened more than 10 times. We also reviewed survey results received in regard to managers and saw 28 had experienced this behaviour.

Analysis of the free-text comments we received, revealed a workforce who felt disconnected from leaders who did not understand, acknowledge, or address issues that staff 'on the ground' faced. Comments spoke to a culture of favouritism and bullying, where problematic behaviour went unchallenged, and concerns went unheard. Staff did not always speak-up because they felt "nothing changes", or from fear of repercussions. Staff spoke of the huge pressure they faced and the negative impacts it had on them, and on patients who they felt were at increased risk of harm as a result.

Leadership was an important theme for respondents who often described a culture of top-down communication, of feeling unheard, and of disconnection at the Trust. Respondents felt information was cascaded down from management, rather than in dialogue with them. They did not feel there were many opportunities for feedback.

Staff told us many senior leaders and managers were not visible to them on a daily basis, further reducing feedback opportunities. For many respondents, issues around communication and visibility compounded feelings of disconnection between management and clinical staff especially.

Some staff referred to the recent restructure and some felt this had been positive, while others felt it had exacerbated existing issues and felt frustrated at the lack of consultation.

Governance

Governance processes were not fully embedded at the time of inspection, due to the newly created health board structures. Staff were not always clear about their roles and accountabilities due to the ongoing operational changes.

Senior leaders outlined the key objectives for the clinical governance framework. They told us these fell into four domains which were patient safety, clinical effectiveness, patient experience and quality improvement. These domains were newly created as part of the health board modelling across the trust.

The structure was then broken down at local level (wards and medics) and the clinical care group (departmental level) to show what each area was required to have in place to meet the governance objectives.

We saw at ward level each area should have patient safety, clinical effectiveness ad patient experience processes. Shared learning and quality improvement including risk management processes sat within the department areas. Senior managers told us that some of these meetings were yet to be carried out due to the newly created structures.

Clinical boards held responsibility for the assurance dashboards and trends including complaints, serious incidents and general incident review, risk registers, new procedures and interventions and escalation of barriers and concerns.

The trust told us that information from the board was then cascaded through the clinical board quality assurance meetings at clinical board level to departmental level in consultant meetings, junior doctor's meetings, sister's meetings and admin meeting. These clinical staff meetings were held through the speciality and quality safety forum, whilst the admin staff were held through the transplant/ NORS Cross board governance and business meetings. Information would then be passed down to local level meetings for each for each of the defined objectives. Again, we saw some of these meetings had not yet been carried out as appointments were made at senior leadership levels.

The ambitions for the trust were to ensure that all areas have similar directorate governance structures in place in regard to planned clinical governance meetings. All areas to identify good practice in addition to areas for improvement and to provide an opportunity for standardisation and shared learning across the boards.

The trust also held model hospital reviews and we saw analysis across breast and general surgery.

The trust acknowledged that these plans were in their infancy and plans were being commenced at the time of inspection.

Management of risk, issues and performance

Leaders and teams used some systems to manage performance. However, they did not always identify and escalate relevant risks or issues which identified actions to reduce their impact and there remained an ongoing risk to patients.

Senior leaders within the health group told us that elective recovery was their biggest challenge and we saw plans to address this within the surgical health board strategy. The current focus was to efficiently manage the delivering of services whilst reducing long waits and backlogs. Managers told us this involved all staff working collaboratively together to meet the complex needs of patients and working proactively with other regions to reduce specific pressures across the trust.

We reviewed the surgical services risk register and saw there were 13 risks identified, 11 of which were ongoing risks at the time of inspection. Each risk had been given a risk score depending on the level of risk. Risks ranged from a lack of a designated IF unit, delays in the development of the new surveillance pathways in BCS, surgical on call intensity at the RVI and backlog of DOSA benign cases in HPB.

However, it was not clear when they had been added to the register as individual risks were not dated and there was no date shown against each action or point of review. It was also not detailed as to whom was accountable to progress each action. Therefore, we saw some actions had been ongoing for prolonged periods of time, for example lost to follow up colorectal patients and the failure to recall endoscopy patients within the required timescales. This risk which was initially rated high at 20 was identified in 2021 and was again due to reviewed in August 2023. Digital shortcomings resulting in a lack of care planning and governance oversight was also not included. F1 and junior doctor workload pressures and the never events were also not included as risks.

We also saw risks identified on the surgical risk register were not included as part of the corporate risk register. For example, we saw within the surgical risk register that cardiothoracic concerns and historic system issues affecting colorectal patients who were lost to follow up were not included as risks.

The cardiothoracic concerns related to a historic cluster of incidents resulting in potential patient harm. Concerns within cardiothoracic were known prior to the inspection and were further highlighted during the inspection. Due to these ongoing concerns within this department, we carried out a further focused visit and completed a separate report. Please refer to this report for further information.

We also saw risks noted within the corporate risk register were not then transferred into the surgical risk register. This included known risks within the ophthalmology services.

The provider told us risk registers were reviewed every month with risk escalated through to board level. We reviewed the integrated board report for May 2023; however, we were not assured that risk was prioritised as the minutes were not sufficiently detailed to ensure robust discussions were held in regard to clinical risk.

We reviewed the endoscopy user group meeting minutes dated March 2023 and saw aspects of clinical governance were discussed.

We spoke with senior managers regarding concerns we saw during the inspection in regard to the management of medicines. Managers were not aware of the current practice undertaken by some staff, as recent internal audits undertaken had not identified these issues. We spoke with pharmacy staff regarding the recent audit findings within theatres, however they were unsure when audits were last completed in regard to medication.

Leaders were also disappointed to learn that we had found concerns when reviewing the surgical safety checklists. We saw within the safe September performance report that the frequency of WHO audits had been doubled but results were not available at the time of inspection. We asked senior managers about the learning following the recent numbers of never events within the health group and were told that there had been three never events to date, but the majority of them had not caused patient harm. Managers told us all incidents are discussed at team meetings and lessons learnt discussed to prevent happening again, however information across the wards we visited were out of date.

The trust told us that each month each clinical board and ward receive a ‘harm free care Dashboard’ which provides an overview of the month and years patient falls, their severity and injury, pressure ulcers their category and location, HCAIs, outbreaks, clinical assurance checks, deterioration compliance and the Take 5 antibiotic audit. Information was compared month on month over 24 months trends and variances visualised.

Matrons and Ward Leaders are asked to share this with their teams and information is shared on the wards public facing ‘How we are Doing’ board. However again we saw historic information displayed.

The service did not always perform routine clinical audits to monitor the quality of care being implemented or the effectiveness of care being delivered, for continuous improvement. This meant the service could not identify risks and improve outcomes for service users.

The service did not perform routine clinical audits to monitor the quality of care being implemented or the effectiveness of care being delivered, for continuous improvement. This meant the service could not identify risks and improve outcomes for service users. We saw gaps in audits undertaken which were not flagged or actioned for further improvement.

Surgery

Ward matrons told us there was no oversight of care implementation plans in accordance with best practice or national guidance. The absence of care plans for patients was not seen as a risk by the trust.

Some staff told us that patients across the speciality had been lost to follow up. We requested data from the provider and saw a number of cases across a variety of specialities that had been lost. Historic action plans to address lost to follow up patients within colorectal services were vague and did not outline clear details and timescales to prevent further occurrence. This remained an ongoing risk to patients within the speciality.

CQC also received information of concern from a whistleblower in relation to a backlog of 'must sign' letters following clinic appointments, patient treatments and operations and inpatient stays. We wrote to the trust on 05 September 2023, using our section 64 powers to request specified information and documentation on this, and we wanted to confirm if this was an issue and the scale of the concern. We were also concerned that this had the potential to lead to delays in patient's receiving appropriate care that would meet their clinical needs, if relevant healthcare practitioners or the patient were not aware of any changes to their condition or treatment.

In their response the trust confirmed this was a known issue in the cardiothoracic department and they had been working to address this since March 2023. Please refer to the cardiothoracic report for further details.

Again, we found no evidence of this risk on the risk register. Following our focussed inspection in September 2023, we spoke with the cardiothoracic management team and asked specifically why this wasn't on the risk register. The management team described it should have been on the risk register but may not be now as it may have been downgraded.

We were therefore unclear of the mechanisms or governance routes used to escalate these risks to the executive oversight register. We were not assured these risks were managed as close to frontline services as possible or there was sufficient managerial oversight either locally or at executive level to ensure sufficient actions and management of these risks.

The trust acknowledge that cancer performance targets were not where they wanted them to be but told us screening backlogs were possibly impacting on recent referral numbers.

Managers also acknowledged challenges within the lower gastric intestine performance figures and outlined difficulties due to the number of specialities the pathways cross.

The speciality had recently developed a new complaints process and were waiting for ratification at the time of inspection.

The trust had recently implemented some additional oversight, in practice the trust has a real time deteriorating patient list. The Deterioration List is visible to all Clinical/Medical staff, Trust Deterioration Nurse Specialist and Critical Care Outreach Teams. The Deterioration Nurse Specialists use this to monitor surveillance daily alongside the critical care outreach teams who monitor this throughout their shifts, to review and respond to patient deterioration across wards, providing support to staff out with the critical care environment. This allows the trust to proactively track, prevent and manage deterioration augmenting the ward escalation process.

Surgery

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure. Data or notifications were not always submitted to external organisations as required.

We found some of the trust's systems and processes for recording inconsistent, for example the lack of electronic recording systems in theatres. Consequently, ward staff spent time transferring paper-based information into the electronic recording systems which posed a risk of lost information during the transfer process. We saw staff confidence using the electronic systems varied from ward to ward. All staff we asked to guide us through the electronic systems told us there were sections of the systems they had not accessed before. We saw the training provided to staff in order to use the digital platforms was only four hours. This is a tailored training programme at induction, with the duration determined by the complexity of the systems to be used and feedback from staff. For some staff this was 4 hours in duration. For the vast majority of nursing staff, this was 7.5 hours, and for some administrative staff, this was shorter. The training at induction was supplemented by on-line how-to guides and further courses are available by request via IT training.

Staff told us that some of the data within the electronic recording system was not accurate. In a small number of records there was an issue with MUST score reporting via the dashboard, which had only been launched 3 weeks prior to the inspection. This was quickly rectified and explained to us by the Digital Health Team during the inspection. The MUST score recorded in the EPR was accurate and available to all clinical staff, there was not a risk to patient safety. We also saw inaccuracies within the electronic whiteboard system in relation to potential isolation of patients. records.

We saw internet dropouts on some of the wards we visited and delays in reaching IT support when needed.

We found some electronic systems where not being used to their full potential. For example, no electronic referrals were evident to specialist staff such as palliative or pain teams. However, both the palliative care and pain team electronic referrals are available within the system. We saw two separate manual digital entries were required by staff to enable an icon to be displayed on the electronic whiteboard.

We also saw care plans suggested by the platform were not created by staff and there was no flag to highlight that these essential care plans were missing. Staff spoke of their frustrations trying to navigate the system and felt much more could be done to improve it.

We also saw the new safety compliance dashboards showcased by senior staff, did not show all of the safety assessments. This resulted in poor oversight of VTE assessments, falls and additional patients risks such as risk of aspiration.

We also saw that incidents which should have been reported through the National Reporting and Leaning data base were not reported in a timely manner. This had been raised to the trust prior to the inspection and was ongoing at the time of report.

Engagement

Leaders and staff engaged with some patients, staff, equality groups, the public and local organisations to plan and manage services.

Surgery

We saw the last staff survey had been completed in October to December 2021, with results published in 2022. For this survey the response rate for the trust was 48.5%, slightly above national median scores. The trust performed in line with the benchmark group median for most sections of the survey. 'We work flexibly' and 'We are a team' were below the median scores nationally.

Staff responded less positively to questions around working flexibly and being able to achieve work/life balance. Also, less positive around questions related to line management and dealing with disagreements in teams effectively.

Staff responded more positively than comparators about teams working well together to achieve objectives and understanding each other's roles.

We requested staff survey data specific to the surgical health board, but we received only summary headlines in relation to the findings. The trust also submitted an action plan to support this summary, but it was brief and did not include all key areas of concern raised in the survey findings. For example, investigating staff feeling short staffed and how staff are supported with personal development.

The trust also submitted details of a number of engagement sessions for staff to attend across the board including clinical board workshops, sisters' updates and general question and answer drop-in sessions.

We saw an endoscopy specific staff survey was completed in December 2022. Responses were generally positive in regard to working conditions, morale and culture. However, we saw only a 30% return rate.

Senior medical staff told us they acknowledged the challenges with morale in some areas due to staffing pressures. Recent recruitment campaigns had gone some way in addressing some of the staff concerns.

We saw colorectal nurse specialists had developed a new bowel cancer support group for patients across the region. These commenced in May 2023 and offered patients an opportunity to learn about some of the advances in colorectal cancer.

We also saw open days held by stoma care nurses offering advice regarding appliances and general care for both patients and staff.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in some research.

The speciality submitted examples of continuous improvement including the complex POLYP MDM, Health – Call which was a non-electronic system to improve patient pre assessment in endoscopy, and the 'Green' endoscopy working group to reduce carbon footprint.

In 2022 the enhanced recovery team won the HSJ performance recovery award. The trust formed an innovative collaborative partnership with a third partner provider, to develop the colorectal enhanced recovery program which resulted in reduction to cancer care backlogs and the trusts length of stay performance to pre-pandemic baseline.

Surgery

The service had created bespoke tools for to increase patients' ability to monitor their health from home. The international normalised ratio (INR) home monitoring programme was an electronic database which monitored results of patients managing blood thinning medications at home to reduce repeat visits and hospitalisation, staff were available to obtain advice 7 days a week.

The trust had pioneered and introduced robotic assisted major lung resections (small incisions in the chest to perform surgery) which had resulted in reduced pain scores, faster recovery time, early discharge, and reports of improved quality of physical, social and mental wellbeing for the patients.

The trust were looking to work with a local regional trust to develop a collaborative on call for obstetrics and gynaecological services.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service provided mandatory and core competency training in key skills to all staff. However, they did not make sure all staff attended this training.

At the last inspection in January 2023, the service did not provide evidence to show staff were up to date with their mandatory or core competency training.

At this inspection we requested, but did not receive, compliance levels for mandatory training. However, the post inspection action plan provided in July 2023 showed 86% of staff had completed mandatory training but this did not meet the trust target of 95%.

We reviewed the overall compliance for core competency training on the July 2023 action plan following the last inspection. This showed staff had completed 52% of core competency training but this did not meet the trust target of 90%. In addition, the service sent information regarding core competency training which confirmed that not all eligible staff had received it. This meant the service had not immediately addressed the issues of compliance with mandatory or core competency training. This was listed as partially compliant on the action plan and did not show date for completion.

Not all eligible staff had attended the annual face to face clinical training day which included responding to emergency situations, adult basic life support and newborn life support, post-partum haemorrhage and birth pool evacuation. It also included fetal monitoring and cardiotocograph (CTG) competency training and human factors training. The overall compliance for this training day attendance over the last 12 months was 85% which did not meet the trust training target of 90%.

Not all staff had attended the perinatal mental health training day. This included maternity safety and public health training, perinatal and infant mental health awareness, and birth trauma training. The overall compliance for this training day attendance over the last 12 months was 70% which did not meet the trust training target of 90%.

The service offered a number of core competency training modules;

- **Newborn infant physical examination (NIPE) training**
- Maternity Support Worker and healthcare assistant training day
- New to post clinical skills day for new band 5 and 6 Midwives
- ‘Live’ emergency skills drills (biannual attendance)

- K2 fetal surveillance online training / perinatal Training Programme Fetal Monitoring Modules and Assessments
- Perineal repair and assessment for midwives and obstetricians
- Intravenous (IV) medicine administration and peripheral IV Cannulation for midwives
- Public health training included topics presented by a specialist midwife on antenatal and newborn screening, domestic abuse, safeguarding level 3, bereavement, diabetes, vulnerable neonates, UNICEF infant feeding.

This meant the service had not immediately addressed the issues of compliance with core competency training for all eligible staff.

Some staff reported they did not have protected time to undertake mandatory training. They were regularly requested to return to work clinically due to unexpected operational pressures and surge to ensure the safe continuance of the service.

For further information on mandatory training please see previous inspection report.

Safeguarding

At this inspection we requested, but did not receive, compliance levels for safeguarding mandatory training However, the post inspection action plan provided in July 2023 showed 87% of staff had completed children's safeguarding level 3 but this did not meet the trust target of 95%.

For further information on safeguarding please see previous inspection report.

Cleanliness, infection control and hygiene

Please see previous inspection report.

Environment and equipment

The design, maintenance and use of facilities, premises did not always keep women, birthing people, and babies safe. Hazardous substances and sharps products were not always stored securely and safely.

At the last inspection in January 2023, the service was told they must ensure equipment used was in date, checked regularly and safe for the intended purpose. At this inspection we found blood pressure monitors on postnatal ward 32 and on postnatal ward 33 which had both expired their safety maintenance dates. This meant the service had not immediately addressed the issues of ensuring all equipment used was properly maintained and safe for the intended purpose.

At the last inspection in January 2023, the service was told they must ensure staff complete daily checks of emergency equipment. At this inspection we found gaps in the daily safety checks of resuscitation equipment on two emergency trolley's on the delivery suite. This meant the service had not immediately addressed the issues of compliance with ensuring all equipment used was checked regularly and safe for the intended purpose.

Across multiple areas within maternity, we found several items which included COSHH chemicals and intravenous fluids which had not been safely, and appropriately stored.

Maternity

On the antenatal ward 41 in a linen drawer trolley in the corridor we found a 4.5g Haz-tab dilution bottle with diluted chorine solution. In the day care room in an equipment trolley drawer, we found 3 x 250ml and 3 x 10ml of Sodium Chloride intravenous infusion fluids. This product should not be stored in temperature which could exceed 25 degrees celsius and we were not assured temperatures were being recorded on this ward.

We found storerooms which had been left open or were unlocked which contained control of substances hazardous to health (COSHH) chemicals and medicines. On the postnatal ward 32 in an unlocked room, we found urine bottles containing boric acid. When we escalated this to staff, they said they needed access to this unlocked room to access the emergency neonatal resuscitation equipment. These areas were accessible to all staff, women, birthing people, and visitors including young children which meant there was a risk of easy access to products which could cause irritation to eyes and skin or be fatal if swallowed. This meant the service was not adhering to COSHH regulations which state the service must “adequately control exposure to materials in the workplace that cause ill health.

At this inspection, the service did not ensure that equipment was safe to use for their intended purpose. For the time period 1 to 26 July 2023, we found five examples across the maternity services when no action had been recorded on the fridge temperature records for when the temperature was out of range between 1 and 5 degrees celsius. This was not in line with the fridge monitoring policy. On the antenatal ward 41 we saw a fridge temperature was 5.4 degrees celsius which meant it was out of range. When we escalated this to staff, they said the fridge had been playing up and was going to be replaced. However, we did not see any records to confirm this action had been taken.

At this inspection, the service did not ensure there were sufficient quantities of equipment to ensure the safety of women, birthing people, and babies to meet their needs. On the antenatal ward 41 there were only two cardiotocograph (CTG) machines for a maximum of 11 women and birthing people. Staff told us if the ward was at full capacity, they would need to borrow CTG machines from other areas.

Staff reported not having access to adequate cleaning equipment such as mops and were told they had to use cloths instead for cleaning.

At this inspection, the service did not manage the safe labelling of sharps boxes. We found five examples when sharps bins had not been labelled and did not show the first date of use. This was for sharps bins on postnatal ward 32, 33 and the delivery suite. This means the service was not adhering to policy with regard to the management of sharps.

The new purpose built transitional care ward was due to open soon.

We reviewed the corporate risk register which showed the service had listed the environment was inadequate to provide safe and quality care. This was due to the age of the building and backlog of the maintenance. The service had completed minor works to minimise further deterioration however the risk remained the same as when it was listed in January 2021.

For further information on environment and equipment please see previous inspection report.

Assessing and responding to patient risk

Staff did not always assess, monitor, or complete risk assessments to ensure the health, safety and welfare for each women, birthing people, and baby. This meant staff did not always identify or quickly acted upon women, and birthing people, at risk of deterioration.

Maternity

Staff working on the maternal assessment unit (MAU) did not have visual oversight of women, and birthing people, who had the potential to deteriorate and act accordingly. This was because the treatment room was adjacent to the midwifery reception area.

In addition, staff could not observe women, and birthing people, who were waiting in the seating area which was around the corner from the midwifery reception area. The service used this space when the unit was full. There was no call bell or signage in this area for women, and birthing people, to alert staff if they became unwell. However, staff did tell us they regularly checked on women, and birthing people.

The service did not always effectively assess and / or continually monitor fetal heart rates to assess fetal wellbeing. Staff on the maternity assessment unit (MAU) did not always have oversight of monitoring cardiotocograph (CTG) readings for women who were in an adjacent room. There was not a permanent member of staff based in this room and we were not aware if women were asked to escalate with CTG readings or concerns to staff. This meant there was a risk to women, birthing people, and unborn children due to lack of effective monitoring. However, staff did tell us there were future plans to implement the CTG's onto the new electronic system yet there was no time given for this.

The service did not always assess and monitor the security risks to the health, safety and welfare of women, birthing people and babies leaving the delivery suite and postnatal ward. We found no improvements had been made since the last inspection in January 2023. We continued to observe women, birthing people and babies leave these areas without any challenge from staff. They did not leave with a staff escort which was one of the immediate actions put in place following the last inspection. This was listed as being fully compliant on the post inspection action plan.

We reviewed the July 2023 action plan following the last inspection which detailed all the security work had been completed and a baby abduction simulation had been planned for August 2023. Staff we spoke with confirmed they had completed multiple baby abduction drills and had received further security training following the last inspection.

At the last inspection in January 2023 the service did not have a robust, formal triage process for women, and birthing people who attended the MAU. At this inspection staff used a new evidence-based triage risk assessment form to help them assess risks of every women, and birthing people, arriving on the unit. It was a paper based form and included recording observations on a maternity early warning score (MEWS) which determined a RAG rating for priority of review and gave clear guidance on decisions for escalation.

We reviewed June 2023 audit for the completion of this new form and the results showed poor compliance. In April 2023 only 5.7% of the forms were fully completed, 38% for May 2023 and 30% for June 2023. This meant that staff did not always complete risk assessments for women, and birthing people, arriving at the MAU. We reviewed the associated action plan which included the need for further education and awareness for staff.

We reviewed the results of a snap shot audit completed in June 2023 which measured the response times from arrival to initial assessment in the MAU. The audit showed 62% of women, and birthing people, were seen within 15 minutes. However, this audit did not investigate the time taken for midwifery assessment against the correct categorisation of risk. For example, the triage form indicated that women who were high risk required a midwifery review within 5 minutes, women of medium risk required a midwifery review of less than 15 minutes and non-urgent women required a midwifery review within 120 minutes.

The audit did show the results for the time taken from initial midwifery triage for medical review for 6 women.

- 33% of women who were high risk did not receive an urgent medical review within the target time of 5 minutes and waited between 97 and 100 minutes.
- 33% of women who were medium risk did not receive a medical review within the target time of 15 minutes and waited between 62 and 263 minutes.
- 17% of women who were non-urgent (low risk) did not receive a medical review within the target time of 120 minutes and waited 191 minutes.

On inspection we also observed delays for medical reviews. This meant 5 out of the 6 women audited, and those observed at the time of inspection, following the initial midwifery review exceeded the recommended time.

We reviewed the action plan following this audit which included the implementation of a monthly audit program and further education with staff to raise awareness. In addition, the service had formed a focus group to identify common causes of delays in medical reviews and find solutions to enable target timescales to be achieved.

We were informed the MAU unit would be introducing a bespoke electronic maternity triage system in September 2023. This was called the Birmingham Symptom Specific Obstetric Triage System (BSOTS) which was an electronic triage assessment tool.

Staff used a nationally recognised tool called the modified early obstetric warning score (MEOWS) to identify woman at risk of deterioration and escalated them appropriately. At the last inspection in January 2023 this was completed on paper records and on this inspection this assessment was being completed electronically. This meant staff could record real time observations and would help with making clinical judgments and indicate signs of deterioration such as sepsis.

We reviewed 8 medical records and found MEOWS to be recorded correctly and escalations to senior staff had been appropriate.

We requested the audit results for the accuracy of completion and escalation of MEOWS using this new system. However, the service were waiting for the new electronic system to become fully embedded before repeating any audits.

We reviewed the results of the latest newborn early warning trigger and track (NEWTT) assessment audit. Staff must complete a NEWTT assessment on newborns within one hour of birth. This was to assess and review risks and detect any deteriorations in clinical condition to prompt a medical review. The results showed that 51% of babies had a risk assessment fully completed, 39% of babies had a risk assessment partially completed and 10% did not have a risk assessment recorded at birth. In addition, the results also showed that 47% of babies had a recorded management plan. The audit action plan recommended further education with staff to raise awareness and a planned reaudit. The service informed us the NEWTT assessment would soon be part of the electronic patient record. However, the service did not have a clear timescale for this.

During the inspection we attended several shift changes and staff handovers, which were attended by relevant staff. They included all necessary key information to keep women, birthing people, and babies safe. We also attended a medical handover on induction of labour which showed clear discussion of criteria for inductions of labour and reasons for admission and discharges based on risk.

However, the service did not always assess and monitor the risks to the health, safety and welfare of women, birthing people, and babies on handovers. We reviewed the most recent audit results from June 2023 on the completion of the handover document called situation, background, assessment, recommendation (SBAR). SBAR's were used for effective communication of critical information especially during handovers, when women, birthing people and babies are

transferred to a different area such as from delivery suite to the postnatal wards. The results showed that midwifery staff did not always fully complete SBAR's for each woman, birthing people, (94%) or baby (86%). We did not know the trust target for these results. The audit action plan recommended further education and guidance for staff on how to complete the SBAR's using an electronic patient record.

We reviewed evidence from the National Reporting and Learning System (NRLS) from January to June 2023. We found multiple examples when handover information relating to risk factors had not been uploaded onto the electronic patient records or documented in notes. For example, risks such as feeding, sepsis, and vitamin K and hepatitis B vaccinations.

The service had introduced new fetal monitoring in labour guidelines following the latest NICE guidance (NG229) fetal monitoring in labour published in December 2022.

The guideline required two midwives to undertake separate CTG reviews every hour which included the monitoring of fetal heart rate and uterine contractions during pregnancy or labour. This is also known as "fresh eyes."

We reviewed the June 2023 audit results for the review of cardiotocography (CTG) documentation and fresh eyes compliance. The results showed that 81% of fresh eyes had been undertaken in a timely manner. We did not know the trust compliance target. The results showed the reasons why fresh eyes could not be completed every hour for example because of transfer or medical review. In addition, results showed that staff had completed 84% of the new fetal monitoring labour review form. We reviewed the audit action plan which recommended further education with staff to raise awareness.

We reviewed the December 2022 sepsis audit results for 33 antenatal, intrapartum, and postnatal women, and birthing people, who had received antibiotics. The results showed that 70% of women had received antibiotics and had the sepsis 6 and MEWS charts completed within one hour and 64% of women had received IV antibiotics within an hour. We reviewed the audit action plan which included the introduction of the BSOT's triage system and a planned reaudit.

The service had completed snapshot audits in January 2023 and June 2023 to review staff compliance for the World Health Organisation (WHO) surgical safety team checklist and team briefings for elective caesarean sections. The results showed 100% overall compliance.

Staff knew about and dealt with any specific risk issues. We saw risk assessments were completed and updated at every contact in the patient records we reviewed. This included venous thromboembolism (VTE) assessments which is a condition when a blood clot forms in a vein.

On the MAU we observed staff effectively triaging women, and birthing people, when they phoned the triage telephone number. Staff were aware of a list of pregnant women, and birthing people, who were high risk in case they phoned or arrived at the unit. At the time of this inspection Newcastle birthing centre was closed which meant MAU staff had to cover the labour telephone number.

We reviewed the draft North East and North Cumbria (NENC) maternity and neonatal escalation policy. It had been developed to enable maternity and neonatal services to align their escalation protocols to a standardised NENC process and escalate when required. It sets out the procedures to manage significant surges in demand regionally and ensure that maternity and neonatal services work together and continue to be provided safely and effectively.

For further information on assessing and responding to risk please see previous inspection report.

Maternity

Midwifery staffing

The service did not have enough midwifery staff as staffing levels did not always match the planned numbers. Although managers regularly reviewed and adjusted staffing levels and skill mix this was based on a birthrate plus review completed in October 2020. The service gave bank and agency staff a full induction.

At the last inspection in January 2023, the service was told they must ensure they had enough midwifery staff as staffing levels did not always match the planned numbers.

At this inspection we found similar concerns with staffing. We reviewed the midwifery rota for the 31 days in July 2023. We counted 18 days where the day shift actual did not meet the planned staffing requirements outlined in the roster template. We counted 16 days where the night shift actual did not meet the planned requirements. The midwifery staff bank supported 78 shifts in total for July 2023.

We reviewed the midwifery planned rota for the 31 days in August 2023. We counted 16 days where the day shift actual did not meet the planned staffing requirements outlined in the roster template. We counted 30 days where the night shift actual did not meet the planned requirements.

This meant the service had not immediately addressed the issues to ensure there were enough midwifery staff to meet minimum staffing levels to keep women, birthing people, and babies safe.

For 6 days in July 2023 the service was in local escalation because of reduced staffing levels which meant the Newcastle birthing centre (NBC) services had been diverted to the delivery suite.

We were informed that the senior staff, including specialist midwives, were working in a supernumery capacity to support the clinical areas including the delivery suite.

At the time of our inspection the midwifery staffing establishment was 250.2 whole-time equivalent (WTE). This was below the recommended staffing levels of 254.62 WTE for midwives Band 5 to 8.

- The sickness absence rate for the last quarter was 5.7% which equated to 14.53 WTE. However, this had increased to 8% for July 2023.
- The staffing vacancy was 3.6% which equated to 9.07 WTE.
- The leave absence was 5% which equated to 13.09 WTE.
- The service had temporary secondment vacancies, but we did not receive any data on this.

The turnover was 0.7% for July 2023 which equated to 1.8 WTE. We heard from staff that approximately 30 midwives had left their roles. Senior managers gave various reasons for this such as retirement, relocation, ill health, and career progression. However, they said the transformation work had caused significant unrest within staff and do not know if this had also contributed to the reasons for leaving.

Staff reported there were significant shortfalls in staffing across the maternity service and at times it felt “unsafe.” They struggled to look after high numbers of woman and babies and told us they did not have the time to provide basic fundamental standards of care.

Maternity

Staff were concerned about the significant impact of staffing on patient safety. We heard phrases such as “every shift is an accident waiting to happen” and “it feels like working in a crisis situation everyday”. Staff felt “burnt out” and exhausted” “hurried and limited,” “rushed all the time” and felt vulnerable on shift. They were unable to take adequate breaks due to acuity on the wards and often finished late to complete all their work.

Ward managers held daily staff huddles with the band 7 coordinators to complete a daily acuity and activity assessment of their own ward. They would regularly review the number and grade of midwifery staff needed for each shift in accordance with national guidance and the acuity of women, and birthing people, within the service.

Managers were skilled at managing skill-mix and reported they allocated staff to patients depending on experience, support needs, and the complexity of the women, and birthing people. All areas consisted of core staff who are more experienced in their area of practice, and rotational staff who would have varying levels of expertise and experience. During times of surge in operational activity regular additional reviews were undertaken with escalations as required. The senior leaders met twice weekly to review acuity, activity, and staffing projections.

However, the staffing establishment was based on the birth rate plus review which had last been completed in October 2020. Staff we spoke with felt that planned staff numbers and skill mix had not reflected high acuity areas especially on postnatal wards.

Although the service had always been a tertiary referral unit and accepted referrals for women, and birthing people, who had significant risks and complex care it was only in September 2021 this had been formalised. The service was named as the maternal medicine centre (MMC) and was part of the maternal medicine network (MNN) for the 9 maternity units distributed across the North East and North Cumbria. This was set up to ensure all women and birthing people who had significant medical problems and who lived in these areas, would receive timely specialist care, and advise before, during and after pregnancy. The service acknowledged that the acuity and complexity of women and birthing people’s births had significantly increased nationally and not just regionally.

From September 2021, at least 363 women, and birthing people, had been referred to the MMC. This did not include the number of women, and birthing people, who used this route from the Newcastle area from September 2021 to April 2023 (due to an information technology fault).

This meant that the service were using a birth rate plus tool which had been completed before the service formally became the maternal medicine centre and was not an accurate reflection based on the levels of acuity and complexity.

We reviewed the non-registered staffing rota for the 31 days in July 2023. We counted 22 days where the day shift actual did not meet the planned staffing requirements outlined in the roster template. We counted 15 days where the night shift actual did not meet the planned requirements. This meant the service did not ensure there were enough non-registered staff to meet minimum staffing levels to keep women, birthing people, and babies safe.

The service informed us that these significant gaps for non-registered staff accounted to the reduction in the numbers of nursery nurses whose roles had been changed due to the transformation. Some nursery nurses had been relocated to work on the bespoke transitional care unit which was due to open in Autumn 2023. The new unit would be staffed by neonatal nurses, nursery nurses, midwives, and maternity support workers. It would be open 24 hours over 7 days to provide specialty specific individualised care to both mothers and babies.

At the time of the inspection ward 33 was being used as a temporary postnatal transitional care ward. This meant that babies could stay on the ward with their mothers without needing to be cared for on the special care baby unit.

There had been a trust wide organisational change to uplift all existing maternity health care assistants to become maternity support workers. They would provide additional support for midwifery staff and nursery nurses. In August 2023 10.91 WTE maternity support workers had been appointed to support the service.

As part of the transformation, staff informed us that a number of specialist midwives roles had been created in line with the recommendations of Birthrate Plus. This meant the numbers of midwives had also decreased. The number of budgeted establishment specialist midwives equated to 25.8 WTE which is 10.29% of staff. This was just below the Birthrate Plus recommendation of 11%.

Following the inspection, we received information which showed the service had 13% of band 5 staff (who have less than two years' experience), 71% are at band 6 staff (more than 2 years' experience) and 14% are at band 7 staff (more than 10 years' experience) and 2% are at band 8 (10 to 25 years' experience).

For further information on nurse staffing please see previous inspection report.

Medical staffing

The service did not have enough medical staff as staffing levels did not always match the planned numbers. However, managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not ensure there were enough medical doctors to meet minimum staffing levels to keep women, birthing people, and babies safe. We reviewed staffing information as part of our inspection and staffing did not match planned numbers.

Since the last inspection in January 2023 the number of consultants had reduced, and the workforce was not sufficient for the acuity of women, and birthing people, and the demand. There was a total of 27.13 programmed activities (PA) total shortfall of consultants. There was a current consultant vacancy which was out to advert which equated to 8.5 PA. This meant the service were 18.63 PA short. The service was in the process of requesting consultant expansion.

Despite the shortage of consultants, the service still met national recommended levels of obstetric consultant presence on the delivery suite. There was consultant on call at all times including evenings and weekends. The service had fully maintained the on call rota with no consultant gaps. This has been achieved entirely through internal consultant locum cross-cover. The consultants did 24 hour on calls from 8am to 8pm and were at the hospital as a resident from 8am to 10pm. The on call frequency was 1 in 12 shifts however sometimes, this was 1 in 10.

The service was only able to deliver a basic 43 week per year antenatal clinic with the use of

of internal consultant locums or with clinic cancellations. Every antenatal clinic had a consultant as the senior decision maker. The aim was to enable all antenatal clinics to be cross covered within consultant job plans for 52 weeks throughout the year regardless of planned consultant leave.

Managers would cover gaps with internal locums when they needed additional medical staff. They did not use staff from independent medical locum agencies.

The service had a medical workforce strategy which detailed the strategic and operational planning of the service, including the roles and responsibilities of the consultant. They had processes to ensure consultants were present at any difficult or high risk births. They had guidelines which outlined the specific situations when consultant presence was required. This strategy was presented to trust board level safety champions meeting and regularly updated in line with national guidance.

There were low numbers of junior doctors which meant they had to cover multiple areas within the service for example, maternity assessment unit (MAU), delivery suite, antenatal and postnatal wards, daycare, and clinics. Staff reported that senior doctors had to also work as a junior doctor on some occasions.

The impact on the reduced medical workforce meant that there was reduced presence on some of the maternity areas for example on the MAU. To mitigate this risk this area had been added onto the morning consultant ward rounds. The service informed us there should be a consultant presence in this area five afternoons a week at peak times.

Staff we spoke with provided examples of delays for medical reviews or assessments. We were given an example when a woman had to wait 8 hours for oral antibiotics.

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

For further information on medical staffing please see previous inspection report.

Records

Staff did not always review or keep detailed records of women, birthing people, and babies care and treatment. Most records were stored securely.

Staff did not always have accurate and complete records to assess, monitor and make decisions for the health, safety and welfare of women, birthing people, and babies.

We reviewed incidents relating to records from the National Reporting and Learning System (NRLS) for the time period January to June 2023. We found 12 examples which related to poor record keeping which included poor information provided on handovers and missed interventions.

This included two examples where known risks had been recorded on the electronic record with no appropriate actions taken. For example, baby's known heart risk was not recorded on a caesarean section theatre list and a baby born with known sepsis risk did not receive a neonatal medical review for 12 hours. We found one example when community midwives did not have up to date information because of an incomplete postnatal discharge.

Women, birthing people, and babies medical records were comprehensive, and all staff could access them easily. The service had recently implemented a new electronic patient record system and most records were recorded as electronic records. We reviewed 8 electronic records and found them to be clear and complete.

All staff we spoke to were frustrated with having to duplicate patient information onto two different electronic systems, the new electronic record and observation systems as they were not yet integrated. In addition, some staff reported that the electronic systems were slow to use.

Maternity

We reviewed the results of a three month audit completed in June 2023 to assess the completeness of electronic records. The results showed that not all information had been recorded in 1011 records.

- 20% of records did not have ethnicity of women, and birthing people, recorded
- 17% of records did not have booking of bloods recorded
- 14% of records did not have a named midwife recorded
- 10% of records did not have combined screening recorded
- 2% of records did not have smoking status recorded

In addition, not all staff had access to the portal to record the information in 5% of notes.

The audit recommended several areas of improvement which included further education for care plan compliance especially for those women, and birthing people, who resided out of area.

We reviewed the results of a postnatal bladder care audit completed in May 2023 to assess the completeness of bladder care management recordings. The results showed that not all information had been recorded.

- 22% of records did not have a documented time for anticipated time to void/ pass urine (this should be within six hours of delivery time).
- 17% of records did not have a documented time for first void / pass urine.
- 52% of records did not have a documented volume of the first void / pass urine.

In addition, the results showed that not all bladder care management recordings were completed in the correct place.

These results meant staff were unable to follow the postnatal bladder management pathway for these women, and birthing people, and start appropriate investigations in a timely manner. Of note this audit highlighted that it was the women's, and birthing people's, responsibility to record the time and volume of the first void and pass this information to staff so they could record this. We reviewed the recommendations from the audit which included further education to staff.

Most records were stored securely. However, we did find some notes left unattended on the temporary postnatal transitional care ward 33.

Staff locked computers when not in use.

For further information on records please see previous inspection report.

Medicines

The service did not always store medicines safety however, they used systems and processes to safely prescribe, administer, and record medicines.

Maternity

At the last inspection in January 2023, the service was told they must ensure the proper and safe management of medicines, ensuring out of date medicines were removed and medicines were stored securely. At this inspection we found similar concerns with the safe storage of medicines, which meant the service had not immediately addressed this issue.

Within multiple clinical areas we found that non-registered staff (who could not prescribe or administer medicines) were able to gain entry via swipe access to rooms which stored medicines and controlled drugs. In one room we found that staff had easy access to keys to unlock a medicine cupboard. At the time of our visit the door to this room was propped open for unsupervised cleaning. In two rooms we found unlocked medicine fridges.

We escalated this at the time of our inspection and were told that access was restricted as per the medicines security policy. However, this did not provide assurance that medicines were stored securely as there was a risk that unauthorised people or visitors could access medicines.

We reviewed the fridge temperature records for the medicines fridge in the delivery room. This showed that staff had been using an incorrect recording chart and had only been recording the current temperatures for June and July 2023 and not the minimum and maximum temperatures in line with policy.

In 1 delivery room we found a clear plastic bag containing an anaesthetic medicine on the bench.

We reviewed the action plan following the last inspection in July 2023. The recommendations included a new process to ensure medicines were stored securely with a monthly review of all stored medicines and IV fluids. There would also be daily oversight from ward managers and weekly oversight from matrons for compliance of correct fridge temperature monitoring. In addition, some estates work would be completed in August 2023 to provide locked storage for IV fluids. This meant the service had not immediately addressed the issues of safe storage of medicines.

We reviewed incidents relating to medicines errors between January and July 2023 which had been reported to the National Reporting and Learning System (NRLS). These had all been graded as no harm and included incorrect medicine dosage, duplication of medicine dosage, incorrect antibiotic given to patient with allergies and medicine given to the incorrect patient.

For further information on medicines please see previous inspection report.

Incidents

The service did not always manage safety incidents well. Staff recognised and reported incidents and near misses however, they did not always report staffing incidents.

At the last inspection in January 2023, we reported that the service managed safety incidents well.

On this inspection we found that the service did not always assess, monitor, and improve the quality and safety of the services in relation to incident reporting. There was a lack of recognition, management, and appropriate response to the recording of risks surrounding measured blood loss and or post-partum haemorrhage (PPH). We were not assured that senior leaders had robust oversight of investigating incidents which were graded as low or no harm.

Maternity

The PPH policy did not clearly guide staff how to define maternal blood loss. We reviewed evidence from the National Reporting and Learning System (NRLS) for the incidents reported between January and July 2023. We found a total of 78 incidents recorded which were defined as either measured blood loss and/ or post-partum haemorrhage (PPH) from 2852 deliveries. Senior leaders confirmed there needed to be consistency with this in relation to the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.

Staff did not report incidents in a consistent and standardised way. We found incidents had been referred to as measured blood loss or PPH, both or neither of these. This meant incident data was not always clear for future analysis.

We found multiple examples when blood loss between 1500ml and 3200ml referred to as PPH or measured blood loss was recorded as no harm. NRLS defined no harm as no physical or psychological harm.

We found multiple examples when blood loss between 1500ml and 5350ml referred to as PPH or measured blood loss was recorded as low harm. NRLS defined low harm as low physical or psychological harm where minimum harm had occurred, and patients required extra observation or minor treatment.

This meant the service did not always define the correct levels of harm according to the NRLS definition. Instead, they might have been graded as moderate or severe harm as these women, and birthing people, would have required immediate life-saving clinical intervention in the form of IV fluid resuscitation and or a blood transfusion to replace the lost bloods.

Following the inspection, we asked the service for assurance the correct level of harm had been assigned correctly to a selection of 12 safety incidents reported between January and July 2023 in accordance with NRLS definitions. These related to incidents which had all been graded as no harm and included PPH over 1500ml, scalpel injuries to babies heads during delivery and post-delivery care and treatment.

Senior managers responded to say that three of the incidents had still been within the review process and were re-graded from no harm to low harm. Four of the incidents (which included the PPH) were re-graded to low harm. They admitted there had been an oversight during the review process. They said they used a grid when ranking harm levels which was consistent with the local maternity and neonatal system (LMNS).

We reviewed other incidents between January and July 2023 which had been reported to the National Reporting and Learning System (NRLS).

We found 4 incidents relating to retained products such as a swab, three were graded as no harm and one as low harm. These were not identified as a never event. A never event is defined by NHS improvement as “the retention of a foreign object in a patient after a surgical/invasive procedure.”

We found at least 11 incidents relating to shoulder dystocia. Shoulder dystocia is defined as a vaginal cephalic delivery that requires additional obstetric manoeuvres to deliver the fetus after the head has delivered and gentle traction has failed. Nine of these had been categorised as no harm, 2 as low harm and 1 as moderate harm. One of the incidents which had been classed as low harm included the statement “felt the humerus break” and in this situation the obstetric anal sphincter injury (OASI) care bundle had not been used.

Maternity

Staff knew what incidents to report and how to report them. However, they reported they did not have time to report incidents due to working clinically especially those relating to staffing. Staff reported they had been discouraged from incident reporting staffing concerns and shortages. We only found once incident reported from January to June 2023 on NRLS relating to low levels of staffing.

We were not assured that senior managers knew that safety incidents did not automatically populate as incidents onto the NRLS.

Staff we spoke to did not always receive learning from incidents. However senior leaders said all learning was sent out in emails, printed briefings, at handovers, team meetings and in the risk business newsletters.

The service did not always manage safety incidents in a timely way. At the time of the inspection there were 86 open incidents recorded as being over 60 days from date reported. The trust did not provide actual numbers for each categories for those awaiting review, under review or awaiting final approval.

For further information on incidents please see previous inspection report.

Is the service effective?

Insufficient evidence to rate

Competent staff

Managers did not always make sure staff had the confidence, experience or the right skills and knowledge to meet the needs of women, birthing people, and babies. However, the service had made significant improvements to make sure staff performance had been appraised but this still did not meet the trust target

All newly qualified band 5 midwives must complete the preceptorship programme over 12 to 18 months to progress to band 6. The preceptorship programme consisted of a week-long clinical skills 'boot camp' and rotations around each area.

Staff had supernumerary time which varied on each area to ensure clinical training which was followed by time spent in a "buddy" support system. For example, on the delivery suite this was three weeks followed by three weeks working with a buddy. Managers informed us this supernumerary time could be extended to ensure that individual midwives feel comfortable and competent to provide care independently.

However, staff we spoke with did not always have the confidence to meet the professional standards which was a condition of their ability to practice and requirement for their role. They raised concerns with the lack of effective buddy support they received during their preceptorship period. This was due to time restraints relating to the high acuity of women, and birthing people, and demands on the service.

We heard significant concerns from staff who felt they did not have the experience or the right skills and knowledge to meet the needs of women, birthing people, and babies. Staff reported that they had been asked to work on areas where they had not completed their full supernumery time periods. For example, one member of staff had worked a night shift after only working one day on the same unit as supernumery.

Staff reported they had been signed off for midwifery competency skills, but still did not feel confident or competent in skills such as wound suturing, reading CTG recordings and taking bloods. In addition, new born baby assessments, baby feeding, nasogastric tube feeding and completing observations. Staff felt they did not have appropriate breast feeding support skills to help women, and birthing people.

Some staff we spoke with felt they did not feel confident to work on different areas especially when they had to care for women, birthing people, and babies who had higher acuity and dependency. We heard other examples of where midwifery staff said they had lost confidence working on the Newcastle birthing centre and delivery suite or felt de-skilled for always caring for low risk deliveries.

During the inspection we raised this concern with senior leaders. They did not know staff were working on areas without being provided the full supernumery period. However, they were aware staff felt “different” when being asked to work in other areas such as the delivery suite when they were used to working on a smaller unit.

The service held staff training days in May and July 2023 which covered a wide range of topics such as cardiotocograph (CTG) workshops, blood gas analyser and medical devices. Training had been organised for band 5 midwives for peripheral IV medicines administration and peripheral IV cannulation workshop, blood gas analyser and blood ketone meter. Training had been organised for maternity support workers and healthcare assistants training for venupucture simulation, aseptic non-touch technique (ANTT), blood transfusion, sepsis, maternity early warning score (MEWS), and deterioration training. However, we were not sent attendance records for these courses.

Nursery nurses were supported with their training development needs which included a bespoke twelve-week programme to help them assist in their transition into their relocated roles.

All band 6 and 7 midwives had completed medicine management training which included peripheral intravenous (IV) workshops and patient group directive (PGD) training which were competency assessed. Half of the band 5 midwives had completed this training as part preceptorship programme.

At the last inspection in January 2023, we found managers did not always support staff to develop through yearly, constructive appraisals of their work. The service had an overall appraisal rate for midwifery staff was 58% and medical staff was 77%.

At this inspection, all staff we spoke with confirmed they had received an appraisal. The service had improved the overall appraisal rate for midwifery staff to 78%. However, this still did not meet the trust target of 95%. The appraisal rate for medical staff had decreased to 73%. We did not receive appraisal rates for managers. We reviewed the action plan following the last inspection and there was an ongoing monitoring plan to meet the trust target of 95% by March 2024.

Midwifery staff were supported by band 7 specialist midwife practice development lead and four band 6 practice support midwives. However, we were informed they had to work clinically due to staffing shortages at times of high acuity.

Medical staff had a competency booklet which was signed off by a senior registrar or consultant.

For further information on competent staff please see previous inspection report under Safe.

Maternity

Is the service caring?

Insufficient evidence to rate

Is the service responsive?

Insufficient evidence to rate

Access and flow

Women, and birthing people, could not always access the service when they needed it to receive the right care promptly. However patient safety was prioritised at all times.

At the time of our inspection the Newcastle birthing centre (NBC) had been put on divert which meant that women, and birthing people, who had planned to use this centre were asked to attend the delivery unit instead. The labour line was also transferred to the staff on the maternity assessment unit when the NBC was on divert.

From March to April 2023 there had been 5 occasions when women, and birthing people, had to be diverted from the NBC when it had been closed continuously for 32.5 hours. From April to June 2023 there had been 7 occasions when women, and birthing people, had been diverted from NBC.

The reasons for the closures was because the NBC midwifery staffing were needed to cover other areas to meet the operation pressures, acuity on the delivery suite or fill gaps in the staffing rotas. Managers completed quality impact assessments for women, and birthing people, affected by the closures and no risks had been identified.

We reviewed the maternity dashboard, but this did not show performance data such as 1 to 1 care in labour. From October 22 to March 23 there had been 9 occasions out of a possible 1092 episodes which equated to 0.8% when the service had been unable to provide continuous 1:1 care and support to women, and birthing people, in established labour.

The service did not ensure women, birthing people and babies received timely care and treatment. Staff provided multiple examples of delays within the maternity service.

- pain relief to women, and birthing people, following caesarean sections
- completing baby assessments such as taking temperature, jaundice, and blood glucose checks
- breastfeeding support. Some women, and birthing people felt pressurised to bottle feed.

We heard there were delays when women were being transferred to a different ward for example from the maternity assessment unit (MAU) to the delivery suite.

We reviewed one incident relating to delays on the National Reporting and Learning System (NRLS) between January and July 2023. One woman, birthing person had a 5 hour delay after delivery to go to theatre for repair of 3rd degree tear due to delivery suite and theatres being busy.

Maternity

Managers confirmed that delays within the maternity services had increased.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. There had been 89 reg flags from October 2022 to March 2023. The most common reg flag was for the delay between admission and the beginning of the IOL process. Staff reported delays of 12-14 hours for artificial rupture of the membranes (ARM).

We asked the service if they had completed any recent audits in relation to delays at each stage of the induction of labour. However, they did not share the results of the last audit completed in 2022 but said it would be reaudited in 2023.

Despite these delays senior leaders gave reassurance that prioritisation was clearly managed and based on clinical need and there was a staggered approach to admissions for IOL. Women were telephoned the evening before by a member of the delivery team to confirm the provisional time of admission. Every morning there was a multidisciplinary ward round on the delivery suite which assessed the planned inductions and current acuity. They would contact woman, and birthing people, if their admission times had changed. If their admission was deferred, they would arrange an inpatient review on the day the induction was planned.

We were informed there were delays with flow through the maternity services. This was significant

when both postnatal wards 32 and 33 were at full capacity. There were several reasons for the

delays in discharging women, birthing people, and babies home which included increased wait

times for medical assessment and discharge medication and delays with the new electronic record

system.

Staff provided examples when women, and birthing people, were discharged too soon or not soon

enough. We also heard that women, and birthing people, had been discharged out of hours.

We reviewed evidence from the National Reporting and Learning System (NRLS) for the incidents relating to readmission reported between January and July 2023. We found two examples when babies had to be readmitted which equated to 0.06% from a total of 3325 babies born between January and July 2023. One baby needed to be checked for newborn infant physical examination (NIPE) which was supposed to be done within 72 hours of birth and another baby had missed bilirubin checks and needed phototherapy.

For further information on access and flow please see previous inspection report under Safe.

Is the service well-led?

Requires Improvement 

Maternity

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

Leadership

Senior leaders were sighted on the priorities and issues the service faced. However, we were concerned that they were not effective in implementing immediate changes according to risk to improve safety. They were not always visible.

At this inspection staff told us senior leaders had not fully recognised the challenges and risks they faced on a day to day basis. They did not feel listened to especially with safety concerns around staffing and were “always played down” and told “just get on with it.”

Staff said they would appreciate a more visible presence and support from the senior leadership team especially during times of significant staff shortages. We heard examples of when managers were too busy and heard quotes from staff who said, “our senior management team simply don't care.”

Staff told us they were well supported by their line managers and ward managers.

We had concerns senior leaders had not taken immediate action to implement some changes in response to concerns identified at the previous inspection in January 2023.

When we spoke with senior leaders to understand the issues with medical staffing, they refused to answer our questions and told us to wait for the inspection data.

The service had created new midwifery leadership and specialist roles to meet with the recommendations of the Birthrate Plus review undertaken in October 2020. These roles have been implemented to enhance the quality of care provision aligned to the national strategic direction. For example, there was a consultant midwife for maternal medicine, and a lead midwives for pastoral support recruitment and retention, perinatal mental health, public health, and preterm births. In addition, a deputy matron role had been developed to support the matron for intrapartum care and also a Band 8a workforce lead to support the creation of the workforce strategy.

For further information on leadership, please see previous inspection report.

Vision and Strategy

Not all staff were aware of the vision and strategy of the service. However, the vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

At the last inspection in January 2023, we were told the new purpose built transitional care ward was due to open. At this inspection senior leaders told us the plans for this had been delayed and there was a new proposed opening date for Autumn 2023. However, staff we spoke with did not know any plans or timescales.

The service had a strategy in development which provided a five year forward view of the vision and key priorities for the Maternity Service. It was anticipated to be published in October 2023. It had been aligned with the three year delivery plan for maternity and neonatal services published by NHS England in March 2022 in response to the Ockenden (2022), Kirkup (2022) and previously Morecambe Bay (2015).

Maternity

The maternity service will focus on growing, retraining, and supporting the maternity workforce with a clear focus on following objectives;

Grow our workforce

- undertaking regular local workforce planning, understaffing to be filled by 2027/2028
- implementing local plan to fill vacancies
- provide admin support to free up pressured clinical time.

Value and retain our workforce

The three year plan wants staff to feel valued and fulfilled through sustainable career and to improve the experience of all staff to increase retention.

In order to value and train workforce

- identifying and addressing local retention issues and develop a retention improvement plan
- implementing equity and equality plan actions to reduce workforce inequalities
- creating an anti-racism workplace
- identifying and adddressing issues highlighed in student and medical trainee feedback
- offering preceptership programmes for all newly registered midwives and mentors to suport all newly appointed band 7 and 8 midwives
- developing future leaders via sucession planning that reflects the ethnic background of wide workforce

For further information on vision and strategy, please see previous inspection report.

Culture

Staff did not feel respected, supported, or valued. The service did not have an open culture where staff could raise patient safety concerns without fear. However, staff were focused on the needs of women, birthing people and babies receiving care.

At the last inspection in January 2023, staff did not feel respected, supported, or valued. Some staff had expressed dissatisfaction they had not been involved in changes to working practices and senior leaders had not communicated these effectively to them.

At this inspection we found similar concerns to January, but this was more widespread amongst staff who spoke with us. Prior to this inspection CQC had been contacted by six whistleblowers to share concerns about the culture in the service and leadership. Staff felt that the recently implemented transformation and changes to the continuity of care models had negatively impacted the service as a whole. They still felt that the transformation had not been handled well and they had received poor communication from senior leaders.

Staff did not understand the reasoning behind the deployment changes in the nursery nurse role and the future numbers of non-registered staff. We heard that the overtime for unfilled shifts had been reduced from double time.

Maternity

Staff felt extremely overworked and undervalued. We heard the following quotes from staff.

- Morale was “the worse it has ever been,” was “at an all-time low” and at “at rock bottom.”
- Staff were “worried about losing their registration over safety issues.”
- Staff “did not enjoy their work,” “had no job satisfaction” and “did not feel they had done a good job” or “provide full support to patients such as baby feeding”
- Staff “did not feel supported by senior managers of band 8 and above” and were told to “just get on with it”
- Staff “did not get time to have toilet or drink breaks” due to workload.
- Staff “felt stressed and anxious when asked to work on different areas at short or no notice when the Newcastle birthing centre (NBC) was closed.”
- Staff felt there was no support when facing complaints.

Although at the last inspection in January 2023 it was reported the service had an open culture where women, birthing people, families, and staff could raise concerns without fear of blame. However, staff we spoke to at this inspection did not feel confident in reporting staffing concerns and incidents. They felt they were not being listened to and we heard an example where staff had been told not to report staffing incidents.

Most staff we spoke with did not know about the role of the freedom to speak up guardian (FTSUG) which meant staff were not aware of available additional support.

At the last inspection in January 2023 staff informed us they often missed regular breaks due to staffing shortages and patient acuity and that this had impacted on their wellbeing. At this inspection we found similar concerns which meant this had not improved. We did observe one staff meeting where managers gave staff their allocated break times.

At the last inspection in January 2023 staff informed us they were proud to work in the service. However, the staff we spoke to at this inspection were not proud to work in the service.

It was evident during this inspection that midwifery and medical staff made every effort, under difficult circumstances, to meet the needs and care for women, birthing people, and babies.

Staff reported positive working relationships across all roles and grade within the multidisciplinary team and we saw positive relationships across multidisciplinary teams during our inspection.

At the last inspection it was reported that senior leaders demonstrated awareness of the impact of recent changes on staff morale. They had introduced a ‘What Matters to You’ programme and had recruited a recruitment and retention midwife to try and bridge the gap between staff on the wards and senior leadership. At this inspection senior leaders acknowledged that the transformation communication could have been better.

For further information on culture please see previous inspection report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

Maternity

Following the recent organisational restructure, the maternity services became part of the family health clinical board.

The service had a formalised governance framework and processes to support the safe and effective delivery of care.

The senior leadership team consisted of a director of operations, associate director of operations, clinical director who supported the head of obstetrics, director of midwifery and head of midwifery who supported the matrons.

We reviewed three clinical governance meeting minutes which were held monthly within the obstetrics governance group and chaired by the head of obstetrics. They had regular attendance by senior leaders. There was a standard agenda which covered quality, safety, and performance issues.

We saw examples of an effective governance structure for sharing maternity safety intelligence. We saw how quality, safety and performance issues could be escalated from front line staff to the risk and governance team via the quality and clinical effectiveness midwife and also directly to the director of quality and effectiveness.

We reviewed the minutes of the January 2023 trust quality committee meeting. We saw evidence of discussion around the identified areas of improvement following the maternity services inspection in January 2023. We also read the maternity services progress against Ockenden recommendations, and that partial compliance had been achieved for 4 out of 7 recommendations. The three outstanding recommendations included workforce planning and sustainability, developing staff conflict of opinion guidance and auditing change to practice as a result from serious incidents.

We reviewed the minutes of the March 2023 trust quality committee meeting. We saw evidence of agreement that the Director of Midwifery should be invited to future meetings to provide maternity updates to the Ockenden recommendations. At this meeting two recommendations remained non-compliant, three partially compliant and two fully compliant. We read discussions about assurance related to evidencing and auditing risk assessment throughout pregnancy using the new electronic system.

The two non-compliant recommendations related to the following:

- calculating a local uplift for midwifery staffing
- Implementing and monitoring change in practice because of a serious incident (SI)

The three partially compliant recommendations related to the following:

- Labour ward coordinators attending role specific maternity system endorsed training course
- Conflict of clinical opinion escalation guidance
- Newcastle birthing centre completion of yearly operational risk assessment

For further information on governance please see previous inspection report.

Management of risk, issues, and performance

Senior leaders did not always use systems to manage performance effectively. They did not always identify actions to reduce the impact of risks in a timely way.

We were not assured the service had an effective systems and processes to support safe quality care.

Maternity

We reviewed the action plan following the previous inspection in January 2023. The service were compliant with 5 out of the 10 listed actions, although these related to the continued issues we found at this inspection with regard to staffing, checking of emergency equipment and security. This meant the service had not immediately addressed some of the issues found at previous inspection and did not provide assurance these risks had been mitigated in the short term.

At this inspection we found no improvement with staffing numbers as they did not always match the planned numbers. The service was 3.8% below the recommended birth rate plus establishment. Most of the staff we spoke with had significant patient safety concerns and felt they were unable to deliver fundamental standards of good care to women, birthing people, and babies to keep them safe.

Senior leaders acknowledged the increased demand in acuity and complexity of women, and birthing people, attending the service and that this had increased regionally and nationally. They were unable to provide assurance that the birth rate plus which was last reviewed in October 2020 was accurate and reflected the current acuity and complexity of women, and birthing people, using the service. Staff we spoke with felt that planned staff numbers and skill mix had not reflected high acuity areas especially on postnatal wards.

This meant that the service were using a birth rate plus tool which had been completed before the service formally became the maternal medicine centre and was not an accurate reflection based on the levels of acuity and complexity.

Senior leaders reported they were doing work to clarify a more accurate picture on the impact the increased activity and acuity of women, and birthing people, attending the MNC had on the service. They said the national maternity safe staffing tool was being reviewed following the recommendations of Ockenden 2022. Therefore, they had not yet made plans to repeat the formal review of this tool within the three year time frame in line with national guidance. They were going to wait for nine months' worth of electronic data before repeating this review.

Senior leaders were waiting until they had nine months' worth of electronic data to analyse before repeating the birth rate plus assessment. They said they wanted to clarify the impact of staffing issues on the delivery of care and treatment on the wards.

We reviewed the nursing and midwifery staffing report to trust board which included the results of the six month review of staffing for Q3 and Q4 2022/23 and quarterly safe staffing assurance report. This report acknowledges the staffing situation remained challenging due to increased patient acuity and dependency and also with balancing the emergency and elective capacity.

The service's staffing escalation level remained at level two due to significant shortfall in planned staffing and also regular reporting of red flag risks relating to staffing. They had mitigated the risks of staffing, skill mix, staffing competencies and high acuity and activity with regular closures of the Newcastle Birthing Centre (NBC) and the internal redeployment of staff.

Senior leaders told us they had mitigated low staffing levels with the recruitment of newly qualified midwives in September 2023 which would take them 4.6% over the established budget. Funding had also recently been approved for an additional permanent midwives. The trust held a careers open day in March 2023 and had a further one was planned for May 2023.

The service did not always assess, monitor, and improve the quality and safety of the services or mitigate the risks relating to the health, safety and welfare of women, birthing people, and babies.

Maternity

At this inspection we found no improvement with regards to

- compliance of mandatory and core competency training
- environment and equipment
- assessing and responding to patient risk
- daily safety checks of specialist equipment.
- access and flow
- patient care records
- safe storage and management of medicines
- incident reporting

This meant there were significant repeated concerns and breaches of regulation.

One of the recommendations from the Ockendon report was to uplift the staff to additional training requirements. Senior leaders were going to review the core competency requirements and revise the training needs analysis. However there had been an unavoidable delay to this work and an update would be made to the trust board in July 2023.

The service did not seek and act on feedback from staff for the purposes of continually evaluating and improving the maternity services. We heard from staff that they did not feel listened to.

From January to June 2023 the service had received only two complaints. These related to behaviours from staff and post treatment complications.

Senior leaders said they triangulated themes from incidents, complaints, and other sources. The most common concerns raised were attitudes of staff and delays to treatment. They were aware patients had reported not being supported with feeding their babies or that midwives didn't visit as expected. They said more oversight work was needed.

We requested the local maternity dashboard. This did not show comparisons with the regional, national, or similar size services. The only internal RAG rated performance metrics were for blood loss 1500ml to 2000ml and over 2000ml. It does not show the average of midwife to birth ratio or when 1:1 care was given when women, and birthing people, were in labour.

However, we were not sent the quarterly maternity dashboard which was referenced in the last inspection report from January 2023 which did show their performance within the region and allowed managers to benchmark and compare performance with others.

We reviewed the mortality review of paediatric deaths which had occurred in Q2. Two of the modifiable factors related to;

- Lack of antenatal steroid prior to delivery, temperature on admission
- Maternal substance abuse, smoking, and alcohol, lack of antenatal care.

Maternity

We reviewed the mortality review of paediatric deaths which had occurred in Q3. Seven of the modifiable factors related to;

- lack of antenatal steroid prior to delivery/High temperature on admission
- maternal smoking/high BMI at booking
- high maternal BMI
- smoking during pregnancy and polypharmacy
- type 2 diabetes
- maternal smoking
- have fully suspended continuity of carer to enhance staffing numbers in unit

Some of these relate to the lack of antenatal care and confirms the evidence found with regard to lack of complete risk assessments.

We reviewed the maternity dashboard and did not have assurance on how well the service

responded to sepsis concerns with staff compliant with taking action within one hour.

- In March 2023 sepsis was found in 1.73% of 463 deliveries and staff were 75% compliant
- In April 2023 sepsis was found in 0.66% of 458 deliveries and staff were 66% compliance
- In May 2023 sepsis was found in 1% of 497 deliveries and staff were 40% compliance.
- From January to June 2023 the maternity dashboard showed 5% post-natal maternal readmissions to the unit.

For further information on management of risk, issues and performance please see previous inspection report.

Information Management

The service did not always have reliable information systems to collect data for analysis. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

At this inspection we had significant concerns regarding the oversight of the information management systems.

Staff could not easily access or effectively record care and treatment information using the new electronic patient record systems.

Staff had to complete a duplicate entry of records of care and treatment on two electronic platforms: the new electronic computer record and e-obs. These two systems were not integrated.

Staff who worked across multiple areas had not received effective training for the new electronic system to enable them to record the care and treatment for women, and birthing people, as the information required was different in each area.

Staff reported they did not have enough ongoing support for the new electronic system. Some staff we spoke with told us the digital support staff had stopped their 'floor walks' on wards offering help and support to staff.

We saw evidence from audits that staff did not know where to correctly record bladder care management.

We reviewed the triage form used on the maternity assessment unit (MAU). This did not allow enough space on the form for staff to record all the attempted requests for medical reviews.

We reviewed the new electronic whiteboards which showed electronic observations information for all women, birthing people, and babies. On every ward visited we noted that there were at least two electronic observations which had expired and saw women, and birthing people, had been waiting over their allocated time for observations to be completed. When we escalated this to staff, they said they did not use the whiteboard information because the parameters for the frequency of observations had not been set up correctly on each ward area. This meant that the information being displayed was incorrect. Staff were able to demonstrate the outstanding observations had been completed in a timely manner.

The service had been unable to count the women, and birthing people, who were referred into the MMC from the Newcastle area from September 2021 to April 2023 due to a technical fault. This meant the service was unable to accurately record the acuity and complexity of these women, and birthing people, being referred and therefore unable to measure the impact of this on the current staffing situation. There had been no further update to this issue when we reviewed the most recent maternity board paper.

We were informed there were two midwives, one of whom was a digital specialist, who had led on the project planning, implementation, and subsequent support of the new electronic patient record.

Staff showed us how they could use the new electronic patient records for reviewing care records for women, and birthing people, who lived out of the area. This was especially relevant when there were safeguarding concerns. They could also print out leaflets and other information in different languages.

The community team had access to the sharing of information between the hospital and community with GP's and other health professionals.

Staff could easily access the electronic patient record systems and care records. Women, and birthing people, had access to their own maternity records and personalised care plan using a telephone application.

We heard of future implementations relating to patient records on the new electronic patient record. For example, staff will have the opportunity to use a standardised referral tool for mental health and wellbeing to support with routine mental health questioning at every appointment and will include a new new patient information leaflet regarding mental health and contact details for support.

For further information on information management, please see previous inspection report.

Engagement

Senior leaders engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, senior leaders were not always effective in their communication or engagement with staff.

Staff we spoke with did not know the reasons for the delay in opening the transitional ward or the pause for the continuity of care model.

We heard that staff would sometimes turn up to work on the Newcastle birthing centre only to discover it had been closed. They had received no prior information about this from managers.

Senior leaders we spoke with acknowledged the impact of system wide issues such as recruitment, retention, sickness, and shift fill on staff experience. They were aware there still remained a disconnect between themselves and staff. They acknowledged staff felt unsupported because of staffing issues especially those staff who were being asked to work on different areas.

We heard that senior leaders did transformation work consultations to provide opportunities to engage with staff and receive feedback on the proposal. Ward managers had completed more than 200 individual 1:1 meetings with staff.

As part of the transformation work, they introduced a flexible working model so that midwives could choose to work permanently within one area or worked rotationally across the service including community. However, some staff we spoke with felt that they were not given enough information about these roles before making their choice.

Staff engagement was a high priority and part of the strategic ambition for 2023. The service arranged for engagement in the form of 'trolley dashes' with treats for staff throughout March-May 2023 to enable staff to feedback on issues of importance and receive information from the leadership team.

There was a culture, communication, and leadership workstream for the maternity improvement plan. This was a multidisciplinary monthly meeting. Members included medical and midwifery staff and organisational development and improvement learning team, human resources.

The service offered pastoral support for staff in various ways. There was a pastoral support lead midwife and a team of professional midwifery advocates (PMA). Staff had access to an inhouse psychologist for further support.

There was a monthly board level safety champion walkabouts by the director for quality and clinical effectiveness, non-executive director, and matron to provide an opportunity for staff to speak with them.

Senior managers planned to undertake a series of talking heads 'who's who' programmes in 2023 through development of an interactive web page. They plan "breaking down the boundaries with bacon baps and brownies" which was an initiative to have open and transparent discussions with staff.

The service had been involved in an improvement project aligned to the 'What matters to you framework.' This had been created to improve staff engagement, cohesive team working and safety huddles.

For further information on engagement please see previous inspection report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

For further information on learning, continuous improvement, and innovation, please see previous inspection report.